FAIR WORK COMMISSION

AM2020/99; AM2021/63; AM2021/65

WORK VALUE CASE – AGED CARE INDUSTRY

SUBMISSION ON WAGE ADJUSTMENT ISSUES

AGED & COMMUNITY CARE PROVIDERS ASSOCIATION LTD

AUSTRALIAN BUSINESS INDUSTRIAL

("THE JOINT EMPLOYERS")

1 NOVEMBER 2023

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PROCEDURAL BACKGROUND

1. On 2 August 2023, the Fair Work Commission (**the Commission**) published a revised *"Stage 3 issues summary"* (**Summary Document**) and President Hatcher gave directions for the programming of Stage 3 (**the Directions**).

2. The Summary Document contains two categories of issues:

   (a) *"classifications and allowance issues"* (Issues 1-16); and

   (b) *"wage and adjustment issues"* (Issues 17-18).

3. The Directions included the following:

> *2. The applicants and other interested union parties shall file evidence in chief and submissions in relation to the wage adjustment issues by* ***5:00 pm (AEST) on Friday, 15 September 2023****.*
>
> *3. Interested employer parties shall file evidence and submissions in response in relation to the wage adjustment issues by* ***5:00 pm (AEST) on Friday, 27 October 2023.***
>
> *…*
>
> *10. Any party which has filed a draft determination pursuant to item 8 of these directions shall file evidence and submissions in support of its draft determination, as well as any other evidence in chief and submissions concerning the classifications and allowance issues, by* ***5:00 pm (AEST) on Friday, 27 October 2023****."*

4. On 12 September 2023, the Health Services Union (**HSU**) sought a 1-week extension to comply with paragraphs 2, 8 and 9 of the Directions. This application was granted to the HSU on 12 September 2023.

5. On 15 September 2023, the following material was filed pursuant to paragraph 2 of the Directions:

   (a) Submissions by the United Workers Union (**UWU**) (**UWU Submissions**), together with 14 witness statements; and

   (b) Submissions by the Australian Nursing and Midwifery Federation (**ANMF**) (**ANMF Submissions**), together with 6 witness statement and the report of Associate Professor Noleen Bennett dated September 2023.

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6. Addressing evidence filed in Stage 1, the UWU confirmed it continues to rely on the evidence previously filed.[1] The ANMF submitted that it continues to rely on the evidenced filed in Stage 1 as identified in the ANMF Submissions.[2]

7. On 22 September 2023, the HSU filed submissions in relation to paragraph 2 of the Directions pursuant to extension granted (**HSU Submissions**), together with 13 statements.

8. On 12 October 2023, the Joint Employers sought a 1-week extension to comply with paragraphs 3 and 10 of the Directions. The ANMF submitted that the length of the extension sought is *"likely to cause prejudice"* to the applicants and other interested union parties. No other party sought to be heard, save for the UWU noting it did not object to the Joint Employers' application.

9. On 13 October 2023, President Hatcher granted the Joint Employers an extension to Wednesday, 1 November 2023 to comply with paragraphs 3 and 10 of the Directions (**the Amended Directions**).

[1] UWU Submissions at [2].
[2] ANMF Submissions at [3(1)].

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WAGE ADJUSTMENT ISSUES: SUBMISSION AND EVIDENCE

10. Pursuant to the Directions, the Joint Employers file this submission, together with the following:

    (a) Witness Statement of Johannes Brockhaus, Chief Executive Officer (**CEO**) at Buckland Aged Care Services (**Buckland**) dated 31 October 2023, together with annexures JB-1 to JB-4;

    (b) Witness Statement of Louanne Riboldi, Chief of Operations at Royal Freemans' Benevolent Institution (**RFBI**) dated 1 November 2023, together with annexures LR-1 to LR-4;

    (c) Witness Statement of Stuart Hutcheon, Partner at StewartBrown, dated 31 October 2023, together with annexures SH-1 to SH-3; and

    (d) Witness Statement of Chris Mamarelis, CEO at Whiddon dated 1 November 2023, together with annexures CM-1 to CM-4.

11. The Joint Employers continue to rely upon the evidence filed in Stages 1 and 2. The following statements are highlighted as having particular application to the wage adjustment issues:

    (a) Witness Statement of Kim Bradshaw dated 4 March 2022 at [22];

    (b) Witness Statement of Johannes Brockhaus dated 3 March 2022 at [14]. [19], [111]-[143], Annexure JB-01;

    (c) Witness Statement of Emma Brown dated 2 March 2022 at [66]-[68], [78]-[79], Annexure EB-12;

    (d) Witness Statement of Paul Sadler dated 1 March 2022 at [90]-[91];

    (e) Witness Statement of Mark Sewell dated 3 March 2022 at [109]-[111]; and

    (f) Witness Statement of Cheyne Woolsey dated 4 March 2022 at [69]-[74].

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SUMMARY OF POSITION

Structure

12. The Joint Employers' submissions address the following matters in relation to wage adjustment issues:

    (a) Part I: Indirect care employees;

    (b) Part II: Impact of the pandemic;

    (c) Part III: Work intensification and staffing levels;

    (d) Part IV: Sections 157(2)(b), 134(1)(g) and 284(1)(d); and

    (e) Part V: Sections 157(2)(b) & 134(1)(f): financial stability.

Industry support for increasing funded wages

13. The aged care industry has advocated with government for an extended period to secure additional funding for increased wages for its workforce to assist in promoting attraction and retention of quality vocational and professional staff.

14. The industry as a whole strongly supports these efforts to lift wages in the industry and ACCPA has led this advocacy. The funded interim wage increase for direct care workers was universally welcomed by the industry.

15. There is early, anecdotal evidence that the interim wage increase for direct care workers is assisting the industry to attract and retain direct care staff and improving the morale of the sector after an extremely challenging period of time. There remains significant stress at the registered nurse level which is being driven by a real supply side challenge. We note that since the commencement of this matter we have advocated for an increase of 34% for registered nurses for reasons set out in Stage 1.

16. There is also anecdotal evidence that the lack of an increase in wages for indirect care staff has impacted on recruitment and retention of those staff and impacted cultural harmony within employer organisations. Therefore, any increase to those workers on work value grounds would also be welcomed by the industry.

17. This matter involves a consideration of work value reasons examining minimum award wages and should the Commission determine that work value reasons exist to increase minimum award wages further for direct care workers or for indirect care workers we submit that:

    (a) any such changes to minimum wages must be fully funded and aligned to funding; and

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(b) for cultural harmony reasons within aged care facilities, should an increase apply to indirect care workers it would be more desirable for that increase to be uniform across such workers.

Observations

18. By way of overview, these submissions seek to present a balanced and objective position to assist the Commission in its deliberations.

19. The following contentions are made, which will be supported by these submissions and the evidence advanced by the Joint Employers in Stage 3:

Part I: Indirect care employees

(a) The safety and experience of the resident is the priority for all residential aged care providers. [3]

(b) The aged care provider is responsible for ensuring any relevant training and information is provided to their management and staff. This includes a combination of induction training, mandatory training and on-the-job training, which is informed by the established procedures and practices of the aged care provider and any applicable law and regulation (e.g. work health and safety law, aged care quality standards, etc). [4]

(c) The aged care provider is responsible for keeping abreast of the changes and developments within the aged care sector and ensuring the training and information provided to their staff has regard to the latest advice from Federal and State Government bodies and agencies (example, Department of Health and Aged Care, NSW Ministry of Health, [5] etc). [6]

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[3] See generally, Witness Statement of Johannes Brockhaus dated 31 October 2023, Witness Statement of Chris Mamarelis dated 1 November 2023; Witness Statement of Louanne Riboldi dated 31 October 2023.

[4] See generally, Witness Statement of Johannes Brockhaus dated October 2023 at [8]-[28], Witness Statement of Chris Mamarelis dated 1 November 2023 at [22]-[29]; Witness Statement of Louanne Riboldi dated 31 October 2023 at [13]-[29]. See also *Quality of Care Principles 2014*, Schedule 2 (**ACQS**).

[5] See example, NSW Ministry of Health, *"Management of acute respiratory infections (including COVID-19, influenza, and respiratory syncytial virus)"* (Last updated 5 September 2023) <https://www.health.nsw.gov.au/Infectious/covid-19/Pages/racf-latest-advice.aspx> (**NSW Guidelines**); Department of Health and Aged Care, *"Prevention, Control and Public Health Management of Outbreaks of Acute Respiratory Infection (including COVID-19 and Influenza) in Residential Care Facilities"* (published 30 September 2022, last updated 6 October 2022) <https://www.health.gov.au/resources/publications/national-guidelines-for-the-prevention-control-and-public-health-management-of-outbreaks-of-acute-respiratory-infection-including-covid-19-and-influenza-in-residential-care-facilities> (**National Guidelines**).

[6] See also *Australian Liquor, Hospitality and Miscellaneous Workers Union re Child Care Industry (Australian Capital Territory) Award 1998 and Children's Services (Victoria) Award 1998 – re Wages rates* PR954938 [2005] AIRC 28 (**ACT Child Care Decision**) at [190], cited in the *Stage 1 Decision* [2022] FWCFB 200 (***Stage 1 Decision***) at [194]. Whilst noting the caution highlighted by the Full Bench in the *Stage 1 Decision* with respect to freely adopting the observations at [190] in the *ACT Child Care Decision*, the observations made with respect to training are highlighted.

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(d) All workers complete mandatory training each year, which includes modules addressing the Aged Care Quality Standards (**ACQS**) and infection prevention and control (**IPC**). The modules are often delivered *"online"*. They take between 30-90 minutes to complete, with most modules requiring satisfactory completion of a short quiz, based on the content covered during the online module. No prior study is required. The training is generally performed during work hours.[7]

(e) The increased availability of technology has impacted the way some work is performed by indirect care workers as has already been identified by the Commission.[8]

(f) Indirect care workers are in a position to make passing observations of residents throughout the performance of their work.[9] All staff are instructed to communicate any concerns about resident welfare to the registered nurse (**RN**) or care team leader.[10]

(g) Indirect care workers may observe and/or have interactions with residents that have varying degrees of dementia or other forms of memory loss. Indirect care workers are increasingly called upon to:

(i) be conscious of the increasing prevalence of residents with dementia in the residential aged care settings in which they work;

(ii) possess a basic understanding that residents with dementia may communicate and behave differently to residents without dementia; and

(iii) exit the room and contact the RN/care team if the worker ever feels unsafe in the presence of a resident or residents.[11]

(h) Direct care workers, due to the nature of their role and responsibilities, have a higher frequency of interactions with residents that have varying degrees of dementia. These interactions are also longer in duration and require direct care workers to exercise

[7] See Witness Statement of Pamela Little dated 30 March 2021 [21]-[23]; Witness Statement of Kevin Mills dated 30 March 2021 [10]; Statement of Jane Wahl dated 21 April 2022 [22]; Witness Statement of Ross Heyan dated 31 March 2021 [8]. See Witness Statement of Johannes Brockhaus dated October 2023 at [16]-[22], Witness Statement of Chris Mamarelis dated 1 November 2023 at [26]; Witness Statement of Louanne Riboldi dated 31 October 2023 at [13].

[8] See example, Witness Statement of Fiona Gauci dated 29 March 2021 [47]-[48]; See also Report to Full Bench (Commissioner O'Neill, 20 June 2022) at [578], [580]; Witness Statement of Kathy Sweeney dated 14 April 2022 [50]-[51]; Witness Statement of Lynette Flegg dated 14 April 2022 [27],[30]; Witness Statement of Pamela Little dated 30 March 2021 [25]; Witness Statement of Sandra Joy O'Donnell dated 13 April 2022 [61]-[62].

[9] Witness Statement of Johannes Brockhaus dated October 2023 at [29]-[33], Witness Statement of Chris Mamarelis dated 1 November 2023 at [40]-[44] and Witness Statement of Louanne Riboldi dated 31 October 2023 at [33]-[37]. Cf Report to Full Bench (Commissioner O'Neill, 20 June 2022) at [393]-[400].

[10] Witness Statement of Johannes Brockhaus dated October 2023 at [34]-[37], Witness Statement of Chris Mamarelis dated 1 November 2023 at [56]-[59]; Witness Statement of Louanne Riboldi dated 31 October 2023 at [38]-[40].

[11] See Witness Statement of Louanne Riboldi dated 31 October 2023 at [24]-[29]; Witness Statement of Pamela Little dated 30 March 2021 [21]-[23]; Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [24]; Statement of Jane Wahl dated 21 April 2022 [37]; Witness Statement of Mark Castieau dated 29 March 2021 [90], [92].

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developed competences in order to identify, prevent and de-escalate challenging behaviour.[12]

(i) The prevalence of residents with dementia is increasingly recognised as a part of the workplace for indirect care workers, with most if not all providers including a dementia module within their mandatory training for all staff.[13]

(j) All employees experience interactions with the families and friends of residents (to varying degrees).[14] There are established protocols that all staff follow in relation to feedback and complaints, which is reinforced via mandatory training. If the matter falls within the indirect care worker's scope of responsibility, they may address that matter. For example, a maintenance employee can attend to a request from a family member to re-hang a painting that has fallen in their mother's room. Complaints are handled in a structured manner and are promptly communicated to someone with the required level of authority (e.g. a manager, supervisor or RN) so that the complaint can be actioned in accordance with the facility's complaints procedures.[15]

(k) Interactions include greeting residents and engaging in conversations in a polite and friendly manner. The profile of the residents in terms of their needs has changed over time. To the level of their responsibility and competency and the scope of their roles, indirect care workers are to cater and attend to the preferences of residents.[16] For example, if a resident prefers that their clothes be ironed in a particular way, the laundry employee will cater to that request.

(l) The findings of the Full Bench in the *Stage 1 Decision* recognised the change in resident demographic, together with increased prevalence of dementia, as a permanent feature of the work environment. Indirect care workers operate within the same environment which has introduced a requirement for such workers to learn to perform their work in this changed environment.

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[12] See example, Witness statement of Antoinette Schmidt, 30 March 2021, at [44]-[83]; Witness Statement of Geromina Bowers, 1 April 2021 at [30].

[13] See Witness Statement of Louanne Riboldi dated 31 October 2023 at [24]-[29]; Witness Statement of Pamela Little dated 30 March 2021 [21]-[23]; Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [24]; Statement of Jane Wahl dated 21 April 2022 [37]; Witness Statement of Mark Castieau dated 29 March 2021 [90], [92].

[14] See example, Transcript, 5 May 2022, PN6848-PN6851 (Charlene Glass, Administrative Assistant);

[15] Transcript, 5 May 2022, PN6846-PN6847 (Charlene Glass, Administrative Assistant);

[16] Witness Statement of Louanne Riboldi dated 31 October 2023 at [41]-[48]; Witness Statement of Johannes Brockhaus dated October 2023 at [38]-[42], Witness Statement of Chris Mamarelis dated 1 November 2023 at [45]-[55].

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Part II: Impact of the pandemic

(m) COVID-19 remains a permanent risk to be managed by residential aged care facilities, together with seasonal influenza.[17] Both respiratory viruses can result in serious respiratory illness and, in severe cases, death.

(n) While the pandemic has abated there remains an ambient shift in the awareness of infection control and hygiene across the industry which is typified by the increased emphasis and adherence to many hygiene practices including hand washing and use of sanitisers etc.[18] The lessons learnt from the pandemic continue to benefit residents in this post-pandemic period.

(o) Facilities operate with IPC and outbreak management plans to minimise the risk of infection to residents, and these now encompass procedures for SARS-CoV-2.[19]

(p) SARS-CoV-2 resulted in a dramatic intensification of work practices during the pandemic. The primary basis for that intensification was due to COVID-19 being a *"new"* infection. Everyone working in aged care from the personal care worker through to the CEO was impacted by the requirement to adapt to the rapidly changing situation as evidence-based knowledge and advice became available. The intensification was compounded by mandatory requirements in relation to lockdowns (in facilities and in the community), PCR testing and vaccinations. This intensification of the work was in the context of a declared pandemic.[20]

(q) The discovery of a new virus introduced a period of necessary research, study and education for the industry – as evidence and knowledge about SARS-CoV-2 was collated. With that knowledge barrier having been bridged, COVID-19 is now grouped together with management of other acute respiratory infections and viruses.[21]

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[17] See Witness Statement of Johannes Brockhaus dated October 2023 at [55]-[60], Witness Statement of Chris Mamarelis dated 1 November 2023 at [74]-[76] and Witness Statement of Louanne Riboldi dated 31 October 2023 at [67]-[72].

[18] See Witness Statement of Johannes Brockhaus dated October 2023 at [55]-[60], Witness Statement of Chris Mamarelis dated 1 November 2023 at [74]-[76] and Witness Statement of Louanne Riboldi dated 31 October 2023 at [67]-[72].

[19] See Witness Statement of Johannes Brockhaus dated October 2023 at [49]-[52], [55]-[60], Witness Statement of Chris Mamarelis dated 1 November 2023 at [65]-[69], [74]-[76] and Witness Statement of Louanne Riboldi dated 31 October 2023 at [55]-[60], [67]-[72].

[20] See Witness Statement of Johannes Brockhaus dated October 2023 at [53]-[54], Witness Statement of Chris Mamarelis dated 1 November 2023 at [70]-[73]; Witness Statement of Louanne Riboldi dated 31 October 2023 at [61]-[66].

[21] See NSW Ministry of Health, *"Management of acute respiratory infections (including COVID-19, influenza, and respiratory syncytial virus)"* (Last updated 5 September 2023) <https://www.health.nsw.gov.au/Infectious/covid-19/Pages/racf-latest-advice.aspx> (**NSW Guidelines**); Department of Health and Aged Care, *"Prevention, Control and Public Health Management of Outbreaks of Acute Respiratory Infection (including COVID-19 and Influenza) in Residential Care Facilities"* (published 30 September 2022, last updated 6 October 2022) <https://www.health.gov.au/resources/publications/national-guidelines-for-the-prevention-control-and-public-health-management-of-outbreaks-of-acute-respiratory-infection-including-covid-19-and-influenza-in-residential-care-facilities> (**National Guidelines**).

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(r) The introduction of the *"IPC Lead"* is an ongoing material change in all facilities.[22]

(s) As at 2023, the conditions under which work is done in aged care settings no longer features the level of work intensification that existed in 'peak pandemic', however, as stated above facilities now operate with a greater focus on infection control and hygiene practices evolving from the pandemic experience.[23] The lessons learnt during the pandemic are giving benefit to the evolution of these practices and procedures in facilities as they operation post the pandemic.

(t) At an administrative level the aged care industry has worked to streamline its IPC and outbreak management processes in relation to acute respiratory infections (including COVID-19 and influenza) post pandemic.[24]

Part III: Work intensification and staffing levels

(u) Work intensification is a complex issue that requires a cautious approach. This is because work intensification can be a temporary occurrence that abates with an increase in staffing levels.[25]

(v) *"Staffing shortages"* and *"staffing levels"* are not a feature of the work relevant to the assessment of work value reasons. They are, however, important considerations to be borne in mind when assessing the permanency of any suggested work intensification.[26]

(w) Staffing shortages introduce differing outcomes. At a macro level staffing shortages have driven reductions in capacity within the sector.[27] At a micro level staffing shortages have resulted in:

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[22] See Witness Statement of Johannes Brockhaus dated October 2023 at [59]-[60], Witness Statement of Chris Mamarelis dated 1 November 2023 at [70]; Witness Statement of Louanne Riboldi dated 31 October 2023 at [64]; Department of Health and Aged Care, "Infection Prevention and Control Leads" (Webpage, Last updated 23 October 2023) <https://www.health.gov.au/our-work/infection-prevention-and-control-leads#training-requirements>; Aged Care Quality and Safety Commission, "Infection Prevention and Control Leads: updated for providers" (Fact Sheet) <https://www.agedcarequality.gov.au/sites/default/files/media/final_a4_ipc_fact_sheet.pdf>.

[23] See Witness Statement of Johannes Brockhaus dated October 2023 at [55]-[60], Witness Statement of Chris Mamarelis dated 1 November 2023 at [74]-[76] and Witness Statement of Louanne Riboldi dated 31 October 2023 at [67]-[72].

[24] See example, Witness Statement of Louanne Riboldi dated 31 October 2023 at [67]-[68], Annexure LR-4. See also See NSW Ministry of Health, *"Management of acute respiratory infections (including COVID-19, influenza, and respiratory syncytial virus)"* (Last updated 5 September 2023) <https://www.health.nsw.gov.au/Infectious/covid-19/Pages/racf-latest-advice.aspx> (**NSW Guidelines**); Department of Health and Aged Care, *"Prevention, Control and Public Health Management of Outbreaks of Acute Respiratory Infection (including COVID-19 and Influenza) in Residential Care Facilities"* (published 30 September 2022, last updated 6 October 2022) <https://www.health.gov.au/resources/publications/national-guidelines-for-the-prevention-control-and-public-health-management-of-outbreaks-of-acute-respiratory-infection-including-covid-19-and-influenza-in-residential-care-facilities> (**National Guidelines**).

[25] *Stage 1 Decision* [2022] FWCFB 200 at [220].

[26] *Stage 1 Decision* [2022] FWCFB 200 at [220].

[27] Witness Statement of Stuart Hutcheon 1 November 2023, Expert Report at [3.5] (**Expert Report**).

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(A) an increased reliance on agency staff;[28]

(B) ad hoc reorganisation of activity on shifts; and

(C) increased use of external services such as the hospital system.[29]

Part IV: Sections 157(2)(b), 134(1)(g) and 284(1)(d)

(x) We rely on previous submissions as set out in the body of this submission.

Part V: Sections 157(2)(b) & 134(1)(f): financial stability

(y) The economic conditions of the aged care sector is more parlous than when the Commission made the interim decision in Stage 1. The capacity of the industry to sustain any wage increases without immediate and direct funding from the Commonwealth is even more challenging than was the case when the interim decision was given in November 2022.[30]

(z) It is essential that any further adjustments to modern award minimum wages determined by the Commission are pre-conditionally aligned to full funding and the timing of its commencement.[31] If the Commonwealth are not in a position to do that, the Commission should be guided by any proposal the Commonwealth make in regard to funding and the operative date or dates.

[28] See Witness Statement of Johannes Brockhaus dated October 2023 at [61]-[66]; Witness Statement of Chris Mamarelis dated 1 November 2023 at [78]-[86]; Witness Statement of Louanne Riboldi dated 31 October 2023 at [73]-[83].

[29] See generally Witness Statement of Johannes Brockhaus dated October 2023 at [61]-[66]; Witness Statement of Chris Mamarelis dated 1 November 2023 at [78]-[86]; Witness Statement of Louanne Riboldi dated 31 October 2023 at [73]-[83].

[30] See Witness Statement of Stuart Hutcheon 1 November 2023, Annexure SH-3.

[31] See Witness Statement of Stuart Hutcheon 1 November 2023, Annexure SH-3.

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PART I – INDIRECT CARE WORKERS

Introduction

20. As observed in the *Stage 1 Decision,* it is common ground between the parties that in order to vary modern award minimum wages the Commission must be satisfied that the variation is:

    (a) justified by work value reasons;

    (b) necessary to achieve the modern awards objective (and minimum wages objective); and

    (c) that the Commission must take into account the rate of the national minimum wage as currently set in a national minimum wage order.[32]

21. The *Stage 1 Decision* has already made findings concerning the evidence concerning indirect care workers.[33]

22. The Joint Employers made observations on the evidence in Stage 1 set out in Closing Submissions filed 22 July 2022 (**Closing Submissions**).[34]

23. The *Stage 1 Decision* made clear that *"work value reasons"* is a defined term and that its meaning should focus on the text in s 157(2A) of the *Fair Work Act 2009* (Cth).

24. Section 157(2A) provides that *"work value reasons"* are reasons justifying the amount that an employee should be paid for doing a particular kind of work, beings reasons related to any of the following:

    (a) the nature of the work;

    (b) the level of skill or responsibility involved in doing the work; and

    (c) the conditions under which the work is done.[35]

25. The Full Bench also confirmed that matters such as social utility, attraction and retention do not fall within that definition.[36]

26. These submissions primarily respond to matters arising from the submissions and evidence filed by the HSU and UWU,[37] with a view to assisting the Commission to identify and assess the degree to which work value reasons may exist and justify an increase in minimum award rates

[32] *Stage 1 Decision* [2022] FWCFB 200 at [867].
[33] *Stage 1 Decision* [2022] FWCFB 200 at [900].
[34] Joint Employer Closing Submissions dated 22 July 2022 (**Closing Submissions**) at [11.3]-[17.4].
[35] *Fair Work Act 2009* (Cth) s 157(2A).
[36] *Stage 1 Decision* [2022] FWCFB 200 at [228], [269].
[37] Noting the ANMF did not file evidence or submissions in respect of this issue.

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for workers falling within the *"aged care employee—general"* classifications in the *Aged Care Award* (referred to in Stage 3 as *"indirect care workers"*).

Response to HSU and UWU Submissions

27. With a view to minimising repetition, these submissions do not address every submission advanced by the HSU or UWU[38], but focus on matters considered pertinent to assisting the Commission in assessing any work value reasons.

28. Broadly, there are five themes in the submissions advanced by the HSU and UWU, namely:

    (a) the work performed by indirect care workers has increased in *"complexity"* due to the requirement to complete and apply mandatory training in Aged Care Quality Standards (**ACQS**) and infection prevention and control (**IPC**), as well as the requirement to use technology (e.g. iPads) (**Theme 1**);

    (b) indirect care workers are consistently placed in a position of *"first responder"* or are otherwise the first to witness incidents within a facility (e.g. a resident fall or observe signs of unwellness in a resident) and in some instances provide clinical care (**Theme 2**);

    (c) indirect care workers interact with residents that *"display complex care needs"* (e.g. dementia), which contributes to psychological and physical risks in the work environment and requires indirect care workers to have knowledge of *"de-escalation"* skills (**Theme 3**);

    (d) indirect care workers are required to interact with families: engaging in conversations, receiving feedback and responding to complaints (**Theme 4**); and

    (e) indirect care workers are required to interact with residents on a regular basis: engaging in conversations and responding to preferences (consistent with the increased focus on person-centre care under the ACQS) (**Theme 5**).

29. In summary the Joint Employers do not cavil with these themes but make the following observations:

    (a) Indirect care workers do complete training in Aged Care Quality Standards (**ACQS**) and may undertake training in infection prevention and control (**IPC**) and utilise modern technologies such as computers, smart phones and tablets (**Theme 1**).

    (b) Indirect care workers may be the first person present when an incident (such as a fall) involving a resident occurs and if they are trained in first aid may be permitted to apply

[38] This should not be taken to be agreement with those matters not addressed.

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first aid skills and then will follow internal procedures to escalate incidents immediately to a member of the care staff to ensure the best care is provided to the resident (**Theme 2**).

(c) Indirect care workers usually complete training in dementia and all follow internal procedures for escalating any challenging resident behaviour to care staff. Indirect care staff may find themselves in challenging situations with a resident and if personally at risk are required to leave the situation and call for assistance from the care team. (**Theme 3**).

(d) Indirect care workers do and are encouraged to interact with families engaging in conversations, responding to requests within their competence and escalating any complaints in accordance with standard complaint procedures in a polite and friendly manner (**Theme 4**).

(e) Indirect care workers do and are encouraged to interact with residents: engaging in conversations and responding to a resident's preferences within their competence in a polite and friendly manner (**Theme 5**).

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Theme 1: Complexity: Training and Technology

Mandatory Training

30. The nature of the work in aged care has always required workers to be provided with information and training relevant to their work. This includes a combination of induction training, mandatory training and on-the-job training, which is informed by the established procedures and practices of the aged care provider and any applicable law and regulation (e.g. work health and safety law, aged care quality standards, etc).[39] The provider is responsible for ensuring any relevant training and information is provided to their management and staff.

31. Since the implementation of the *Quality Care Principles 1997* (**the Former Standards**), the regulations have required:

    (a) a commitment to actively pursue continuous improvement across all aspects relevant to the delivery of services within aged care settings; and

    (b) the provision of safe systems within aged care settings, including the existence of an infection control program and the provision of information to management and staff to ensure they have appropriate knowledge and skills to perform their roles safely and effectively. [40]

32. Both requirements continue to feature in the ACQS. [41]

33. Consistent with those regulations, providers in keeping abreast of the changes and developments within the aged care sector are to ensure the training and information provided to their staff has regard to the latest advice.[42]

34. The mandatory training typically addresses the following topics:

    (a) ACQS;

    (b) customer service;

    (c) elder abuse;

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[39] See *Quality of Care Principles 1997*, Schedule 2, Part 1, item 1.3; Part 2, item 2.3; Part 3, item 3.3; Part 4, item 4.3; item 4.5, item 4.6. See example, Witness Statement of Johannes Brockhaus dated October 2023 at [16]-[19], Witness Statement of Chris Mamarelis dated 1 November 2023 at [22]-[39]; Witness Statement of Louanne Riboldi dated 31 October 2023 at [13]-[23].

[40] Witness Statement of Craig Smith dated 2 March 2022 at [18]-[19]; Witness Statement of Emma Brown dated 2 March 2022 at [21]-[23], Annexure EB-04; See example, *Quality of Care Principles 1997*, Schedule 2, Part 1, item 1.1; Part 2, item 2.1; Part 3, item 3.1; Part 4, items 4.1-4.8.

[41] See example, ACQS, Standard 1(3)(b); Standard 2(3)(a), (c); Standard 3(2), (3)(a)-(g); Standard 6(2), (3); Standard 8(3)(c).

[42] *ACT Child Care Decision* at [190], cited in the *Stage 1 Decision* at [194]. Whilst noting the caution highlighted by the Full Bench in the *Stage 1 Decision* with respect to freely adopting the observations at [190] in the *ACT Child Care Decision*, the observations made with respect to training are highlighted.

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(d) mandatory reporting;

(e) whistle blower policies;

(f) feedback and complaint handling;

(g) IPC; and

(h) manual handling.[43]

35. Other mandatory modules referred to in evidence include:

(a) chief and area warden training;

(b) equal employment opportunity;

(c) discrimination, bullying and harassment;

(d) fire awareness and evacuation;

(e) privacy legislation; and

(f) Serious Incident Response Scheme (**SIRS**).[44]

36. This section will focus on two areas of mandatory training: ACQS and IPC.

ACQS

37. In the *Stage 1 Decision*, the Full Bench had regard to the impact of regulatory change on the work performed by aged care workers.[45] The evidence before the Commission in relation to the impact of ACQS on indirect care workers included the following:

(a) the requirement to complete mandatory training in ACQS (set out below);

(b) Mr Kent, chef, gave evidence that standards 1 and 6 are relevant to his work, namely, *"consumer dignity and choice"* and *"feedback and complaints"*;[46]

(c) Mr Basciuk, maintenance employee, gave evidence that Aged Care Quality and Safety Commission auditors visit the workplace and that during that visit they may speak with any employee at the facility;[47] and

(d) Ms Little, administration officer, gave evidence that as a result of regulatory change, her administrative work now includes ensuring tests of electrical equipment are

[43] Witness Statement of Johannes Brockhaus dated October 2023 at [17], Witness Statement of Chris Mamarelis dated 1 November 2023 at [23]-[33]; Witness Statement of Louanne Riboldi dated 31 October 2023 at [13].
[44] Witness Statement of Emma Brown dated 2 March 2022 at [68]; Witness Statement of Louanne Riboldi dated 31 October 2023 at [13].
[45] *See Stage 1 Decision* [2022] FWCFB 200 at [664]-[672]. See also *Stage 1 Decision* [2022] FWCFB 200 at [695]-[707].
[46] Witness statement of Darren Kent, 31 March 2021 at [107]
[47] Witness statement of Eugene Basciuk, 28 May 2022 at [53].

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completed, kitchen audits are completed, accurate records of visitors are maintained and the clinical management system is up to date.[48]

38. Having regard to the lay and expert evidence in Stage 1, the Full Bench found changes to the regulatory regime in aged care had a direct impact on the workload of nurses and personal care employees, with requirements to meet increased quality and safety standards and meet increased documentation requirements contributing the intensity and complexity of the work.[49]

IPC

39. In *Stage 1* the following evidence was before the Commission on IPC:

(a) The Witness Statement of Emma Brown dated 2 March 2022, provided insight into the IPC training provided at Warrigal. Ms Brown gave evidence that, at the time of preparing her statement, all staff were required to complete two online infection control training modules:

(i) *"COVID19 (infection control)"*; and

(ii) *"infection control"*.[50]

Ms Brown described the addition of *"COVID19 (infection control)"* as the *"main change"* to mandatory training *"over the last 10 years"*.[51]

(b) The Witness Statement of Johannes Brockhaus dated 3 March 2022, annexed a list of the training modules offered at Buckland.[52] This includes reference to IPC training modules for all staff, together with role-specific IPC training for laundry and cleaning employees.

(c) The Witness Statement of Jocelyn Hoffman dated 29 October 2021, RN, identified IPC as a function she performs in residential aged care.[53]

40. IPC was not addressed in any great detail in the *Stage 1 Decision*.[54]

41. Further submissions about IPC and COVID-19 are addressed in **Part II: Impact of the pandemic** below.

[48] Witness statement of Pamela Little, 30 March 2021 at [69]-[70].
[49] *Stage 1 Decision* at [648]-[672], [809].
[50] Witness Statement of Emma Brown dated 2 March 2022 at [66]-[68].
[51] Witness Statement of Emma Brown dated 2 March 2022 at [66]-[68].
[52] Witness Statement of Johannes Brockhaus dated 3 March 2022 at [14], Annexure JB-01
[53] Witness statement of Jocelyn Hofman, 29 October 2021 at [39].
[54] IPC was mentioned in both lay and expert evidence filed in Stage 1.

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Format and delivery of mandatory training

42. During Stage 1, the evidence about mandatory training (including ACQS and IPC) was consistent:

    (a) Mandatory training is delivered primarily in the form of a series of online modules that may take between 30-90 minutes to complete, which is followed by a short quiz to assess and confirm understanding. [55] For example, Ms Spangler, AIN, stated she completed 42 in-house courses mapped against the ACQS, each taking around 20-30 minutes to complete. [56] There is evidence of some modules taking 15 minutes to complete. [57]

    (b) All staff are required to undertake annual mandatory training to refresh their knowledge and stay familiar with the content of their mandatory training. This does not require additional study, with all relevant information included in the online module (or in person by the educator if the training is face-to-face).[58]

43. The requisite level of knowledge is achieved by satisfactory completion of the mandatory training, the application of that knowledge is then supported by the provision of on-the-job training[59] building on any prior qualifications or experience in their field in or outside of the aged care industry.

44. Following the Royal Commission, there has been a marked increase in the pace of change and reform impacting all providers which has increased the need for ongoing mandatory training for all staff.

Observations

45. The experience of the resident is the priority for all residential aged care providers, and this is conveyed to every worker. To ensure all workers understand this expectation, all workers complete mandatory training, which includes training modules that address the ACQS and IPC. The mandatory training reinforces the message of person-centred care and highlights

[55] See Witness Statement of Pamela Little dated 30 March 2021 [21]-[23]; Witness Statement of Kevin Mills dated 30 March 2021 [10]; Statement of Jane Wahl dated 21 April 2022 [22]; Witness Statement of Ross Heyan dated 31 March 2021 [8]; Witness Statement of Johannes Brockhaus dated October 2023 at [16]-[22], Witness Statement of Chris Mamarelis dated 1 November 2023 at [26]; Witness Statement of Louanne Riboldi dated 31 October 2023 at [13]; Witness statement of Christine Spangler, 29 October 2021 at [8]. See also example, Transcript, 5 May 2022, PN6531 (Sandra O'Donnell).

[56] Witness statement of Christine Spangler, 29 October 2021 at [8]

[57] Witness Statement of Johannes Brockhaus dated October 2023 at [19].

[58] See generally, Witness Statement of Johannes Brockhaus dated October 2023 at [16]-[22], Witness Statement of Chris Mamarelis dated 1 November 2023 dated 1 November 2023 at [22]-[29]; Witness Statement of Louanne Riboldi dated 31 October 2023 at [13]-[29].

[59] Witness Statement of Johannes Brockhaus dated October 2023 at [10]-[24], Witness Statement of Chris Mamarelis dated 1 November 2023 at [36]-[39]; Witness Statement of Louanne Riboldi dated 31 October 2023 at [17]-[19].

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matters relevant to working in a residential aged care setting. Following the Royal Commission the industry expects the focus on mandatory training to increase. It is highly important that all aged care employees are properly trained and aware of the specific elements of their working environment.

Increased Technology

46. In the *Stage 1 Decision*, the Full Bench observed that the evidence *"as to the impact of the increasing reliance on technology was inconsistent"*,[60] with some reporting the increased use of technologies had assisted them in the performance of their duties and others saying it did not necessarily make it easier.[61]

47. The evidence in Stage 1 referred to indirect care workers being required to use iPads, smart phones, computers and, subject to their role, certain computer programs or applications as part of their role.[62] Some witnesses also cited limitations in computer literacy as impacting their user experience within their role.[63]

48. Similar references to technology are made in the evidence filed in Stage 3.[64]

Observations

49. All workers in aged care variously utilise computers, smart phones and tablets etc. The use of such technology may come easier to some workers than others and is aimed at replacing manual methods of working with information and improving the experience and outcomes of residents and clients.

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[60] *Stage 1 Decision* at [729].

[61] See example, Amended witness statement of Kerrie Boxsell dated 19 May 2022 at [47]–[48]; Witness statement of Judeth Clarke dated 29 March 2021 at [34]; Amended witness statement of Virginia Mashford dated 6 May 2022 at [50]; Witness statement of Paul Sadler dated 1 March 2022 at [95]–[98].

[62] See example, Witness Statement of Kathy Sweeney dated 14 April 2022 [50]-[51]; Witness Statement of Pamela Little dated 30 March 2021 [26]. See also Report to Full Bench (Commissioner O'Neill, 20 June 2022) at [578], [580].

[63] See Witness statement of Geronima Bowers dated 1 April 2022 at [31]; Amended witness statement of Pauline Breen dated 9 May 2022 at [21]; Witness statement of Judeth Clarke dated 29 March 2021 at [26]; Reply witness statement of Lynette Flegg dated 14 April 2022 at [31].

[64] See example, Witness Statement of Chris Mamarelis dated 1 November 2023 at [47]-[48].

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Theme 2: Responding to incidents: *"First responders"* and clinical care

50. Residential aged care providers provide training and information to all staff about the procedures to be followed if a resident has a fall and/or if a worker has a concern about the welfare of a resident.

Falls

51. In *Stage 1*, Ms Brown gave evidence about incident management at Warrigal, which sets out the level of authority and processes for staff to respond to incidents.[65] A similar process is communicated and followed at Buckland and RFBI. and Whiddon.[66] Consistently, the process is to get help from either the *"RN"* or the *"care team"*.[67] The indirect care workers must follow the processes that are set down by the provider that they work for should they witness a resident have a fall or other serious medical incident.

52. Ms Wahl, gardener, gave evidence about the procedures she is to follow when a resident has a fall:

> *"41. ... if there is an incident, I need to know what to do and to know how to report it. There is a greater emphasis now on reporting and record keeping. I've witnessed a few incidents when residents have fallen and have needed to know how to react in those situations, such as not to move them, and to make sure that they are safe and comfortable and how to call for assistance. This means I need to know when and how to make contact such as where there are call bells. I also need to use judgement about whether the incident can wait on a call bell response or whether it is so urgent that I have to physically and quickly find someone for assistance. Sometimes there is no-one around in the immediate area, especially during a change of shift."*[68]

Concerns about welfare

53. The work environment of an indirect care worker coincides with the home of the residents. Due to this fact, they are in a position to make observations of the residents.[69] The frequency of this opportunity can be higher if the provider adopts a dedicated rostering system.[70] For example,

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[65] Witness Statement of Emma Brown dated 2 March 2022 at [79], Annexure EB-12.
[66] Witness Statement of Johannes Brockhaus dated October 2023 at [33]-[37], Witness Statement of Chris Mamarelis dated 1 November 2023 at [55]-[59]; Witness Statement of Louanne Riboldi dated 31 October 2023 at [38]-[40].
[67] Witness Statement of Johannes Brockhaus dated October 2023 at [33]-[37]; Witness Statement of Louanne Riboldi dated 31 October 2023 at [38]-[40]; Witness Statement of Chris Mamarelis dated 1 November 2023 at [55]-[59].
[68] Statement of Jane Wahl dated 21 April 2022 [41] and [20]; see also Transcript dated 2 June 2022 at PN14183 (Eugene Basciuk, Maintenance Officer).
[69] Witness Statement of Johannes Brockhaus dated October 2023 at [29]-[33], Witness Statement of Chris Mamarelis dated 1 November 2023 at [40]-[44]; Witness Statement of Louanne Riboldi dated 31 October 2023 at [33]-[37]. Cf Report to Full Bench (Commissioner O'Neill, 20 June 2022) at [393]-[400].
[70] See example, Witness Statement of Chris Mamarelis dated 1 November 2023 at [43].

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the same cleaner may be designated to a particular wing within a facility, such that the resident may benefit from a level of continuity in the services as the worker becomes more familiar with them.[71]

54. If an indirect care worker forms a concern about the welfare of a resident whilst performing their role, they are instructed to communicate any concerns or observations to the RN or care team leader.[72] This is an important aspect of their work within an aged care facility and forms part of the caring environment that it is created for residents.

Clinical care

55. Indirect care workers are not required or expected to provide clinical care or possess *"clinical skills"*. There are two clear exceptions to this:

    (a) some indirect care workers hold a first aid certification and may be permitted to render first aid in a critical situation in the absence of a care worker;[73] and

    (b) some indirect care workers are themselves qualified care workers and may act as such from time to time.[74]

56. Ms Riboldi gave evidence in relation to administering first aid. She states that in the event of a life-threatening situation an indirect care employee is to get help (e.g. call RN or triple-0) and start administering first aid (e.g. applying pressure to a wound to stop bleeding). To ensure all indirect care staff are able to follow that established process, if required, RFBI ensure that *all staff* at its villages are certified in first aid.[75] This is a regular requirement of workers in aged care.

[71] See generally, Witness Statement of Chris Mamarelis dated 1 November 2023 at [43].
[72] Witness Statement of Johannes Brockhaus dated October 2023 at [36], Witness Statement of Chris Mamarelis dated 1 November 2023 at [57]-[59]; Witness Statement of Louanne Riboldi dated 31 October 2023 at [38]-[40].
[73] See Witness Statement of Louanne Riboldi dated 31 October 2023 at [39]-[40]. See also Witness Statement of Ross Heyan dated 31 March 2021 [24] (Ross Heyan, cleaner, is trained in first aid); Statement of Donna Cappelluti dated 21 April 2022 [15], Transcript, 11 May 2022, PN12101-PN12106 (Ms Cappelluti, Food Assistant completed a course entitled *"first aid dealing with the elderly"*).
[74] See example, Anita Field, works as a laundry hand but commenced as a AIN. She hold both a Certificate III and IV in Health Services Assistant (Assistant-In-Nursing): Witness Statement of Anita Field dated 30 March 2021 [2].
[75] Witness Statement of Louanne Riboldi dated 31 October 2023 at [38]-[40].

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Theme 3: Interaction with residents with "complex care needs"

Dementia

57. In the *Stage 1 Decision*, the Full Bench found that the expert evidence in the proceeding supports a finding that *"the workload of nurses and PCW/AINs has increased, as has the intensity and complexity of their work".*[76] The Full Bench also found that:

> *"The remaining 15 contentions provide further detail of the nature of the work of direct care workers, including relating to high levels of acuity, frailty and co-morbidities, dementia and palliative care among residents and home care clients, as well as changes in the demographic makeup of the aged care workforce. These factors all contribute to the intensity of work and workload of aged care workers."*[77]

58. Focusing on dementia, the Full Bench found the expert evidence in Stage 1 supports a finding that *"the proportion of residents and clients in aged care with dementia and dementia-associated conditions has increased".*[78] The evidence of Prof Meagher was cited, who observed that *"the majority of people in residential aged care suffer from multiple forms of ill health, with around half having a diagnosis of dementia".*[79]

59. In Stage 1, both direct care and indirect care workers gave evidence about the impact of residents with dementia:

    (a) The evidence of Ms Schmidt who is employed as a *"Specialised Dementia Care Worker"* addressed the difference in residents that live in *"low-level care cottages"* vs *"high-care cottages".* The latter typically homes residents *"who may be in the later stages of dementia and who require greater assistance with personal care".*[80]

    (b) Ms Schmidt also gave evidence about the sometimes *"exhausting"* nature of taking a resident's blood pressure. She states "*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".*[81] Similar observations were made by Ms Bowers, who added it takes twice as long to administer medication.[82]

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[76] *Stage 1 Decision* at [557].
[77] *Stage 1 Decision* at [569], emphasis added.
[78] *Stage 1 Decision* at [602].
[79] *Stage 1 Decision* at [603]. See also *Stage 1 Decision* at [608] and [610].
[80] Witness statement of Antoinette Schmidt, 30 March 2021, at [37]-[39].
[81] Witness statement of Antoinette Schmidt, 30 March 2021, at [44]-[83].
[82] Witness Statement of Geromina Bowers, 1 April 2021 at [30].

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(c) Ms Bowers, who works in an Acute Dementia Ward (i.e. a secure ward of high care dementia residents), gave evidence that *"[t]here 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."*[83]

(d) Mr Castieau, chef, gave evidence that he received specialised training from his employer about how to deal with residents with dementia. This involved completion of an online course followed by a multiple-choice-type assessment that takes about an hour.[84] (This is consistent with the format of mandatory training that is provided by aged care providers to their staff (see previous section ***Format and delivery of mandatory training***).

(e) Mr Basciuk, maintenance employee, gave evidence that if he is aware a resident has dementia, prior to doing work in that resident's room he contacts a carer to either remove the resident or distract the resident.[85] 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.[86]

(f) Ms Wahl, gardener, also gave evidence of observing an incident of a resident with dementia being aggressive with a nurse, due to a mistake with that resident's medication. She said the voluntary training she has undertaken has helped her in those situations.[87]

60. At RFBI, Ms Riboldi gave evidence that due to the prevalence of dementia all employees are required to complete a training module about dementia. The purpose of this basic training is to communicate to all workers the process they must follow of leaving a situation if a resident is showing signs of annoyance, mood-change or challenging behaviours. Following which the RN should be notified by the worker.

Dangerous work

61. In Stage 1, the Full Bench held:

> *"We accept that while the dangers encountered by direct care workers in the aged care sector are capable of being mitigated to some extent, they cannot be entirely removed*

[83] Witness Statement of Geromina Bowers, 1 April 2021 at [23].
[84] Witness statement of Mark Castieau, 29 March 2021 at [90]; Transcript, 29 April 2022, PN1121.
[85] Witness statement of Eugene Basciuk, 28 May 2022 at [43].
[86] Report to Full Bench (Commissioner O'Neill, 20 June 2022), page 272.
[87] Witness statement of Jane Wahl, 21 April 2022 at [36]-[37].

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given the nature of the work performed. It is appropriate that this consideration be taken into account in our assessment of the work value reasons justifying the amount direct care workers should be paid.

It is also apparent that direct care workers are called upon to exercise considerable skill in order to identify, prevent and de-escalate violence and aggression. This too is a work value consideration to be taken into account."[88]

62. As to dangerous work, the Full Bench in Stage 1 summarised its approach to application of the legal principles as follows:

> *"3. As a general proposition, the Commission and its predecessor bodies have approached the issue of 'dangerous work' from an occupational health and safety perspective—that is; as far as practicable the risk should be removed or mitigated — rather than seeking to compensate employees for the risk posed from being required to work in dangerous conditions.* ***But this principle has limitations where the danger cannot be removed and employees are nonetheless required to perform the work as an essential service.***
>
> *4. We accept that while the dangers encountered by direct care workers in the aged care sector are capable of being mitigated to some extent, they cannot be entirely removed given the nature of the work performed. It is appropriate that this consideration be taken into account in our assessment of the work value reasons justifying the amount direct care workers should be paid.*
>
> *5. It is also apparent that* ***direct care workers are called upon to exercise considerable skill in order to identify, prevent and de-escalate violence and aggression****. This too is a work value consideration to be taken into account."*[89]

Observations

63. The evidence suggests that indirect care workers, to varying degrees, interact with residents that have dementia. In light of the Full Bench finding as to the increased prevalence of dementia in residents, this appears to be a permanent feature of the work in question, resulting in a change in the broader environment in which work is performed. Increasingly, in their working

[88] *Stage 1 Decision* at [253]-[254].
[89] *Stage 1 Decision* at [293].

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environment, indirect care workers may observe and/or have interactions with residents that have varying degrees of dementia[90].

64. The evidence does suggest that indirect care workers are increasingly called upon to:

(a) be conscious of the prevalence of dementia in residents;

(b) possess an understanding that dementia can impact how a resident communicates and behaves; and

(c) leave the room and contact the RN/care team if a resident demonstrates challenging behaviours.

[90] The impact of that change is necessarily different to that of direct care workers. The interaction by direct care workers is also of a longer duration and higher frequency. See Witness statement of Antoinette Schmidt, 30 March 2021, at [37]-[39], [44]-[83]; Witness Statement of Geromina Bowers, 1 April 2021 at [23].

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Themes 4: Interaction with Families (conversations, feedback and complaint handling)

65. In the *Stage 1 Decision*, the Full Bench found that *"aged care employees have greater engagement with family and next of kin of clients and residents"*. That finding was supported by expert evidence,[91] and the majority of the lay evidence cited focused upon the impact on direct care workers (although the evidence of Mr Castieau was also cited).[92]

66. In Stage 1, the Joint Employers' evidence highlighted the ongoing expectation that all aged care workers:

(a) engage in informal conversations with family members and visitors when they encounter them during the course of their duties;[93]

(b) attend to matters within the scope of their competence;[94] and

(c) follow the established procedures of the provider with respect to feedback and complaints.[95]

67. That evidence included the following:

(a) Ms Brown gave evidence about the expectations communicated to Warrigal staff about communication with families:

(i) administrative staff at the front desk may be approached by family members, they are not required to know the answers to all questions asked – but they are expected to direct these questions to the appropriate person;[96]

(ii) all staff working in the facility (including administrative, cleaners, servery, personal care workers, lifestyle employees, etc) may be approached by a family member and be engaged in conversation. They are permitted to convey information in this informal engagement *"within the scope of their practice"*. However, formal communications to the family do not fall within the responsibility of the personal care worker, general administrative, maintenance, kitchen, cleaning workers, etc.[97]

[91] *Stage 1 Decision* at [708].
[92] *Stage 1 Decision* at [709]-[714]
[93] Statement of Emma Brown dated 2 March 2022 [78].
[94] Statement of Emma Brown dated 2 March 2022 [78].
[95] See Statement of Emma Brown dated 2 March 2022 [79], Annexure EB-12.
[96] Witness Statement of Emma Brown dated 2 March 2022 at [78(a)].
[97] Witness Statement of Emma Brown dated 2 March 2022 at [78(b)].

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(b) Mr Mark Sewell also gave evidence about the expectations of Warrigal with respect to staff interacting with families.[98]

(c) Mr Paul Sadler gave evidence about his experience as CEO at Presbyterian Aged Care. He observed, *"It has always been the expectation that all persons employed in residential aged care engage with the consumers and their families in a friendly and helpful manner."*[99] He observed the engagement has become more *"conscious"* in that workers *"are more aware of what is being said to ensure they are considering the consumer in their communications"*.[100]

(d) Mr Brockhaus gave evidence that Buckland expects cleaners to engage with the residents when they are in the rooms or see them in the facility. This can be a general conversation or helping them getting a glass of water.[101]

68. Employees also gave evidence of interactions and the procedures followed:

(a) Mr Basciuk, maintenance officer gave evidence that he *"often"* communicates with resident's family members to provide an explanation about the work he is performing if they are in the room, gives them directions or provide information about the process of getting electronics tagged and tested.[102]

(b) Ms Glass, administrative assistant, explained that complaints are immediately transferred to the Village Manager and questions about certain health conditions will be passed onto the RN. If the query is beyond Ms Glass' knowledge, she will speak with the Care Manager / RN and/or take a message.[103]

69. Further insight into the nature of the *"established procedures"* and expectations in relation to feedback and complaint handling is provided by Mr Brockhaus and Ms Riboldi.[104] Consistent with the evidence in Stage 1, their evidence highlights:

(a) If the matter falls within the scope of the employee's competency they may attend to the matter. For example, if a maintenance employee is asked to put up a picture.

[98] Witness Statement of Mark Sewell dated 3 March 2022 at [109]-[111].
[99] Witness Statement of Paul Sadler dated 1 March 2022 at [91].
[100] Witness Statement of Paul Sadler dated 1 March 2022 at [90].
[101] Statement of Johannes Brockhaus dated 3 March 2022 [135]
[102] Witness Statement of Eugene Basciuk, dated 28 May 2022 at [50]
[103] Transcript, 5 May 2022, PN6846-PN6847.
[104] Witness Statement of Johannes Brockhaus dated October 2023 at [43]-[45]; Witness Statement of Louanne Riboldi dated 31 October 2023 at [49]-[54].

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(b) If the matter falls outside the scope of the employee's competency, they are to direct the matter to the RN/care team. For example, if the family had an enquiry about the care being provided but approached the cleaner because they were in the room at the time.

(c) If a family member has a complaint, the employee is instructed to be polite and apologetic and to escalate it in a timely manner to management so that established complaint procedures are followed.[105]

70. Additionally, all staff receive training about *"customer service"* and *"feedback and complaints"* to be prepared to handle such situations in their work environment.[106]

Observations

71. Due to the nature of the work location, all employees may from time-to-time experience interactions with family (to varying degrees) and engage with them subject to their competence and the internal procedures of a facility.

[105] Witness Statement of Johannes Brockhaus dated October 2023 at [18], [43]-[45]; Witness Statement of Louanne Riboldi dated 31 October 2023 at [53].

[106] Witness Statement of Johannes Brockhaus dated October 2023 at [17]-[18]; Witness Statement of Louanne Riboldi dated 31 October 2023 at [13], [50].

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Theme 5: Interaction with residents (conversations and responding to preferences)

Communication

72. All aged care workers understand that they are performing their work within the residents' home.[107] This requires all employees to be conscious of their work environment. To assist with this, indirect care workers receive mandatory training (e.g. ACQS, customer service, code of conduct, etc).[108]

73. Ms O'Donnell, laundry assistant, gave evidence that she found the mandatory training modules concerning interactions with residents to be helpful.[109]

Preferences

74. The primary documentation of resident preferences in a residential aged care facility is the care plan. In the *Stage 1 Decision*, the Full Bench observed:

    (a) *"The evidence before us indicates that the care and service plans in residential aged care are generally signed off by RNs"*;[110]

    (b) The requirement to prepare care plans *"has resulted in aged care workers, including RNs, spending more time with each resident to assess their needs and identify their goals and preferences"*[111] (by reference to evidence cited, that observation is primarily directed at direct care workers); and

    (c) *"With increasing changes in acuity and care needs of residents, the requirement has led to greater complexity in care planning and has led to an increase in workloads on RNs, ENs and PCWs to maintain care plans".*[112]

[107] See example, Witness Statement of Ross Heyan dated 31 March 2021 [13]; Witness Statement of Johannes Brockhaus dated October 2023 at [29].
[108] Witness Statement of Johannes Brockhaus dated October 2023 at [29]-[33], Witness Statement of Chris Mamarelis dated 1 November 2023 at [40]-[44] and Witness Statement of Louanne Riboldi dated 31 October 2023 at [33]-[37]. See also Witness Statement of Pamela Little dated 30 March 2021 [21]-[23]; Transcript, 6 May 2022, PN7710 (Anita Field); Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [24].
[109] See Transcript, 5 May 2022, PN6677, PN6680.
[110] *Stage 1 Decision* at [487], citing Item 3.8 of Part 3 of Schedule 1 of the Quality of Care Principles require initial assessment and care planning to be carried out by a nurse practitioner or registered nurse, and ongoing management and evaluation carried out by a nurse practitioner, registered nurse or enrolled nurse acting within their scope of practice. See, for example Transcript, 29 April 2022 at PN1270–PN1273 (XXN of Paul Jones) and PN1663–PN1666 (XXN of Virginia Ellis).
[111] *Stage 1 Decision* at [487], citing Witness statement of Emma Brown dated 2 March 2022 at [26].
[112] *Stage 1 Decision* at [487].

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75. While the care plan does not fall within the responsibility of the indirect care worker, relevant extracts may be shared with indirect care workers when it is necessary for them to know this information in performing their duties.[113]

76. In Stage 1, the Commission received some evidence about the impact of responding to the preferences of residents:

(a) Mr Castieau, chef, gave evidence that it increased his workload as he is trying as hard as possible to meet the wants and needs of residents.[114]

(b) Ms Field, laundry hand, gave evidence 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 fold them a certain way.[115]

77. Subject to their competence, an indirect care worker will respond to a resident's preferences. This could also include such things as changing a TV channel to the resident's favourite show or changing a meal.

78. The evidence of Mr Brockhaus, Mr Mamarelis and Ms Riboldi emphasises the expectation that indirect care workers cater to resident preferences where possible.[116]

Observations

79. Indirect care workers will respond to a resident's preferences as communicated to them by care staff or as learned through ongoing interaction with them and this will be within the competence and training of the specific worker and the context of the interaction. All staff are increasingly expected to focus on the resident's experience in order to ensure compliance with the ACQS and that factor makes these types of interactions more common and more consistent.

[113] Witness Statement of Louanne Riboldi dated 31 October 2023 at [41]-[48]. See also Witness Statement of Chris Mamarelis dated 1 November 2023 at [45]-[48].
[114] Witness statement of Mark Castieau, 29 March 2021 at [95].
[115] Report to Full Bench (Commissioner O'Neill, 20 June 2022), page 166.
[116] Witness Statement of Johannes Brockhaus dated October 2023 at [38]-[42], Witness Statement of Chris Mamarelis dated 1 November 2023 at [45]-[55]; Witness Statement of Louanne Riboldi dated 31 October 2023 at [41]-[48].

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Further Matters

HSU Submissions

80. The following submissions are advanced in reply to the HSU:

(a) To the extent the HSU seek to suggest that indirect care workers are put in an environment that is unsafe by their multiple references to *"risk"* is firmly rejected by the Joint Employers. As set out in the evidence filed by the Joint Employers, all staff are provided with extensive onboarding and induction training, together with ongoing training and education relevant to their roles. This is to ensure each worker is familiar with the established processes and procedures within the facility they work in and understand the nature of the work environment.[117]

(b) The work of the laundry employee is described as *"dirty work"* (at [20]). This aspect of the work is recognised by the provision of a *"nauseous work allowance"*.[118] Such that employees required to handle soiled linen or clothing are compensated for the "*dirty work"* with an allowance. Matters relating to COVID-19 and IPC will be further developed at **Part II: Impact of the pandemic** below.

(c) As to [29], the IPC protocols followed by cleaners post the pandemic do have a heightened emphasis on ensuring cleaning is undertaken effectively.

(d) For clarity, at [33], the HSU align the *"aged care employee–general—level 1"* to the *"cleaning services employee – level 1"* (**CSE Level 1**) to support an argument that a cleaner in a *"comparative"* role outside the aged care industry is better off. Little may turn on this but the assertion should be approached with caution as the comparison is not factually correct:

(i) To the extent the reference to the operation of different penalty rates (i.e. shift loading and part-time loading) operating in the contract cleaning services industry and the aged care industry is relied upon to suggest issues of fairness, that submission should be approached with caution. Especially absent an application to vary the penalty rates and, furthermore, absent any evidence in relation to the setting of the penalty rates.

(ii) Finally and while little may turn on it, cleaners in residential aged care facilities do not work the night shift in practice. The shift generally falls between 7.30am

[117] See Witness Statement of Johannes Brockhaus dated October 2023 at [8]-[27]; Witness Statement of Chris Mamarelis dated 1 November 2023 at [22]-[29]; Witness Statement of Louanne Riboldi dated 31 October 2023 at [13]-[29].
[118] *Aged Care Award* clause 15.5.

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and 4pm (with *"night shift"* under the Aged Care Award commencing at 4pm[119]).[120]

(e) In relation to the HSU's submissions with respect to the impact of "*increased emphasis on diet and nutrition for aged care residents"* on kitchen staff at [36]-[37], for completeness it is noted the evidence cited in support of extending that finding to kitchen employees is the statement of Ms Twyford filed in Stage 1. The Full Bench has already had regard to the lay evidence in the *Stage 1 Decision* (which included Ms Twyford, together with Mr Castieau, chef and Ms Cappelluti, food services assistant).[121]

(f) Again for completeness, the submissions advanced at [41]-[44] with respect to the work performed by administrative employees elaborates on matters previously considered by the Commission:

(i) 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;

(ii) assisting staff and residents with any administration requests (e.g. enrolling in training courses and postage requests);

(iii) rostering of employees;

(iv) ordering stock for the facility, for example stationery;

(v) organising admissions and discharges for residents;

(vi) liaising with family members regarding non-clinical issues;

(vii) maintaining the facility's client management system;

(viii) arranging and recording onsite and offsite visits for family members, residents, allied services workers and any other visitors attending the facility;

(ix) logging and monitoring requests for minor maintenance, for example blown light bulbs or broken blinds, and organising vehicle servicing and maintenance;

(x) attending to IT issues, including providing support to staff members; and

(xi) invoicing, receipting and paying bills, payroll and banking.[122]

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[119] *Aged Care Award* clause 26.1

[120] See Witness Statement of Johannes Brockhaus dated 3 March 2022 at [131]; Witness Statement of Kim Bradshaw dated 4 March 2022 at [22].

[121] *Stage 1 Decision* at [716]-[724]

[122] Report to Full Bench (Commissioner O'Neill, 20 June 2022) at [184].

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UWU Submissions

81. With a view to avoid repetition, the Joint Employers do not propose to respond to the specific submissions advanced by the UWU. Rather, we repeat and rely upon the submissions above.

Survey Evidence filed by UWU

82. We do not object to the Commission receiving the Statement of Carolyn Smith dated 15 September 2023 and Annexure CS-1 but it should be received subject to weight.[123]

[123] See *Re 4 yearly review of modern awards - Social, Community, Home Care and Disability Services Industry Award 2010 - Substantive claims* [2021] FWCFB 2383 at [58]. See also *Stage 1 Decision* at [436]-[437].

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PART II – THE IMPACT OF THE PANDEMIC

Introduction

83. In the *Stage 1 Decision*, the Full Bench invited all parties to prepare submissions on *"the extent to which the changes to work resulting from the pandemic have become permanent."*[124] In the context of a work value case, that question is necessarily directed to the permanency of the impact of the pandemic on the following:

    (a) the nature of the work;

    (b) the level of skill or responsibility involved in doing the work; and

    (c) the conditions under which the work is done.[125]

84. The Full Bench also confirmed that *"the impact of the COVID-19 pandemic"* was not taken into account in the interim increase awarded to direct care workers.[126]

85. The Joint Employers advance the following submissions with respect to the impact of the COVID-19 pandemic on the aged care sector and its relevance to the determination to be made by the Commission.

The nature of the work

Pre-pandemic

86. Residents of aged-care homes are especially vulnerable to infection.[127] Prior to the discovery of severe acute respiratory syndrome coronavirus 2 (**SARS-CoV-2**), the risk of *respiratory infections* among older adults in residential aged care facilities was widely documented globally,[128] with commonly cited respiratory infections include influenza, respiratory syncytial virus (**RSV**) and pneumonia.[129]

87. Infections that are known to be of particular risk in aged care settings include:

    (a) respiratory infections;

    (b) gastrointestinal (norovirus, rotavirus and clostridium difficile) viruses;

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[124] *Stage 1 Decision* at [973].
[125] *Fair Work Act 2009* (Cth) s 157(2A).
[126] *Stage 1 Decision* at [973].
[127] See Leslie Dowson et al, "*The 2018 Aged Care National Antimicrobial Prescribing Survey: results show room for improvement"* (December 2019) 42(6) *Australian Prescriber* 200-203 (published online). <https://australianprescriber.tg.org.au/assets/p200-Dowson-et-al.pdf>.
[128] See Arielle Childs et al, *"The burden of respiratory infections among older adults in long-term care: a systematic review"* (August 2019) 19(1) *BMC Geriatrics* (published online).
[129] See Arielle Childs et al, *"The burden of respiratory infections among older adults in long-term care: a systematic review"* (August 2019) 19(1) *BMC Geriatrics* (published online).

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(c) urinary tract infections; and

(d) multi-resistant organisms. [130]

88. Factors that contribute to the established nature of this risk include the age of the residents/clients, presence of comorbidities and third-party contact with resident/clients via family, friends and staff. As well as the known seasonal patterns of infections, with many typically flourishing in cold weather and when people live in closed environments. [131]

89. In aged care settings, infection prevention and control (**IPC**) and antimicrobial stewardship (**AMS**) programs protect older people and staff by reducing the risk of transmission of infections and the development of antimicrobial resistance. [132] These are necessary steps responsive to the seriousness of the risk.

90. As such, IPC practices and protocols were established and prevalent throughout residential aged care facilities prior to the COVID-19 pandemic. Additionally, consistent with the evidence of the Joint Employers, pre-pandemic studies into IPC practices in aged care facilities published in the *Infection, Disease & Health* journal also suggest IPC was a critical feature and priority for aged care providers in Australia prior to the discovery of SARS-CoV-2 (**pre-pandemic studies**). [133]

91. Both pre-pandemic studies found the overwhelming majority of respondents reported having a documented IPC program and a dedicated employee with IPC responsibilities. [134]

92. The approach to IPC and outbreak management in aged care was never stagnant; being directly tied to risk management, the systems must be maintained and reviewed. To ensure the best risk management practices and health outcomes for older Australians, government bodies publish and provide authoritative guidance. [135] This requirement to maintain, review and update

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[130] See generally, Lyn-Li Lim and Noleen Bennett, "Improving management of urinary tract infections in residential aged care facilities" (August 2022) 51(8) *Australian Journal of General Practice* (published online) <https://www1.racgp.org.au/getattachment/d140bdeb-d0ae-475b-a2ff-27c7f9584064/UTIs-in-residential-aged-care-facilities.aspx >.

[131] See Auda Fares, *"Factors influencing the seasonal patterns of infectious diseases"* (February 2013) 4(2) *International Journal of Preventive Medicine* 128-32. < https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3604842/pdf/IJPVM-4-128.pdf >.

[132] Australian Commission on Safety and Quality in Health Care, "Infection prevention and control in aged care" (Webpage) <https://www.safetyandquality.gov.au/our-work/infection-prevention-and-control/infection-prevention-and-control-aged-care>.

[133] Brett G Mitchell et al, *"Organisation and governance of infection prevention and control in Australian residential aged care facilities: A national survey"* (2019) 24(4) *Infection, Disease & Health* 187, 187-193; Ramon Z Shaban et al, *"Scope of practice and educational needs of infection prevention and control professionals in Australian residential aged care facilities"* (November 2020) 25(4) *Infection, Disease & Health* 286, 286-293.

[134] Brett G Mitchell et al, *"Organisation and governance of infection prevention and control in Australian residential aged care facilities: A national survey"* (2019) 24(4) *Infection, Disease & Health* 187, 187-193; Ramon Z Shaban et al, *"Scope of practice and educational needs of infection prevention and control professionals in Australian residential aged care facilities"* (November 2020) 25(4) *Infection, Disease & Health* 286, 286-293.

[135] See example, Clinical Excellence Commission in NSW (established in 2004).

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practices based on evidence and improved understanding is not new. This requirement featured in the Former Standards and was carried into the ACQS. Further, both Mr Brockhaus and Ms Riboldi referred to the need to consistently update outbreak management plans per the latest advice.[136]

Impact as at 2023

93. While the pandemic has abated there remains an ambient shift in the awareness of infection control and hygiene across the industry which is typified by the increased emphasis and adherence to many hygiene practices including hand washing and use of sanitisers etc.

94. With the end to the pandemic, SARS-CoV-2 as a respiratory infection now operates as part of a facility's ongoing IPC program.

95. Consistent with the requirement to maintain and update risk management procedures, guidance with respect to management of *"COVID-19"* is now delivered in conjunction with advice about managing acute respiratory infections in residential aged care. This streamlined approach has been adopted in the most recent material published by the Department of Health and Aged Care (Commonwealth), ACQSC and the NSW Ministry of Health.

Department of Health and Aged Care

96. The Department of Health and Aged Care published National Guidelines for *"Prevention, Control and Public Health Management of Outbreaks of Acute Respiratory Infection (including COVID-19 and Influenza) in Residential Care Facilities"* was published on 30 September 2022 (updated 6 October 2022) (**the National Guidelines**).[137]

97. The Department of Health and Aged Care provide the following description of the National Guidelines:

> *"These guidelines are provided to assist public health authorities, residential care services, healthcare workers and carers* ***by providing best practice information for the prevention and management of outbreaks of acute respiratory infection (including COVID-19 and influenza)*** *in residential care facilities.*
>
> *These guidelines were developed to create* ***a single unified guidance to support a risk-based approach for the early identification of acute respiratory infection and***

[136] Witness Statement of Johannes Brockhaus dated 31 October 2023 at [49], [55]-[58]; Witness Statement of Louanne Riboldi dated 31 October 2023 at [55]-[56], [63], [69]-[70].

[137] Department of Health and Aged Care, *"Prevention, Control and Public Health Management of Outbreaks of Acute Respiratory Infection (including COVID-19 and Influenza) in Residential Care Facilities"* (published 30 September 2022, last updated 6 October 2022) <https://www.health.gov.au/resources/publications/national-guidelines-for-the-prevention-control-and-public-health-management-of-outbreaks-of-acute-respiratory-infection-including-covid-19-and-influenza-in-residential-care-facilities>.

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***management of outbreaks**, supported by specific resources and tools provided by jurisdictions and guidance from their local public health unit."*[138]

98. The National Guidelines replace two-separate sets of guidelines previously published with respect to COVID-19 and Influenza:[139]

(a) *"National Guidelines for the Prevention, Control and Public Health Management of COVID-19 Outbreaks in Residential Care Facilities"* (published 13 March 2020, last updated 15 February 2022) (**COVID-19 National Guidelines**);[140] and

(b) *"CDNA National Guidelines for the Prevention, Control and Public Health Management of Influenza Outbreaks in Residential Care Facilities in Australia"* (published March 2017, last updated 2 March 2017) (**Influenza National Guidelines**).[141]

ACQSC

99. The ACQSC also publish guidance material for residential aged care providers, which is relevantly consolidated under the following heading: *"Managing infection-related risks"*. The publications include:

(a) Aged Care Quality and Safety Commission: *"*Oral antiviral treatments for COVID-19 and influenza viruses in residential aged care services*"*[142] (previously the guidance for COVID-19 was separate: "*COVID-19 oral antiviral treatments in residential aged care services"*);[143]

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[138] Department of Health and Aged Care, *"National Guidelines for the Prevention, Control and Public Health Management of Outbreaks of Acute Respiratory Infection (including COVID-19 and Influenza) in Residential Care Facilities"* (Webpage) <https://www.health.gov.au/resources/publications/national-guidelines-for-the-prevention-control-and-public-health-management-of-outbreaks-of-acute-respiratory-infection-including-covid-19-and-influenza-in-residential-care-facilities> (emphasis added).

[139] Department of Health and Aged Care, *"National Guidelines for the Prevention, Control and Public Health Management of Outbreaks of Acute Respiratory Infection (including COVID-19 and Influenza) in Residential Care Facilities"* (Webpage) <https://www.health.gov.au/resources/publications/national-guidelines-for-the-prevention-control-and-public-health-management-of-outbreaks-of-acute-respiratory-infection-including-covid-19-and-influenza-in-residential-care-facilities>.

[140] Link to access archived COVID-19 National Guidelines: <https://webarchive.nla.gov.au/awa/20220327142851/https://www.health.gov.au/resources/publications/cdna-national-guidelines-for-the-prevention-control-and-public-health-management-of-covid-19-outbreaks-in-residential-care-facilities-in-australia>.

[141] Link to access archived Influenza National Guidelines: <https://webarchive.nla.gov.au/awa/20220817062719/https://www.health.gov.au/resources/publications/cdna-national-guidelines-for-the-prevention-control-and-public-health-management-of-influenza-outbreaks-in-residential-care-facilities-in-australia>.

[142] https://www.agedcarequality.gov.au/sites/default/files/media/covid-19-oral-antiviral-treatments-in-residential-aged-care-services-fact-sheet.pdf

[143] Aged Care Quality and Safety Commission, *"Oral antiviral treatments for COVID-19 and influenza viruses in residential aged care services"* (Factsheet, August 2023) <https://www.agedcarequality.gov.au/sites/default/files/media/covid-19-oral-antiviral-treatments-in-residential-aged-care-services-fact-sheet.pdf>

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(b) Aged Care Quality and Safety Commission: *"Infection Prevention and Control Leads: Updates for providers"*;[144]

(c) Aged Care Quality and Safety Commission: *"Are you alert and ready? Safeguarding against infectious illness in aged care settings"*;[145]

(d) Aged Care Quality and Safety Commission: *"IPC online tools"*;[146]

(e) AHPPC: *"Australian Health Protection Principal Committee (AHPPC) statement on the Infection Control Expert Group"*;[147]

(f) Communicable Diseases Network Australia (CDNA): *"National Guidelines for the Prevention, Control and Public Health Management of Outbreaks of Acute Respiratory Infection"*;[148]

(g) Department of Health and Aged Care: *"Transmission of respiratory diseases and managing the risk"*;[149] and

(h) National Health and Medical Research Council: *"Australian Guidelines for the Prevention and Control of Infection in Healthcare (2019)"*.[150]

100. To further illustrate a return to a streamlined approach with respect to the prevention and management of outbreaks of acute respiratory infection, some aspects of the above publications are highlighted below.

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[144] Aged Care Quality and Safety Commission, "Infection Prevention and Control Leads: updates for providers" (Factsheet) <https://www.agedcarequality.gov.au/sites/default/files/media/final_a4_ipc_fact_sheet.pdf>.

[145] Aged Care Quality and Safety Commission, *"Are you alert and ready? Safeguarding against infectious illness in aged care settings"* (Factsheet, August 2023) <https://www.agedcarequality.gov.au/sites/default/files/media/are-you-alert-and-ready.pdf>.

[146] Aged Care Quality and Safety Commission, "IPC online tools" (Webpage) <https://www.agedcarequality.gov.au/providers/ipc-online-tools>.

[147] Department of Health and Aged Care, "Australian Health Protection Principal Committee (AHPPC) statement on the Infection Control Expert Group" <https://www.health.gov.au/news/Australian-health-protection-principal-committee-ahppc-statement-on-the-infection-control-expert-group>.

[148] Department of Health and Aged Care, *"Prevention, Control and Public Health Management of Outbreaks of Acute Respiratory Infection (including COVID-19 and Influenza) in Residential Care Facilities"* (published 30 September 2022, last updated 6 October 2022) <https://www.health.gov.au/resources/publications/national-guidelines-for-the-prevention-control-and-public-health-management-of-outbreaks-of-acute-respiratory-infection-including-covid-19-and-influenza-in-residential-care-facilities>.

[149] Department of Health and Aged Care, "Influenza (flu)" (Webpage) < https://www.health.gov.au/diseases/influenza-flu?utm_source=health.gov.au&utm_medium=callout-auto-custom&utm_campaign=digital_transformation>.

[150] National Health and Medical Research Council, "Australian Guidelines for the Prevention and Control of Infection in Healthcare" (2019) < https://www.nhmrc.gov.au/about-us/publications/39ustralian-guidelines-prevention-and-control-infection-healthcare-2019#block-views-block-file-attachments-content-block-1>.

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Example 1: *"Are you alert and ready? Safeguarding against infectious illness in aged care settings"*

101. The ACQSC identify two broad categories of infectious illness:

(a) *"**Acute respiratory illnesses** (**ARI**) cause cold or flu-like symptoms. This may include fever, chills, cough, sore throat, runny nose, headache, and fatigue. ARI in older people can be caused by many viruses, including influenza, parainfluenza, respiratory syncytial virus, pertussis, and COVID-19"*; [151] and

(b) *"**Gastroenteritis** (or **gastro**) is an infection of the bowels that presents as sudden onset vomiting and/or diarrhoea and can be caused by viruses, bacteria, and parasites. It is usually a self-limiting illness; however, it can also cause elderly people and children to become dehydrated very quickly if fluid intake is not monitored."* [152]

102. The ACQSC identify the following *"key areas"* as relevant to prevention and reduction of the *"spread of contagious diseases, and to respond effectively if an outbreak does occur"*: [153]

(a) **Prevention:** best practice includes:

(i) *"promote **COVID-19 and influenza** vaccination among residents and staff, and monitor and record vaccination status of residents, and staff"*; [154]

(ii) *"plans in place for rapid access of oral antiviral treatments for **COVID-19 and influenza**"*; [155]

(iii) *"[e]nsure staff are trained in detecting and responding to an ARI or gastroenteritis outbreak; support enhanced IPC training for staff"*; [156]

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[151] Aged Care Quality and Safety Commission, *"Are you alert and ready? Safeguarding against infectious illness in aged care settings"* (Factsheet, August 2023) <https://www.agedcarequality.gov.au/sites/default/files/media/are-you-alert-and-ready.pdf> page 1.
[152] Aged Care Quality and Safety Commission, *"Are you alert and ready? Safeguarding against infectious illness in aged care settings"* (Factsheet, August 2023) <https://www.agedcarequality.gov.au/sites/default/files/media/are-you-alert-and-ready.pdf> page 1.
[153] Aged Care Quality and Safety Commission, *"Are you alert and ready? Safeguarding against infectious illness in aged care settings"* (Factsheet, August 2023) <https://www.agedcarequality.gov.au/sites/default/files/media/are-you-alert-and-ready.pdf> page 1.
[154] Aged Care Quality and Safety Commission, *"Are you alert and ready? Safeguarding against infectious illness in aged care settings"* (Factsheet, August 2023) <https://www.agedcarequality.gov.au/sites/default/files/media/are-you-alert-and-ready.pdf> page 2.
[155] Aged Care Quality and Safety Commission, *"Are you alert and ready? Safeguarding against infectious illness in aged care settings"* (Factsheet, August 2023) <https://www.agedcarequality.gov.au/sites/default/files/media/are-you-alert-and-ready.pdf> page 2.
[156] Aged Care Quality and Safety Commission, *"Are you alert and ready? Safeguarding against infectious illness in aged care settings"* (Factsheet, August 2023) <https://www.agedcarequality.gov.au/sites/default/files/media/are-you-alert-and-ready.pdf> page 2.

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(iv) *"[e]nsure adequate supplies of personal protective equipment (PPE), hand hygiene products, waste and cleaning supplies and equipment for regular operations and in event of an outbreak."*;[157] and

(v) Staff exclusion from work if unwell, with the recommended period varying subject to the infection: 48 hours – gastroenteritis; 7-days from positive test – COVID-19; 5-days – influenza.[158]

(b) **Visitor vigilance:** best practice includes:

(i) screening protocols *"to protect people receiving care and staff and reduce the risk of transmission of respiratory illnesses and gastroenteritis"*;[159]

(ii) *"ask visitors whether they have recently had symptoms or been diagnosed with any of these infectious diseases"*;[160]

(iii) *"Encourage visitors to perform hand hygiene and have accessible alcohol-based hand rub products for them to use (including instructions); and ask them to practise respiratory and cough etiquette and use masks as appropriate"*.[161]

(c) **Resident and home care wellbeing:** which includes being mindful of the balance when isolating residents for protection even during an outbreak because *"maintaining connections with family and friends is vital to the wellbeing of aged care residents and elderly people in home care"*. The guidance expressly acknowledges that *"times of outbreak, isolation and lockdown can interrupt this connection and have negative effects both physically and mentally. Plans to avoid and minimise this effect should be in place for each person"*.[162]

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[157] Aged Care Quality and Safety Commission, *"Are you alert and ready? Safeguarding against infectious illness in aged care settings"* (Factsheet, August 2023) <https://www.agedcarequality.gov.au/sites/default/files/media/are-you-alert-and-ready.pdf> page 2.

[158] Aged Care Quality and Safety Commission, *"Are you alert and ready? Safeguarding against infectious illness in aged care settings"* (Factsheet, August 2023) <https://www.agedcarequality.gov.au/sites/default/files/media/are-you-alert-and-ready.pdf> page 2.

[159] Aged Care Quality and Safety Commission, *"Are you alert and ready? Safeguarding against infectious illness in aged care settings"* (Factsheet, August 2023) <https://www.agedcarequality.gov.au/sites/default/files/media/are-you-alert-and-ready.pdf> page 3.

[160] Aged Care Quality and Safety Commission, *"Are you alert and ready? Safeguarding against infectious illness in aged care settings"* (Factsheet, August 2023) <https://www.agedcarequality.gov.au/sites/default/files/media/are-you-alert-and-ready.pdf> page 3.

[161] Aged Care Quality and Safety Commission, *"Are you alert and ready? Safeguarding against infectious illness in aged care settings"* (Factsheet, August 2023) <https://www.agedcarequality.gov.au/sites/default/files/media/are-you-alert-and-ready.pdf> page 3.

[162] Aged Care Quality and Safety Commission, *"Are you alert and ready? Safeguarding against infectious illness in aged care settings"* (Factsheet, August 2023) <https://www.agedcarequality.gov.au/sites/default/files/media/are-you-alert-and-ready.pdf> page 3.

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Example 2: *"Oral antiviral treatments for COVID-19 and influenza viruses in residential aged care services"*

103. Similarly, the guidance published by the ACQSC with respect to *"oral antiviral treatments"* now sets out the treatments specific to COVID-19 *and* influenza.[163] In both cases, the recommendation is that older Australians receiving either treatment *"should be closely monitored for medication side-effect"*.[164]

104. The recommendations regarding responsibilities, preparatory steps, monitoring the preparedness to access and deploy oral antivirals and, significantly, the ACQSC's expectations of provides for the management and mitigation of infection-related risks is the same for both COVID-19 and influenza.[165]

NSW Ministry of Health

105. The uniform approach is also observed in the advice provided by NSW Health to residential aged care facilities about *"Management of acute respiratory infections (including COVID-19, influenza, and respiratory syncytial virus)"* (**NSW Guidance**).[166]

106. An extract of the NSW Guidance appears below:

> *"COVID-19 and influenza continue to co-circulate in the community. It is important to protect those at higher risk of severe disease, including residents of residential aged care facilities (RACFs).*
>
> *NSW Health is working with general practitioners (GPs) and aged care providers to make sure residents have a plan in place in case they develop symptoms of COVID-19 or influenza; including a plan for testing and a discussion about antiviral medicines."*[167]

107. The NSW Ministry of Health also publish the following guidance material for RACFs:

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[163] Aged Care Quality and Safety Commission, *"Oral antiviral treatments for COVID-19 and influenza viruses in residential aged care services"* (Factsheet, August 2023) <https://www.agedcarequality.gov.au/sites/default/files/media/covid-19-oral-antiviral-treatments-in-residential-aged-care-services-fact-sheet.pdf> pages 1-2.

[164] Aged Care Quality and Safety Commission, *"Oral antiviral treatments for COVID-19 and influenza viruses in residential aged care services"* (Factsheet, August 2023) <https://www.agedcarequality.gov.au/sites/default/files/media/covid-19-oral-antiviral-treatments-in-residential-aged-care-services-fact-sheet.pdf> page 2.

[165] Aged Care Quality and Safety Commission, *"Oral antiviral treatments for COVID-19 and influenza viruses in residential aged care services"* (Factsheet, August 2023) <https://www.agedcarequality.gov.au/sites/default/files/media/covid-19-oral-antiviral-treatments-in-residential-aged-care-services-fact-sheet.pdf> pages 2-3.

[166] NSW Ministry of Health, "Management of acute respiratory infections (including COVID-19, influenza, and respiratory syncytial virus)" (Last updated 5 September 2023) <https://www.health.nsw.gov.au/Infectious/covid-19/Documents/racf-ari-guidance.pdf>; NSW Ministry of Health, *"Advice to residential aged care facilities (RACFs)"* (Webpage) <https://www.health.nsw.gov.au/Infectious/covid-19/Pages/racf-latest-advice.aspx>.

[167] NSW Ministry of Health, "Guidance on use of antivirals in residential aged care facilities (RACF)" (Webpage) <https://www.health.nsw.gov.au/Infectious/covid-19/Pages/racf-antivirals.aspx>.

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(a) *"COVID-19 and flu antiviral medicines – advice for people at high risk of severe illness"*: A fact sheet for people at high risk of severe illness, including residents of RACFs, and their loved ones to help guide decisions about using antivirals for COVID-19 and influenza treatment and prevention.[168]

(b) *"Pre-assessment action plan for respiratory infections in aged care facility residents"*: To be completed by a GP and supports the resident (or their guardian) to collaboratively form a plan with their doctor as to what antiviral medicines would be best for them. The pre-assessment form will not replace the requirement for a GP to prescribe the medication prior to administration but it will expedite access to the medication post exposure and for a confirmed case.[169]

(c) *"Influenza and COVID-19 antiviral medicines - advice for clinicians"*: A fact sheet for clinicians to provide guidance on the use of oseltamivir, molnupiravir and nirmatrelvir/ritonavir.[170]

108. NSW Health also collects data about *"respiratory virus activity"* in NSW.[171] For example, data that is collected with respect to influenza and COVID-19 is published in the same surveillance report. [172]

109. Consistently, the NSW Ministry of Health sets out advice, guidance and data with respect to COVID-19 together with influenza because both are considered an acute respiratory infection.

Concluding observations: nature of the work

110. The Joint Employers accept that *"COVID-19"* remains a permanent risk to be managed by residential aged care facilities, together with seasonal influenza. Both respiratory viruses can result in serious respiratory illness and, in severe cases, death.

111. The purpose of the IPC and outbreak management plans is to minimise the risk of infection to residents: a known risk for all providers of residential aged care facilities. The discovery of a new virus introduced a period of necessary research, study and education for the industry – as evidence and knowledge about SARS-CoV-2 was collated. However, with that knowledge

[168] NSW Ministry of Health, *"COVID-19 and flu antiviral medicines – advice for people at high risk of severe illness"* (Factsheet, last updated 25 August 2023) <https://www.health.nsw.gov.au/Infectious/factsheets/Pages/flu-and-covid-antiviral.aspx>.
[169] NSW Ministry of Health, "Pre-assessment action plan for respiratory infections in aged care facility residents" <https://www.health.nsw.gov.au/Infectious/covid-19/Documents/gp-antiviral-pre-assessment-form-aged-care.pdf>.
[170] NSW Ministry of Health, "COVID-19 and influenza antiviral medicines" <https://www.health.nsw.gov.au/Infectious/factsheets/Pages/racf-antiviral-treatments-and-prophylaxis.aspx>.
[171] https://www.health.nsw.gov.au/Infectious/covid-19/Documents/weekly-covid-overview-20230930.pdf
[172] NSW Ministry of Health, *"NSW Respiratory Surveillance Report - week ending 30 September 2023"* (Report, NSW COVID-19 weekly data overview, Epidemiological week 39, ending 30 September 2023) <https://www.health.nsw.gov.au/Infectious/covid-19/Documents/weekly-covid-overview-20230930.pdf>.

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barrier having been bridged, COVID-19 is now grouped together with management of acute respiratory infections and viruses.

112. The aged care industry was able to streamline its IPC and outbreak management processes because both *"IPC"* and *"outbreak management"* are critical pre-existing features of work in aged care.

The level of skill or responsibility involved in doing the work

Pre-pandemic

113. Prior to the pandemic, all staff received the same basic IPC training, which included training about the processes and procedures that take effect during an outbreak. [173] Whilst the definition of an *"outbreak"* is subject to the nature of the infection, the procedures that applied with respect to personal protective equipment, isolation and/or restricted movements throughout the facility applied to each form of outbreak.[174]

114. As previously mentioned, the pre-pandemic studies found the overwhelming majority of respondents reported having a documented IPC program and a dedicated employee with IPC responsibilities. Reference was also made to the existence and use of IPC committees (or equivalent) and Clinical Care Leads as part of IPC protocols .[175]

115. The evidence filed by the Joint Employers also confirms the existence of pre-pandemic IPC protocols. [176]

116. Ms Riboldi also gave evidence of the existence of an IPC committee at RFBI, which meets on a regular basis and oversees the quality control of IPC protocols throughout the villages.[177]

117. For cleaning and laundry roles, additional IPC training is also now built into their training due to the nature of their work. This is because as part of their roles they are required to handle infectious material and/or clean settings/surfaces that may have been exposed to infection.[178]

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[173] See generally, Witness Statement of Johannes Brockhaus dated October 2023 at [16]-[22], [52]; Witness Statement of Chris Mamarelis dated 1 November 2023 at [65]-[68]; Witness Statement of Louanne Riboldi dated 31 October 2023 at [55]-[60].
[174] See Witness Statement of Johannes Brockhaus dated October 2023 at [52].
[175] See generally, Brett G Mitchell et al, *"Organisation and governance of infection prevention and control in Australian residential aged care facilities: A national survey"* (2019) 24(4) *Infection, Disease & Health* 187, 187-193; Ramon Z Shaban et al, *"Scope of practice and educational needs of infection prevention and control professionals in Australian residential aged care facilities"* (November 2020) 25(4) *Infection, Disease & Health* 286, 286-293.
[176] Witness Statement of Johannes Brockhaus dated October 2023 at [49]-[52], Witness Statement of Chris Mamarelis dated 1 November 2023 at [65]-[69]; Witness Statement of Louanne Riboldi dated 31 October 2023 at [55]-[60].
[177] Witness Statement of Louanne Riboldi dated 31 October 2023 at [57].
[178] See generally, Transcript, 6 May 2022, PN7703- PN7704 (Anita Field); Witness Statement of Sandra Joy O'Donnell dated 25 March 2021 [50]; Witness Statement of Ross Heyan dated 31 March 2021 [8].

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The pandemic

118. Between 2020 and 2021, the evidence of the Joint Employers is that their staff and management were met with a steep learning curve (especially early on) as all members of the team were required to adjust to fast changing environment as the latest knowledge and updates were communicated.[179] This was a highly challenging time for those working in aged care and the workforce had huge pressures on them especially during lockdowns.

119. During the peak of the pandemic, the following practices occurred:

(a) all staff received IPC training, which include a combination of online modules and face-to-face training;[180]

(b) IPC training was required to be completed at a higher frequency;[181]

(c) IPC training was updated to incorporate specific *"donning and doffing"* training with respect to PPE (Ms Riboldi's evidence is that RFBI staff were required to complete refresher training *"every three months"*);[182]

(d) providers were required to have a standalone COVID-19 Management Plan (i.e. it could not be imbedded into an existing Outbreak Management Plan);[183]

(e) the cleaning of surfaces or high touch points increased in frequency as part of their COVID-19 Management Plan (some plans may have required a change in chemical[184]);

(f) all providers were required to appoint IPC leads in each of their facilities;[185]

(g) lockdown protocols applied to facilities that encountered a COVID-19 outbreak;[186]

(h) mandatory vaccination and polymerase chain reaction (**PCR**) testing protocols were in force; and

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[179] Witness Statement of Johannes Brockhaus dated October 2023 at [54]; Witness Statement of Chris Mamarelis dated 1 November 2023 at [70]-[71]; Witness Statement of Louanne Riboldi dated 31 October 2023 at [66].

[180] See Witness Statement of Louanne Riboldi dated 31 October 2023 at [66]; Witness Statement of Chris Mamarelis dated 1 November 2023 at [70]; Witness Statement of Johannes Brockhaus dated October 2023 at [54].

[181] Witness Statement of Johannes Brockhaus dated October 2023 at [54], [59]; Witness Statement of Chris Mamarelis dated 1 November 2023 at [70]; Witness Statement of Louanne Riboldi dated 31 October 2023 at [66].

[182] Witness Statement of Johannes Brockhaus dated October 2023 at [59]; Witness Statement of Chris Mamarelis dated 1 November 2023 at [70]; Witness Statement of Louanne Riboldi dated 31 October 2023 at [66].

[183] See Witness Statement of Louanne Riboldi dated 31 October 2023 at [62].

[184] Witness Statement of Johannes Brockhaus dated October 2023 at [54], [59].

[185] See Witness Statement of Johannes Brockhaus dated October 2023 at [59]-[60], Witness Statement of Chris Mamarelis dated 1 November 2023 at [70]; Witness Statement of Louanne Riboldi dated 31 October 2023 at [64]; Department of Health and Aged Care, "Infection Prevention and Control Leads" (Webpage, Last updated 23 October 2023) <https://www.health.gov.au/our-work/infection-prevention-and-control-leads#training-requirements>; Aged Care Quality and Safety Commission, "Infection Prevention and Control Leads: updated for providers" (Fact Sheet) <https://www.agedcarequality.gov.au/sites/default/files/media/final_a4_ipc_fact_sheet.pdf>.

[186] Witness Statement of Johannes Brockhaus dated October 2023 at [59].

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(i) providers were communicating information to all staff about new and/or change requirements at a higher frequency (some change their communication practices to text messages as opposed to email or other forms).

IPC Lead

120. In December 2020, the Department of Health and Aged Care introduced a new requirement for all residential aged care facilities: all residential aged care homes must have an ongoing IPC Lead on site.[187] Home care providers are not required to appoint an IPC Lead.[188]

Description & Purpose

121. The guidance published by the ACQSC stated: *"residential aged care providers must appoint at least one nursing staff member as an infection prevention and control (IPC) lead"*. The purpose of the IPC lead is *"[t]o ensure that residential aged care providers are better prepared to prevent and respond to infectious diseases, including COVID-19 and influenza"*.[189]

122. The ACQSC provide the following description of the IPC lead role:

> *"The IPC lead(s) role within the service is to observe, assess and report on infection prevention and control, and to assist with developing procedures and providing best practice advice. This is to ensure that each service has up-to-date processes and procedures in place regarding infection prevention and control, and outbreak management, which are reflective of best practice."*[190]

123. The ACQSC also state:

> *"Implementation of IPC leads is designed to increase infection prevention and control expertise across the aged care sector. Each residential aged care facility will have at least one dedicated expert who will maintain responsibility for designing, implementing and monitoring infection prevention and control practices to support safe and quality aged care service provision. In addition, all staff must have completed IPC training and be competent in IPC practices.*
>
> *The Commission expects that, in accordance with the Aged Care Quality Standards, each residential aged care provider will develop and implement an effective infection*

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[187] Department of Health and Aged Care, *"Infection Prevention and Control Leads"* (Webpage) <https://www.health.gov.au/our-work/infection-prevention-and-control-leads#training-requirements>.
[188] Aged Care Quality and Safety Commission, "Infection Prevention and Control Leads: updates for providers" (Factsheet) <https://www.agedcarequality.gov.au/sites/default/files/media/final_a4_ipc_fact_sheet.pdf>.
[189] Aged Care Quality and Safety Commission, "Infection Prevention and Control Leads: updates for providers" (Factsheet) <https://www.agedcarequality.gov.au/sites/default/files/media/final_a4_ipc_fact_sheet.pdf>.
[190] Aged Care Quality and Safety Commission, "Infection Prevention and Control Leads: updates for providers" (Factsheet) <https://www.agedcarequality.gov.au/sites/default/files/media/final_a4_ipc_fact_sheet.pdf>.

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prevention and control program that is in line with national guidelines, including recommendations, advice or guidelines from the Infection Control Expert Group which advises both Communicable Disease Network Australia (CDNA), and the Australian Health Protection Principal Committee (AHPPC). Other guidance issued by the Commission, state and territory governments and the Department of Health should also be referenced, noting that guidance is being updated frequently."[191]

Specialist Training

124. An IPC Lead is required to complete the following training:

(a) *"specialist"* IPC training; and

(b) COVID-19 Aged Care Infection Control Online Training Modules. [192]

125. The Department of Health and Aged Care identify four features of a *"suitable"* IPC specialist course:

(a) focus on IPC;

(b) are specified at the level of AQF8;

(c) are delivered by a recognised education or training provider; and

(d) require students to pass assessments to complete the course.

126. The Department of Health and Aged Care also provide examples of training courses that meet the requirements prescribed by the Department:

(a) *"Foundations of Infection Prevention and Control for Aged Care Staff"*;

(b) *"Graduate Certificate in Infection Prevention and Control, Griffith University"*;

(c) *"Master in Infection Prevention and Control, Griffith University"*;

(d) *"Graduate Certificate of Infection Control, James Cook University"*; and

(e) *"Graduate Certificate in Nursing Science (Infection Control Nursing), University of Adelaide"*. [193]

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[191] Aged Care Quality and Safety Commission, "Infection Prevention and Control Leads: updates for providers" (Factsheet) <https://www.agedcarequality.gov.au/sites/default/files/media/final_a4_ipc_fact_sheet.pdf>.
[192] Department of Health and Aged Care, *"Infection Prevention and Control Leads"* (Webpage) <https://www.health.gov.au/our-work/infection-prevention-and-control-leads#training-requirements>.
[193] Department of Health and Aged Care, *"Infection Prevention and Control Leads"* (Webpage) <https://www.health.gov.au/our-work/infection-prevention-and-control-leads#training-requirements>.

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Impact as at 2023

127. As at 2023, the following practices occur:

(a) All staff continue to receive IPC training, which retains updated content in relation to PPE (example, training in relation to *"donning and doffing"*). However, the frequency has returned to annual. [194]

(b) Providers are not required to have a standalone COVID-19 Management Plan, both Buckland and RFBI have incorporated management of COVID-19 into their outbreak management plan.[195] However, some providers continue to keep their COVID-19 protocol separate.

(c) The requirement to appoint IPC Leads in each facility continues, due to the responsibilities of the IPC Lead this has a corresponding impact of increasing awareness and education about IPC for all staff.[196]

128. The following practices are no longer prevalent:[197]

(a) outside of an outbreak, mandatory practices in relation to mask wearing and increased surface cleaning do not apply;

(b) a high frequency of messages about changes to IPC and outbreak management protocols and government notifications about official advice in relation to COVID-19;

(c) mandatory vaccination and daily/weekly PCR testing (although some providers continue to implement policies with respect to vaccinations and/or rapid antigen tests (**RATs**)); and

(d) mandatory widespread facility lockdowns in the event of an outbreak (this response is now actively discouraged).

Observations

129. The Joint Employers acknowledge that a material change in responsibility has occurred for the IPC lead. Since the end of the pandemic the ongoing management of COVID-19 now forms part of a facility's IPC programs alongside other similar conditions such as influenza.

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[194] See Witness Statement of Louanne Riboldi dated 31 October 2023 at [71]; Witness Statement of Johannes Brockhaus dated October 2023 at [59].

[195] See Witness Statement of Johannes Brockhaus dated October 2023 at [55]-[58], Annexure JB-4 (combined with managed of acute repository infection); Witness Statement of Louanne Riboldi dated 31 October 2023 at [67], Annexure LR-4.

[196] Witness Statement of Johannes Brockhaus dated October 2023 at [60]; Witness Statement of Louanne Riboldi dated 31 October 2023 at [72]; Department of Health and Aged Care, *"Infection Prevention and Control Leads"* (Webpage) <https://www.health.gov.au/our-work/infection-prevention-and-control-leads>.

[197] See generally, Witness Statement of Johannes Brockhaus dated October 2023 at [59]; Witness Statement of Chris Mamarelis dated 1 November 2023 at [74]-[76]; Witness Statement of Louanne Riboldi dated 31 October 2023 at [67].

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The conditions under which the work is done

The pandemic

130. During the peak of the pandemic, the conditions under which work was done was stressful in the extreme. Direct care workers in particular were described as *"frontline workers"*, working in a position where they may be required to provide personal or clinical care to someone with COVID-19. Even if the facility was not encountering an outbreak, it was an extremely challenging time for all staff members at various points.

131. The conditions were particularly difficult due to how much was unknown at that time. Governments, health and medical practitioners, aged care providers and Australian citizens were all working through an unfolding and developing situation. A key message that was made clear was that COVID-19 could lead to serious health complications and possibly death, which was particularly worrisome when there was no clear advice on treatment or the option of vaccination available.

Impact as at 2023

132. As at 2023, the conditions under which work is done have reverted back to *"pre-pandemic"* times in the following sense:[198]

(a) while the pandemic has abated there remains an ambient shift in the awareness of infection control and hygiene across the industry which is typified by the increased emphasis and adherence to many hygiene practices including hand washing and use of sanitisers etc.

(b) each provider is able to set and communicate its Outbreak Management Plan to staff and provide clear messaging and training with respect to the same;

(c) all staff continue to complete IPC training (and annual refreshers) but not at the intensified frequency as occurred during the peak of the pandemic;

(d) providers are very much encouraged to avoid lockdown of facilities; and

(e) the requirements for regular PCR testing and RATs no longer apply, save for instances in which staff members display symptoms – which is set out in the outbreak management plan (similar to not attending work if you show flu like symptoms).

[198] See Witness Statement of Johannes Brockhaus dated October 2023 at [55]-[60]; Witness Statement of Chris Mamarelis dated 1 November 2023 at [74]-[76]; and Witness Statement of Louanne Riboldi dated 31 October 2023 at [71].

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133. The severity of the pandemic and how it impacted aged care during the pandemic is never far from the minds of staff, the residents and their families. IPC continues to play a major role in the protection of residents in the care of aged care providers.

Observations

134. As at 2023, the conditions under which work is done in aged care setting no longer features that same level of work intensification; we are no longer in a pandemic. However, the ambit environment concerning hygiene and infection control has been refocussed for all in aged care.

135. COVID-19 continues to be recognised as a permanent risk and its management is now approached in conjunction with other acute respiratory infections.

Response to ANMF Submissions

136. To the extent the ANMF submissions suggest that IPC protocol and outbreak management plans did not exist prior to the COVID-19 pandemic that characterisation of residential aged care settings is unsound.

137. Whilst the discovery of SARS-CoV-2 and declaration of a pandemic prompted a period of heightened measures, especially between 2020-2021, that period of dramatic work intensification was a transitory phenomenon. The evidence reveals that the 'peak pandemic' intensification is now abated.

138. The following submissions are advanced in reply to the ANMF:

(a) The ANMF submissions at [13] refer to the permanency of SARS-CoV-2 (i.e. it will be around for the long haul like influenza) and the requirement for aged care facilities to manage the risk of COVID-19 outbreaks.

(b) COVID-19 is a respiratory illness that the aged care industry will need to respond to for as long as it persists in the community. If a facility experiences an outbreak it will need to respond to it in accordance with current government requirements.

(c) This is reflected in IPC protocols and outbreak management plans. Such protocols and plans have obviously evolved through the pandemic and there remains a real focus on COVID-19 and an increased focus on hygiene generally in the industry following the end of the pandemic.

(d) Importantly, the introduction of the IPC Lead is a key component of this and has introduced a new level of responsibility for that role.

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(e) Reference is made to the evidence of Mark Sewell (CEO of Warrigal[199]) that referred to IPC lessons learned from COVID being incorporated going forward (at [8(2)]). That observation demonstrates how existing practices and procedures have evolved and been updated to reflect the latest knowledge about managing respiratory infections, which now includes SARS-CoV-2 as the pandemic developed and since its passing. Reference in that respect is made to the evidence of Ms Riboldi and Mr Brockhaus.[200]

(f) The ANMF refer to an *"overhaul"* of education in IPC as a result of COVID-19 (at [21]). Between 2020-2021, the peak of the pandemic, SARS-CoV-2 was a new respiratory infection and was treated as such. Clearly its discovery caused widespread disruption to the industry as determinations were made about how to manage the risks of transmission and spread. Working from their existing IPC protocols, facilities have further evolved those protocols and practices through the pandemic and now the pandemic has passed which has brought an increase in focus for IPC generally.

Response to HSU Submissions

139. The HSU submissions largely advance the view that there is now an ongoing risk of SARS-CoV-2 in aged care which, in principle, is not a contested issue.

[199] At the time of his evidence.

[200] Witness Statement of Johannes Brockhaus dated October 2023 at [59]-[60]; Witness Statement of Louanne Riboldi dated 31 October 2023 at [67]-[72].

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PART III – WORK INTENSIFICATION AND STAFFING LEVELS

140. In the *Stage 1 Decision*, the Full Bench held that that "work intensification **may** constitute an increase in work value" (emphasis added). However, such a finding requires assessment of whether "work intensification is a **permanent feature of the work** in question; or **a transitory phenomenon which will abate when staffing levels increase**".[201]

141. By that statement of principle, the Full Bench clearly distinguishes between two types of work intensification:

(a) permanent features of the work that will not be altered by an increase in staffing levels (**permanent work intensification**); and

(b) a temporary feature of the work that may be reduced with an increase in staffing levels (**temporary work intensification**).

142. The Full Bench provided an example of permanent work intensification, namely, *"the needs of those living in residential aged care facilities and those being cared for in their homes, have significantly increased in terms of* ***clinical complexity, frailty and cognitive and mental health****"* (emphasis added).[202] That instance of work intensification contributed to the decision to award direct care workers an increase in the *Stage 1 Decision.*

143. Whilst the Full Bench in the *Stage 1 Decision* confirmed that *"the* ***issues arising*** *from understaffing"* were not taken into account in the interim increase awarded to direct care workers,[203] the Full Bench emphasised the need for a *"cautious approach to the assessment of workload and work value,"*[204][205]

144. The aged care industry is suffering a shortage of employed staff. The industry is responding to this in large measure through reducing capacity and increasing its reliance on agency staff.[206] Separate to this, staff shortages do give rise to ad hoc reorganisation of activity on shifts and increased use of external services such as the hospital system.

145. The Full Bench findings of *"work intensification"* with respect to nurses and PCWs in the *Stage 1 Decision*, illustrates the type of evidence required to demonstrate permanent work

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[201] *Stage 1 Decision* at [220] (emphasis added).
[202] *Stage 1 Decision* at [220].
[203] *Stage 1 Decision* at [973].
[204] *Stage 1 Decision* at [220].
[205] *Stage 1 Decision* at [220] (emphasis added).
[206] See Department of Health, *"2020 Aged Care Workforce Census Report*" <https://www.health.gov.au/sites/default/files/documents/2021/10/2020-aged-care-workforce-census.pdf>; Department of Health, "The Aged Care Workforce, 2016" (March 2017) <https://www.gen-agedcaredata.gov.au/www_aihwgen/media/Workforce/The-Aged-Care-Workforce-2016.pdf>; Committee for Economic Development of Australia, "Duty of care: Aged-care sector running on empty" (2023) <https://cedakenticomedia.blob.core.windows.net/cedamediacontainer/kentico/media/attachments/ceda-duty-of-care-3.pdf>.

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intensification. At [557], the Full Bench found that *"the workload of nurses and PCW/AINs has increased, as has the intensity and complexity of their work".*[207] The expert evidence cited as underpinning that finding referred to the following:

(a) the needs of older people in residential care have increased over the last decade, with residents requiring more complex and varied assistance with their physical, psychological, social and emotional lives;[208]

(b) increased diversity among residents in aged care, who are recognised as having special needs;[209]

(c) new regulatory requirements have increased the amount and quality of assessment and documentation required in the provision of care;[210]

(d) the requirement for workers to flexibly switch between *"everyday tasks" and "more specialised clinical duties"*;[211] and

(e) the circumstances in which *"due to increases in the complexity and amount of work they have less time to spend with each resident".*[212]

146. Significantly, each of those features represent a permanent change to the work in question. Such that an increase in staffing levels would not abate the resulting *"work intensification"* to the roles of nursing employees and personal care workers. Each is a *permanent* feature of the work.

147. However, issues relating to staffing levels should not be simply conflated with work value reasoning as the Commission has observed.

[207] *Stage 1 Decision* at [557].
[208] *Stage 1 Decision* at [558], citing evidence of Prof Meagher.
[209] *Stage 1 Decision* at [558], citing evidence of Prof Meagher.
[210] *Stage 1 Decision* at [558], citing evidence of Prof Meagher.
[211] *Stage 1 Decision* at [562].
[212] *Stage 1 Decision* at [567].

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PART V – SECTIONS 157(2)(b), 134(1)(g) AND 284(1)(d): ANALYSIS OF AWARD MINIMUM WAGES

Introduction

148. If the Commission determines that a change to the classification structure and/or minimum award rates is justified by work value reasons, it is also required to be satisfied that any determination outside the system of annual wage reviews is necessary to achieve the modern awards objective and minimum wages objective: s 157(2)(b).[213]

149. The Joint Employers continue to rely on the submissions advanced in Closing Submissions at [23.1]-[23.26].

[213] *Fair Work Act 2009* (Cth), s 157 (2) refers s 134.

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PART VI – SECTIONS 157(2)(b) & 134(1)(f): FINANCIAL STABILITY

150. The aged care industry is only sustainable on the basis of government funding. Absent funding the outcome for many employers will be the imposition of further losses and deficits and the undermining of normal and prudent financial operations; introducing further erosion to already challenged financial stability.[214]

151. The Joint Employers rely on the Expert Witness Report *"Financial Effect of FWC Award Increase"* prepared by Stuart Hutcheon of StewartBrown (**Expert Report**).

152. Mr Hutcheon provides the following summary of the conclusions reached based on the analysis set out in the Expert Report:

> • *The current financial position and sustainability of the aged care sector is at a very vulnerable level. Residential aged care has experienced significant operating losses for over the last four years with the operating deficit for the 2022-23 financial year representing $1.05 billion ($16.54 per bed day). Home care operating results have declined to be of a marginal level and were $3.14 per client day.*
>
> • *A 10% increase for direct care workers (including ROAs) would increase staffing costs by an estimated $1,148 million per annum and the aged care sector would not have the ability to absorb this without being fully funded by the Government.*
>
> • *A 25% increase for residential indirect care workers would increase staffing costs by a further estimated $763 million per annum (excluding the impact of the 10% increase noted above) and the residential aged care sector would not have the ability to absorb this without being fully funded by the Government.*
>
> • *A 18.11% increase for nursing employees covered by the Nurses Award would increase staffing costs by a further estimated $1,074 million per annum (excluding the impact of the 10% increase and 25% increase noted above) and the aged care sectors would not have the ability to absorb this without being fully funded by the Government.*
>
> • *There exists a significant workforce shortage which impacts the ability of residential aged care and home care Providers to maintain adequate staffing levels without using agency staff or overtime which comes at a significant additional cost.*[215]

153. The relevance of this of course is amplified when one considers the role of the industry in the community and the vulnerable group of people that it services, supports and cares for.

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[214] See Witness Statement of Stuart Hutcheon 1 November 2023, Annexure SH-3.

[215] Witness Statement of Stuart Hutcheon 1 November 2023, Annexure SH-3 at [1.3].

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154. Revenue for residential aged care providers has been consistently failing to keep up with the cost of delivering services. This has led to the majority of providers losing money with the trend continuing despite recent injections of funding from government. This is particularly critical in relation to indirect care staff, many of whom provide daily services to residents and are therefore funded through a combination of the 'basic daily fee', paid by residents, and the 'hotelling supplement' paid by government. These amounts combined are substantially less than the cost of delivering daily services such as meals, cleaning and laundry to residents. This deficit is one of the key drivers of provider losses and unsustainability. Any increase in indirect care staff wages without attendant funding would not only exacerbate this issue but likely lead to an increase in home closures, which are already accelerating.

155. As a result of the Royal Commission, reform has been rapid and wide ranging. These reforms are welcomed where they improve outcomes and quality of life for residents and clients, but many have increased the financial impost on providers without resolving the underlying financial situation of the industry, thereby worsening it.

For the Joint Employers

Nigel Ward

CEO + Director

Australian Business Lawyers & Advisors

Alana Rafter

Senior Associate

Australian Business Lawyers & Advisors

1 November 2023

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FAIR WORK COMMISSION

AM2020/99; AM2021/63; AM2021/65

WORK VALUE CASE – AGED CARE INDUSTRY

SUBMISSIONS IN SUPPORT OF DRAFT DETERMINATIONS AND CLASSIFICATIONS AND ALLOWANCE ISSUES

AGED & COMMUNITY CARE PROVIDERS ASSOCIATION LTD

AUSTRALIAN BUSINESS INDUSTRIAL

("THE JOINT EMPLOYERS")

1 NOVEMBER 2023

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PROCEDURAL BACKGROUND

1. On 2 August 2023, the Fair Work Commission (**the Commission**) published a revised *"Stage 3 issues summary"* (**Summary Document**) and President Hatcher gave directions for the programming of Stage 3 (**the Directions**).

2. The Summary Document contains two categories of issues:

   (a) *"classifications and allowance issues"* (Issues 1-16); and

   (b) *"wage and adjustment issues"* (Issues 17-18).

3. The Directions included the following:

   > *"8. Any party proposing a variation to award classification and pay structures, classification descriptors or allowances shall file a draft determination setting out its proposed variations by* ***5:00 pm (AEST) on Friday, 15 September 2023****.*
   >
   > *9.Each interested party shall file a document setting out its position with respect to each of the classification and allowance issues by* ***5:00 pm (AEST) on Friday, 15 September 2023****.*
   >
   > *10. Any party which has filed a draft determination pursuant to item 8 of these directions shall file evidence and submissions in support of its draft determination, as well as any other evidence in chief and submissions concerning the classifications and allowance issues, by* ***5:00 pm (AEST) on Friday, 27 October 2023****."*

4. On 15 September 2023, the following draft determinations were filed pursuant to paragraph 8 of the Directions:

   (a) Draft Determination – *Aged Care Award 2010* prepared by the Joint Employers (**JE-DD1**);

   (b) Draft Determination – *Social, Community, Home Care and Disability Services Industry Award 2010* (***SCHADS Award***) prepared by the Joint Employers (**JE-DD2**);

   (c) Draft Determination – *Aged Care Award 2010* prepared by the Australian Nursing and Midwifery Federation (**ANMF**) (**ANMF-DD1**); and

   (d) Draft Determination – *Nurses Award 2020* prepared by the ANMF (**ANMF-DD2**).

5. On 28 September 2023, the Health Services Union (**HSU**) filed the following draft determinations:

   (a) Draft Determination – *Aged Care Award* 2010 (**HSU-DD1**); and

   (b) Draft Determination – *SCHADS Award* 2010 (**HSU-DD2**).

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6. On 13 October 2023, President Hatcher amended paragraph 10 of the Directions, by extending the filing deadline to 5:00pm (AEST) on Wednesday, 1 November 2023.

7. These submissions are filed pursuant to paragraph 10 of the Directions (as amended).

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SUMMARY OF POSITION

Structure

8. The Joint Employers' submissions address the following matters:

   (a) Part I: Draft Determination – *Aged Care Award* (JE-DD1);

   (b) Part II: Draft Determination – *SCHADS Award* (JE-DD2); and

   (c) Part III: Classification and allowance issues.

Approach

9. The Applications seek that the Commission vary the modern award minimum wages and classification structures in the *Aged Care Award*, *SCHADS Award* and *Nurses Award* (**the Awards**). This determination requires a consideration of *"work value reasons"*, the modern awards objective and the minimum awards objective.[1]

10. For avoidance of doubt and an abundance of caution, this submission does not deal with *"work value reasons"*. This submission deals with an explanation of the Joint Employers' proposed variations to the classification and pay structures, classification descriptors and allowances in the *Aged Care Award* and *SCHADS Award*, which appear in in JE-DD1 and JE-DD2 (collectively, **the Draft Determinations**).

11. The relevant principles are set out in the *Stage 1 decision* and will not be repeated in these submissions,[2] save for highlighting particular matters that guided the Joint Employers' construction of the Draft Determinations.[3]

Fixing Modern Award Minimum Wages

12. Consistent with approaches adopted in the *Pharmacy Decision*[4] and the *ACT Child Care Decision*[5], the fixing of minimum wages in the Draft Determinations was guided by the *"C10 Metals Framework Alignment Approach"*.[6]

---

[1] *Fair Work Act* (2009) (Cth), s 157(2), (2A).
[2] See *Stage 1 decision* [2022] FWCFB 200 at [125]-[293].
[3] *Stage 1 decision* [2022] FWCFB 200 at [66]-[293].
[4] *Four Yearly Review of Modern Awards – Pharmacy Industry Award 2010* [2018] FWCFB 7621 (**Pharmacy Decision**).
[5] *Australian Liquor, Hospitality and Miscellaneous Workers Union re Child Care Industry (Australian Capital Territory) Award 1998 and Children's Services (Victoria) Award 1998 – re Wages rates* PR954938 [2005] AIRC 28 (**ACT Child Care Decision**).
[6] See *Stage 1 decision* at [176]-[178], citing Pharmacy Decision at [150]–[161] and ACT Child Care Decision at [155].

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13. The C10 Metals Framework Alignment Approach was described in the *ACT Child Care Decision* as a three step process for the determination of *"properly fixed minimum rates"*.[7] Those three steps are as follows:

> *"1. The key classification in the relevant award is to be fixed by reference to appropriate key classifications in awards which have been adjusted in accordance with the MRA process with particular reference to the current rates for the relevant classifications in the Metal Industry Award. In this regard the relationship between the key classification and the Engineering Tradesperson Level 1 (the C10 level) is the starting point.*
>
> *2. Once the key classification rate has been properly fixed, the other rates in the award are set by applying the internal award relativities which have been established, agreed or maintained.*
>
> *3. If the existing rates are too low they should be increased so that they are properly fixed minima"*[8]

14. In the *Stage 1 decision*, the Full Bench observed that the C10 Metals Framework Alignment Approach and Australian Qualifications Framework (**AQF**) are *"useful tools"* with respect to s 134(1)(g) in *the Fair Work Act 2009* (Cth).[9] The Full Bench observed *"aligning rates of pay in one modern award with classifications in other modern awards with similar qualification requirements will support a system of fairness, certainty and stability"*.[10]

15. This exercise, of course, does not negate the need for the Commission to consider whether *"work value reasons"* exist which justify an increase in award minimum wages.[11] That remains to be an important evaluative judgment to be made by the Commission having regard to the evidence filed in Stages 1, 2 and 3. This exercise sits outside of the basis upon which we have considered the classifications and their relationship to each other at first instance and in undertaking this first instance exercise we have:

    (a) ensured that no minimum rate is reduced; and

    (b) suggested some increases to minimum rates to ensure better alignment with the C10 framework.

16. The C10 Metals Framework Alignment Approach underpins the assessment of the value of work, by providing the Commission with a means to *objectively* assess the existing award

[7] *ACT Child Care decision* at [155].
[8] *ACT Child Care decision* at [155].
[9] *Stage 1 decision* [2022] FWCFB 200 at [192].
[10] *Stage 1 decision* [2022] FWCFB 200 at [192] (emphasis added).
[11] *Stage 1 decision* [2022] FWCFB 200 at [960].

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minimum wages and whether they represent properly fixed minimum rates, which is entirely consistent with the promotion and pursuit of the modern awards objective and the minimum wages objective, especially the need to ensure a "*stable and sustainable modern award system*" and have regard to the principle of *"equal remuneration for work of equal or comparable value"*.[12]

17. Whether any further adjustment to the award minimum wages is warranted will be determined by the Commission based upon its satisfaction that the variation is justified by the work value reasons and a consideration of the modern awards objective and minimum wages objective.

Classification Structure & Definitions

18. Turning then to classification structure and definitions included in the Draft Determinations, consistent with the approach taken in the *Teachers Decision*, the construction was informed by *"the essential elements of qualifications, displayed competence and acquired experience and responsibility"* of each classification level[13] based upon the evidence before the Full Bench in Stage 1.[14] This approach ensures that markers of distinction and progression between classification levels are clear, simple and easy to understand by both employee and employer.[15]

19. Further, with a view to promote a stable modern award system, reference is also made to the construction of comparative classification definitions in other industry awards (see Annexure A).[16]

Part I: Draft Determination – *Aged Care Award* (JE-DD1)

C10 Metals Framework Alignment Approach

20. By reference to the analysis of modern award minimum wages in Part I, the Joint Employers' position as to the setting of award minimum wages in the *Aged Care Award* is as follows:

    (a) the award minimum wage for aged care employee—general levels 1-5 should be maintained;

    (b) the award minimum wage for aged care employee—direct care levels 1-5, should be maintained;

    (c) the award minimum wage for aged care employee—general level 6 should be increased (it is currently below the C7 level, albeit only marginally lower); and

[12] *Fair Work Act 2009* (Cth) s 134(1)(g).
[13] See *Independent Education Union of Australia* [2021] FWCFB 2051 at [647] (**Teachers Decision**).
[14] The Full Bench also had the benefit of an overview of the evidence of law witnesses called by union parties in the Report to the Full Bench (Commissioner O'Neill, 20 June 2022).
[15] *Fair Work Act 2009* (Cth) s 134(1)(g).
[16] *Fair Work Act 2009* (Cth) s 134(1)(g).

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(d) the award minimum wage for aged care employee—direct care level 6 should be marginally increased.

21. Based upon observations of the Stage 1 evidence, JE-DD1 does not include a classification level for either aged care employee—general—level 7 or aged care employee—direct care—level 7.

Classification Structure & Definitions

22. The classification structure and definitions proposed in JE-DD1 are consistent with the evidence in Stage 1 and the modern awards objective. The Joint Employers propose that the existing classification streams in Schedule B be deleted and replaced with following classification streams:

(a) **direct care stream**, which covers employees that perform *"direct care duties"*;

(b) **recreational activities stream**, which covers employees that perform *"leisure and lifestyle duties"*;

(c) **general services stream**, which covers employees that perform *"general services duties"* in residential aged care facilities. General services duties is defined as including *"laundry duties"*, *"cleaning duties"* and *"driving duties"*;

(d) **maintenance services stream**, covers employees that perform "*maintenance services"* in residential aged care facilities, which may include *"gardener duties"* or *"maintenance duties"*;.

(e) **administration services stream**, which covers employees that perform *"administration duties"* in residential aged care facilities; and

(f) **food services stream**, which covers employees that perform ***"****kitchen and servery duties"* or *"cooking duties"* in residential aged care facilities.

23. The inclusion of distinct employment streams, together with descriptions of the work performed, skills and minimum qualification requirements of each role provides much needed clarity to the *Aged Care Award*. The proposal in JE-DD1 introduces essential detail into the classification structure to ensure that all aged care employers and employees can easily understand the minimum terms and conditions that apply to classifications in the aged care industry.

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Part II: Draft Determination – *SCHADS Award* (JE-DD2)

C10 Metals Framework Alignment Approach

24. By reference to the analysis of modern award minimum wages in Part II, the Joint Employers' position is that the award minimum wage for home care employees providing services to an aged person (levels 1 to 5) should be maintained. Upon that basis, no variation to the minimum weekly wages for home care employees is proposed in JE-DD2.

Classification Structure & Definitions

25. The Joint Employers propose only minimal variation to the existing classification structure and definitions in Schedule E of the *SCHADS Award*.

26. There are two broad variations proposed in JE-DD2:

    (a) *First*, Schedule E expressly distinguishes between two types of home care employee, with inclusion of the following classification levels:

        (i) *"home care employee—aged care—levels 1-5"*; and

        (ii) *"home care employee—disability—levels 1-5"*.

    (b) *Second*, the classification definitions for *"home care employee—aged care—levels 1-5"* include a series of minor amendments, with the most material amendments being a restructure of the *"specialist knowledge and skills"* section of each classification level (but retaining the majority of the existing text).

27. The collective effect of the proposal in the JE-DD2 serves to enhance the usability and clarity of Schedule E (to the extent it applies to home care employees in aged care). No changes were proposed to the content of the *"disability"* classification levels, save for express inclusion of *"disability"* with the classification level heading (i.e. "*home care employee—disability"*).

Part III: Classification and allowance issues

28. Turning to the classification and allowance issues, the Joint Employers rely on the submissions advanced in this document, together with the submissions set out in the position document filed 15 September 2023.

29. The Joint Employers submit that the classification structure, definitions and allowances set out in JE-DD1 and JE-DD2 are consistent with the applicable legal principles and supported by the evidence in the proceedings.

30. The Joint Employers will provide a further response to the draft determinations filed by the HSU and ANMF, pursuant to paragraph 11 of the Directions, following the opportunity to review their submissions in support of the respective draft determinations filed by the unions.

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PART I: DRAFT DETERMINATION – *AGED CARE AWARD* (JE-DD1)

C10 Metals Framework Alignment Approach

Step 1: Key Classification

31. Consistent with the approach set out in *ACT Child Care Decision*, the *"key classification"* was identified within the *"direct care"* and *"general"* streams:[17]

    (a) *"aged care employee—general—level 4"*; and

    (b) *"aged care employee—direct care—level 4"*.

32. The *"aged care employee—general—level 4"* aligns to the C10 level in the *Manufacturing Award*, with a minimum weekly wage of $995. Factoring the operation of the 15% increase, the *"aged care employee—direct care—level 4"* aligns to the C10 level (+ 15%), with a minimum weekly wage of $1144.20.

33. By reference to the replies to Background Document 10 filed by each party, identification of the key classification in the *Aged Care Award* appears to be uncontroversial.[18]

34. At this juncture it is noted that the classification structure in JE-DD1 proposes a re-numbering of classification levels. This will be addressed in the context of the submissions in support of classification structure and definitions. For the purpose of applying the C10 Metals Framework Alignment Approach, this part of the submissions will address the existing classification levels in the *Aged Care Award*.

Steps 2 & 3: Analysis of Internal Relativities

35. As the key classification was already properly fixed, an analysis of the internal relativities was conducted by reference to the following:

    (a) the existing internal relativities in the *Aged Care Award* for both *"general"* and *"direct care"* classifications; and

    (b) the minimum award weekly wages in the *Manufacturing Award* that align to the aged care classifications by reference to the minimum training requirements and competencies set out in that award (i.e. **the C10 framework**).

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[17] *ACT Child Care Decision* at [155].

[18] See ANMF Reply to Background Document 10 dated 7 March 2023; HSU Reply to Background Document 10 dated 7 March 2023; UWU Reply to Background Document 10 dated 7 March 2023.

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Preliminary Considerations

36. Prior to turning to that analysis, Tables A1 and A2 provide an overview of the C10 framework and its alignment with the *Aged Care Award*, with reference to minimum training requirements referred to in classification descriptions in the awards and the Stage 1 evidence.

37. At the outset it is also noted that the minimum weekly wages in the C10 framework no longer reflect the relativities because *"some wage increases since 1990 have been expressed in dollar amounts rather than percentages and as a result have reduced the relativities"*.[19] For the purposes of aligning award minimum wages, the Joint Employers have used the minimum weekly wage as opposed to the relativity.

Table A1 – C10 framework

Level	Minimum Training Requirements	Relativity	Minimum weekly wage ($)
C14	Up to 38 hours induction training	78%	859.30
C13	In-house training	82%	882.80
C12	Certificate I or Certificate II or equivalent	87.4%	914.90
C11	Certificate II	92.4%	945.00
C10	**Recognised Trade Certificate or Certificate III or equivalent**	**100%**	**995.00**
C9	C10 (Trade certificate III) + 20% towards Diploma or equivalent	105%	1026.20
C8	C10 (Trade certificate III) + 40% towards Diploma or equivalent	110%	1057.40
C7	Certificate IV, or C10 (Trade certificate III) + 60% towards Diploma or equivalent	115%	1085.60
C6	C10 + 80% towards a Diploma, or equivalent.	125%	1140.70
C5	Diploma or equivalent	130%	1164.10
C4	80% towards an Advanced Diploma or equivalent.	135%	1195.30
C3	Advanced Diploma or equivalent	145%	1257.90
C2(a)	Advanced Diploma or equivalent + additional training	150%	1289.30
C2(b)	Advanced Diploma or equivalent + additional training	160%	1345.70
C1	Degree	180/210%	

[19] See *Manufacturing and Associated Industries and Occupations Award 2020* (**Manufacturing Award**); *Re Metal Industry Award 1984—Part I* (M039 Print J2043)

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Table A2 – Minimum Training Requirements in *Aged Care Award*

ACA Level	ACA Descriptions	Stage 1 Evidence	C10 Level
1	Less than 3 months experience	-	C14
2	-	-	C13 - C12
3	-	-	C11
4	Certificate III or Recognised Trade Certificate	Certificate III[20] or Recognised Trade Certificate[21]	C10
5	Formal qualifications at trade or certificate level (*"may require"*)	Certificate III + 3 years' experience (direct care)[22]	C9
6	Formal qualifications at post-trade or Advanced Certificate or Associate Diploma (*"may require"*)	Certificate IV[23]	C7
7	Formal qualifications at post-trade or Advanced Certificate or Associate Diploma (*"may require"*)	-	C6

Analysis of the internal relativities

38. Tables B1 and B2 provide a side-by-side comparison of the existing internal relativities in the *Aged Care Award*, for both *"general"* and *"direct care"* classifications, respectively, against the C10 framework.

Table B1 – Aged care employee—general

ACA		C10 framework		ACA Minimum Wage Difference
Level 1	910.90	C14	859.30	ACA ↑ 6%

[20] Amended witness statement of Carol Austen dated 20 May 2022 at [8]; Witness statement of Theresa Heenan dated 20 October 2021 at [107]; Witness statement of Sandra Hufnagel dated 30 March 2021 at [16]; Amended witness statement of Virginia Mashford dated 6 May 2022 at [48]; Witness statement of Sandra O'Donnell dated 25 March 2021 at [17]; Witness statement of Lyndelle Park dated 31 March 2021 at [15]; Transcript, 11 May 2022, PN11696; Witness statement of Tracy Roberts dated 23 March 2021 at [4]; Amended witness statement of Veronique Vincent dated 19 May 2022 at [21]; Witness statement of Kristy Youd dated 24 March 2021 at [25]; Witness statement of Mark Sewell dated 3 March 2022 at [92]; Witness statement of Johannes Brockhaus dated 3 March 2022 at [14]; Witness statement of Anna-Maria Wade dated 23 May 2022 at [46].

[21] See Witness Statement of Kevin Mills dated 30 March 2021 [7]-[8] (trade certificate in greenkeeping); Witness Statement of Eugene Basciuk, dated 28 May 2022 at [12] (Electrical Fitter/Mechanical Trade Certificate).

[22] See example, Witness statement of Mark Sewell dated 3 March 2022 at [93]; Statement of Anna-Maria Wade dated 4 March 2022 [48].

[23] See Transcript dated 4 May 2022, at PN4884 (Michelle Harden, RAO); Witness statement of Sally Fox, dated 14 April 2022 at [19]. See also Witness statement of Mark Sewell dated 3 March 2022 at [92]; Witness statement of Johannes Brockhaus dated 3 March 2022 at [14]; Witness statement of Anna-Maria Wade dated 23 May 2022 at [46].

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ACA		C10 framework		ACA Minimum Wage Difference
Level 2	947.00	C13 C12	882.80 914.90	ACA ↑ 7.3% ACA ↑ 3.2%
Level 3	983.40	C11	945.00	ACA ↑ 4.1%
Level 4	**995.00**	**C10**	**995.00**	**ACA = C10**
Level 5	1028.70	C9	1026.20	ACA ↑ 0.2%
Level 6	1084.10	C7	1085.60	ACA ↓ 0.1%
Level 7	1103.60	C6	1140.70	ACA ↓ 3.3%

Table B2: Aged care employee—direct care

ACA		C10 framework		ACA Minimum Wage Difference
Level 1	1047.60	C14	859.30	ACA ↑ 22%
Level 2	1089.00	C13 C12	882.80 914.90	ACA ↑ 23.4% ACA ↑ 19%
Level 3	1130.90	C11	945.00	ACA ↑ 20%
Level 4	1144.20	**C10**	**995.00**	ACA ↑ 15%
Level 5	1183.00	C9	1026.20	ACA ↑ 15.3%
Level 6	1246.80	C7	1085.60	ACA ↑ 15%
Level 7	1269.10	C6	1140.70	ACA ↑ 11.3%

39. The following observations are made:

ACA Levels 1-3

(a) For general employees, the existing award minimum wages for levels 1-3 are higher than the corresponding rates in the C10 framework, ranging from 3% to 7% above in each instance.

(b) For direct care employees, the existing award minimum wages (which incorporate a 15% work value increase) for levels 1-3 are significantly higher than the corresponding rates in the C10 framework, ranging from 19% to 23% above in each instance.

(c) Notably, the minimum wage for an entry level position in age care is either 6% or 22% above the C14 rate, subject to whether the employee commences in the general or direct care stream.

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(d) Tables C1 and C2 serve to further contextualise the impact of that difference within modern award system, by identifying the classification level within the C10 framework that aligns to the award minimum wage in the *Aged Care Award.*

Table C1: Aged care employee—general

ACA		Comparative C10 level and minimum wage	
Level 1	910.90	914.90	(C14) ↑ C12
Level 2	947.00	945.00	(C12) ↑ C11
Level 3	983.40	995.00	(C11) ↑ C10

Table C2: Aged care employee— direct care and recreational activities

ACA		Comparative C10 level and minimum wage	
Level 1	1047.60	1057.40	(C14) ↑ C8
Level 2	1089.00	1085.60	(C12) ↑ C7
Level 3	1130.90	1140.70	(C11) ↑ C6

(e) Despite the non-alignment with the C10 framework, to ensure no *"general"* employee is worse off by a work value determination, the Joint Employers propose that the existing rates for levels 1-3 be *"maintained"* for both general and direct care streams and this is reflected in JE-DD1.[24] Further, in circumstances where the Full Bench have awarded a 15% increase for *"direct care"* employees, the Joint Employers propose that the existing rates be *"maintained"* and this is reflected in JE-DD1.

ACA Level 4

(f) This level reflects C10 and this is reflected in JE-DD1.

ACA Level 5

(g) For general employees, the existing award minimum wage for level 5 sits slightly higher than the C9 rate (+0.2%).

(h) For direct care employees, the existing award minimum wage for level 5 is significantly higher than the C9 rate (15.3%). Focusing on numerical value, this minimum wage more

[24] See *ACT Child Care Decision* at [155(2)].

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closely corresponds to a C4, which has a minimum weekly wage of $1195.30 and has a minimum training requirement of 80% towards an Advanced Diploma or equivalent.

(i) As will be developed below in submissions about classification definitions, the Joint Employers consider alignment to the C9 level to be appropriate for the following reasons:

(i) for *"general"* employees this reflects the increase in competency that arises from experience acquired on the job following the attainment and application of a trade or Certificate III qualification or a post trade qualification;[25] and

(ii) for *"direct care"* employees the marker for increase in competency is more defined by reference to a time-marker of 3-years post qualification experience.[26]

(j) However, given that strict adherence to the C9 rate would result in a decrease in the existing minimum award wages, the Joint Employers support *maintaining* the existing minimum wage for both *"general"* and *"direct care"* classification streams. The Joint Employers are not suggesting that there should be a decrease in these rates.

ACA Level 6

(k) For general employees, the existing award minimum wage for level 6 sits lower than the C7 rate (-0.1%).

(l) For direct care employees, the existing award minimum wage for level 6 is significantly higher than the C7 rate (+15%). Focusing on numerical value, this minimum wage more closely corresponds to a C3, which has a minimum weekly wage of $1257.90 and has a minimum training requirement of Advanced Diploma or equivalent.

(m) As will be developed below in submissions about classification definitions, the Joint Employers consider alignment to the C7 level to be appropriate for the following reasons:

(i) A C7 level includes the minimum training requirement of a Certificate IV qualification.

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[25] See generally, Witness Statement of Eugene Basciuk, dated 28 May 2022; Witness Statement of Kevin Mills dated 30 March 2021; Witness Statement of Darren Kent dated 31 March 2021. See especially, Witness Statement of Darren Kent dated 31 March 2021 [41]: *"It would not be possible to competently do my job straight out of training. After four years of training, you really need to have four to five years of post-training experience working in a kitchen to be able to manage all the different aspects of the job safety and competently".*

[26] See example, Witness statement of Mark Sewell dated 3 March 2022 at [93]; Statement of Anna-Maria Wade dated 4 March 2022 [48].

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(ii) The evidence in Stage 1 suggested both direct care and general employees may attain and use this qualification within the course of their employment.

(iii) The skills, attributes and competencies possessed at this level are distinct from that of a *"level 5"* employee.

(n) The Joint Employers propose that that existing minimum wages for general employees be increased to align to the C9 minimum weekly wage of $1085.60.

(o) Whilst the direct care employees at level 6 have already had the benefit of a 15% increase and there is an argument that this necessarily absorbs any adjustment to the C10 framework, the Joint Employers have proposed a marginal increase to $1248.44 (+0.1%)

(p) It is also noted that the level 6 *"general"* classification is defined as the *"standard rate"* for the purposes of determining allowances etc. Due to the modest nature of the increase, the Joint Employers do not propose any further adjustments to the existing leading hand, nauseous work or sleepover allowances. The increase is not large enough to materially alter the calculations of any of the existing percentage based allowances previously set by the Commission.

ACA Level 7

(q) The proposed omission of Level 7 for the *Aged Care Award* will be addressed in the context of classification structure and definitions below.

Comparative Tables

40. Tables D1 and D2 provide a side-by-side comparison of the minimum weekly wages in the *Aged Care Award* (**ACA**), JE-DD1 and the *Manufacturing Award*.

Table D1: Aged care employee—general

Employee Classification		Minimum Wage		C10 Framework		JE-DD1 Minimum Wage Difference	
ACA	**JE-DD1**	**ACA**	**JE-DD1**	**Level**	**Rate**	**ACA**	**C10**
Level 1	**Intro**	910.90	**910.90**	C14	859.30	**JE-DD1 = ACA**	**JE-DD1** ↑ 6%
Level 2	**Level 1**	947.00	**947.00**	C13 C12	882.80 914.90	**JE-DD1 = ACA**	**JE-DD1** ↑ 7.3% **JE-DD1** ↑ 3.5%
Level 3	**Level 2**	983.40	**983.40**	C11	945.00	**JE-DD1 = ACA**	**JE-DD1** ↑ 4.1%
Level 4	**Level 3**	**995.00**	**995.00**	**C10**	**995.00**	**JE-DD1 = ACA**	**JE-DD1 = C10**
Level 5	**Level 4**	1028.70	**1028.70**	C9	1026.20	**JE-DD1 = ACA**	**JE-DD1** ↑ 0.2%

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Employee Classification		Minimum Wage		C10 Framework		JE-DD1 Minimum Wage Difference	
ACA	**JE-DD1**	**ACA**	**JE-DD1**	**Level**	**Rate**	**ACA**	**C10**
Level 6	**Level 5**	1084.10	**1085.60**	C7	1085.60	**JE-DD1** ↑ 0.1%	**JE-DD1 = C10**
Level 7	**N/A**	1103.60	**N/A**	C6	1140.70	N/A	N/A

Table D2: Aged care employee—direct care and recreational activities

Employee Classification		Minimum Wage		C10 Framework		JE-DD1 Minimum Wage Difference	
ACA	**JE-DD1**	**ACA**	**JE-DD1**	**Level**	**Rate**	**ACA**	**C10**
Level 1	**Intro**	1047.60	**1047.60**	C14	859.30	**JE-DD1 = ACA**	**ACA** ↑ 22%
Level 2	**Level 1**	1089.00	**1089.00**	C13 C12	882.80 914.90	**JE-DD1 = ACA**	**ACA** ↑ 23.4% **ACA** ↑ 19%
Level 3	**Level 2**	1130.90	**1130.90**	C11	945.00	**JE-DD1 = ACA**	**ACA** ↑ 20%
Level 4	**Level 3**	1144.20	**1144.20**	**C10**	**995.00**	**JE-DD1 = ACA**	**JE-DD1** ↑ 15%
Level 5	**Level 4**	1183.00	**1183.00**	C9	1026.20	**JE-DD1 = ACA**	**JE-DD1** ↑ 0.2%
Level 6	**Level 5**	1246.80	**1248.44**	C7	1085.60	**JE-DD1** ↑ 0.1%	**JE-DD1** ↑ **15%**
Level 7	**N/A**	1269.10	**N/A**	C6	1140.70	N/A	N/A

Conclusion

41. Before any further work value reasons assessment, by reference to the preceding analysis, the starting point of the Joint Employers position is as follows:

    (a) the award minimum wage for aged care employee—general levels 1-5 should be maintained;

    (b) the award minimum wage for aged care employee—direct care levels 1-5, should be maintained;

    (c) the award minimum wage for aged care employee—general level 6 should be increased because it is currently below the C7 level; and

    (d) the award minimum wage for aged care employee—direct care level 6 should be increased.

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42. The evidence in Stage 1 did not support recognition of a Level 7 employee for either *"general"* or *"direct care"*. This appears to be predominantly held by non-award employees. The Joint Employers will not object to it being retained, however, there appears to be no compelling basis to retain this classification level within either structure based on the evidence currently before the Commission in this matter.

43. The minimum wages set out in JE-DD1 provide a principled starting point for the Commission to apply any further increase justified by work value reasons.

Classification Structure & Definitions

Classification Structure

44. The *Aged Care Award* currently consists of two broad streams:

(a) *"aged care employee—general"* (**the general stream**); and

(b) *"aged care employee—direct care"* (**the direct care stream**).

45. Each stream consists of seven classification levels. Putting aside the issue of minimum wages, the only point of difference between the two streams is the reference to *"indicative tasks performed"* for each classification level.

46. The definitions within each stream are necessarily broad to enable application to a variety of roles. As such, with minimal exception, the definitions do not include references to role specific qualifications, experience, responsibilities or skills. As such, the primary point of guidance for progression between the classification levels is currently gleamed from the *"indicative tasks"*, which includes a list of indicative roles that may fall within each classification level.

47. To enhance the relevance and clarity of the classifications set out in the *Aged Care Award*, the Joint Employers rely on the classification structure and definitions set out in JE-DD1.

Classification streams

48. The Joint Employers propose that the existing classification streams in Schedule B be deleted and replaced with following classification streams:

(a) **direct care stream**, which covers employees that perform *"direct care duties"*;

(b) **recreational activities stream**, which covers employees that perform *"leisure and lifestyle duties"*;

(c) **general services stream**, which covers employees that perform *"general services duties"* in residential aged care facilities. General services duties is defined as including *"laundry duties"*, *"cleaning duties"* and *"driving duties"*;

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(d) **maintenance services stream**, covers employees that perform "*maintenance services"* in residential aged care facilities, which may include *"gardener duties"* or *"maintenance duties"*;.

(e) **administration services stream**, which covers employees that perform *"administration duties"* in residential aged care facilities; and

(f) **food services stream**, which covers employees that perform ***"****kitchen and servery duties"* or *"cooking duties"* in residential aged care facilities.

(Each reference to a form of *"duty"* is a defined term within the relevant classification stream).

49. The separation of the general stream into four separate streams addresses the uncertainty that arises from the existing structure, where delineation between the classification levels and role types relies heavily on reference to the *"indicative tasks"*. Additionally, the introduction of definitions setting out the typical duties of each role provides further certainty for both employer and employee.

50. Additionally, for each role an introductory level is included. This is consistent with the fact that no minimum qualification was identified as a pre-requisite for working in direct care or general, maintenance, administration and food services. Although progression through the levels, in particular maintenance and food services, typically requires trade qualifications.

51. We suggest that the distinction between *"general*" and *"direct care (and recreational activities)"* streams be retained for the purposes of distinguishing between minimum rates in clause 14 of the *Aged Care Award*.

Classification grades and wage levels

52. To ensure a simple and easy way to understand a modern award, in light of the multiple roles that can fall within a stream, the Joint Employers proposal draws upon the structural devices used in the *Hospitality Industry (General) Award 2020* (***HIGA***), which incorporates a combination of *"grades"* and *"wage levels"* throughout its classification structure in Schedule A. For example, the food services stream in JE-DD1 includes *food assistant employee grades 1-3* and *cook/chef grades 1-3*.

53. The grade system provides clarity of progression for those individual roles and the corresponding wage level ensures clarity as to the applicable minimum wage rate.[27] The enhanced clarity of progression together with identification of wage level is consistent with the modern awards objective.[28]

[27] See *Hospitality Industry (General) Award 2020* Sch A, cl A.2.2 (kitchen stream).
[28] Fair Work Act 2009 (Cth) s 134(1)(g).

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54. Tables F1 and F2 provide an overview of the classification streams, grades and wage levels included in the JE-DD1.

Table F1: Classification Structure: Aged care employee—general

Employee Classification	Employee stream and grade
Introductory Level	General services stream; Maintenance services stream; Administration services stream; Food services stream
Level 1	General services employee—Grade 1; Maintenance services employee—Grade 1; Administration employee—Grade 1; Food assistant employee—Grade 1
Level 2	General services employee—Grade 2; Maintenance services employee—Grade 2; Administration employee—Grade 2; Food assistant employee—Grade 2; Cook—Grade 1
Level 3	General services employee—Grade 3; Maintenance services employee—Grade 3; Administration employee—Grade 3; Food assistant employee—Grade 3; Cook—Grade 2
Level 4	Maintenance services employee—Grade 4
Level 5	Administration employee—Grade 4 Chef—Grade 3

Table F2: Classification Structure: Aged care employee—direct care and recreational activities

Employee Classification	Employee stream and grade
Introductory Level	Direct care stream
Level 1	Direct care employee—Grade 1
Level 2	Direct care employee—Grade 2; Recreational activities officer—Grade 1
Level 3	Direct care employee—Grade 3; Recreational activities officer—Grade 2
Level 4	Direct care employee—Grade 4
Level 5	Direct care employee—Grade 5; Recreational activities officer—Grade 3

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Classification Definitions

55. In support of the construction of classification definitions in JE-DD1, this section will address the following matters:

(a) Overview of Stage 1 Evidence;

(b) Definition of *"or equivalent"*;

(c) Direct care employees—Grades 1 to 5;

(d) Recreational activities officer—Grades 1 to 3;

(e) General services employee—Grades 1 to 3;

(f) Maintenance service employee—Grades 1 to 4;;

(g) Administration services employee—Grades 1 to 4; and

(h) Food assistant employee—Grades 1 to 3.

(a) Overview of Stage 1 Evidence

56. In Stage 1, 72 lay witnesses were called by the Unions. As observed by Deputy President O'Neill in the Report to the Full Bench, to a large extent the cross-examination of those witnesses involved eliciting further details about the duties and responsibilities of the roles referred to in witness statements.[29]

57. By reference to role, the Commission had the benefit of evidence from the following aged care employees:

Table G: Aged Care Employees

Role	Number of Witnesses
Direct care employee (i.e. PCW/AIN)	18[30]
Recreational activities officers (i.e. RAO)	5[31]
Kitchen staff, Food assistants, Cooks and Chefs	5[32]

[29] Report to Full Bench (Commissioner O'Neill, 20 June 2022), page 3.

[30] 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.

[31] Josephine Peacock (Volunteer Coordinator, Divisional Therapy and Volunteer Manager), Michelle Harden (RAO), Sanu Ghimire (Care Service Employee & RAO), Fiona Gauci (Leisure Wellness Coordinator), and Jade Gilchrist (Lifestyle and Volunteer Coordinator). The Report to the Full Bench also noted the evidence of Sally Fox a personal carer who also works regular leisure shifts.

[32] A total of six witnesses gave evidence about their experience as kitchen staff: 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).

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Administration workers	3[33]
Property maintenance (including gardening)	3[34]
Laundry	2[35]
Cleaning	1[36]

58. Table H provides an indication of the recurrent qualifications held by the various roles, together with key qualifications that the Joint Employers have incorporated into the classification definitions.[37]

Table H: Qualifications based on Stage 1 evidence

Employee Role	Qualifications cited from Stage 1	Key Qualifications
Direct care employee (i.e. PCW/AIN)	First Aid Certificate Certificate III Aged Care Certificate III Individual Support Certificate III Aging Support Certificate III Aged Care and Disability Care Assistant in Nursing Aged Care Certificate III Certificate IV Aging Support Certificate IV Mental Health Certificate IV Dementia Care Certificate IV WHS Administration of Medicine Competency	Certificate III Individual Support
Recreational activities officers	Certificate III Aged Care Certificate IV Business Administration Certificate IV Leadership and Management Certificate IV Business Certificate IV Assessment and Workplace Training Certificate IV Training and Assessment Certificate IV Leisure and Health Certificate IV Lifestyle and Leisure	Certificate IV Leisure and Health

[33] In total 7 of the lay witnesses gave evidence about their experience working as administration staff: 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). However, only three were identified as giving evidence primarily directed at their experience in administration.

[34] Two gardeners at residential aged care facilities provided evidence about their experience working in residential care facilities: Kevin Mills and Jane Wahl.

[35] Sandra O'Donnell and Anita Field. Their job titles are 'laundry hand' and 'laundry assistant'.

[36] Two witnesses gave evidence about their experiences working as dedicated cleaners in residential care: Ross Heyen and Tracey Roberts (Tracey Roberts later assumed the position of kitchenhand).

[37] See Report to Full Bench (Commissioner O'Neill, 20 June 2022), Appendix A for complete list of qualifications of each lay witness called.

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	Advanced Diploma in Health Science Bachelor of Arts (Hons), Diploma of Education, Bachelor of Health Science (Leisure and Life)	
Kitchen staff /Food assistants	Certificate III Aged Care Certificate III Hospitality Certificate III Commercial Cookery Food Safety Certificates	Certificate III Commercial Cookery
Cooks and Chefs	Certificate III Commercial Cookery Certificate in Food Handling and Food Safety, Certificate in Food Safety Supervising Trade Certificate in Commercial Cookery Level 1 Food Handling Certificate Level 1 Food Safety Supervisor Certificate Level 2 Food Safety Supervisor Certificate	Certificate III Commercial Cookery
Administration workers	Certificate II Business Administration Certificate III Business Administration Certificate III Business Administration Diploma of Business Administration	Certificate III Business
Property maintenance (gardening)	Trade Certificate in Greenkeeping Certificate II Horticulture	Trade
Property maintenance (tradesperson and/or handyperson)	Electrical Fitter/ Mechanic Trade Certificate, Certificate II in Telecommunications Cabling	Trade
Laundry	(no laundry specific qualifications held by witnesses)	(Certificate III Laundry)
Cleaning	Certificate III Cleaning Operations	Certificate III Cleaning

(b) Definition of "or equivalent"

59. Throughout Stage 1, the Joint Employers made reference to *"or equivalent"* when referring to a recognised qualification such as *"Certificate III"* or *"Certificate IV"*.[38] The expression *"or equivalent"* is derived from the *Manufacturing Award*,[39] appearing as a *"classification definition"* in Schedule A:

> *"**Or equivalent** means:*

[38] See example *Stage 1 Decision* [2022] FWCFB 200 at [885] and [964].

[39] *Manufacturing Award* Schedule A.

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· *any training which a registered provider (e.g. TAFE), or State recognition authority recognises as equivalent to a qualification which the relevant industry committee, which is currently the Manufacturing and Engineering Industry Reference Committee, recognises for this level, which can include advanced standing through recognition of prior learning and/or overseas qualifications; or*

· *where competencies meet the requirements set out in the metal and engineering competency standards in accordance with the National Metal and Engineering Competency Standards Implementation Guide."*

60. That definition ensures that references to minimum training requirements do not result in rigidity that is unworkable in practice. It also sets out a clear basis upon which prior learning or fulfilment of related competencies may be found to be *"equivalent"* for the purposes of a classification level.

61. Due to the absence of an aged care industry RTO or body that sets the guidelines upon which qualifications in the aged care industry are set, a modified definition of *"or equivalent"* was included in JE-DD1. For ease of reference it is extracted below:

> ***"Or equivalent** means:*
>
> ***(i)** any training which a Registered Training Organisation (e.g. TAFE), State Training Authority or State Overseas Qualification Unit recognises as equivalent to the qualification for this level, which can include advanced standing through recognition of prior learning and/or overseas qualifications; or*
>
> ***(ii)** where an employer assesses and determines the employee's prior experience or prior leaning meets the competencies for this level."*[40]

62. Insertion of an *"or equivalent"* definition ensures that references to minimum training requirements are not treated with any impractical rigidity. Further, it brings about certainty as to the process by which prior learning, experience and/or other qualifications may be recognised as *"equivalent"*. As submitted in Stage 1:

> *"The Joint Employers also note that the majority of PCWs/AINs who gave evidence in the proceedings had a Certificate III qualification but observe that 'there are still a large number of PCWs without a Certificate III who qualify as equivalent based on their depth and length of experience in the industry.' In final oral submissions, the representative for the Joint Employers clarified that they were 'entirely comfortable'*

[40] JE-DD1.

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with the proposition that 'there is a person who doesn't hold a Certificate III formally but has been assessed as being equivalent based on experience.'"[41]

63. The definition makes it clear that employers can make decisions as to the satisfaction of an employee's competencies as being *"equivalent"* to a Certificate III or Certificate IV or the qualification otherwise identified. Thus, the inclusion of *"or equivalent"* provides scope for an employer to recognise prior leaning or experience as equivalent to a minimum qualification requirement within a classification level.

(c) Introductory Level

64. Both *"aged care employee-general—level 1"* and *"aged care employee—direct care—level 1"* are examples of transitory classification levels within the *Aged Care Award*. This characterisation is indicated by the following descriptions within the current definition: *"Entry level*" and *"[a]n employee who has less than three months' work experience in the industry…"*.[42]

65. Not all persons who enter the aged care industry hold qualifications or have prior experience. As such, the classification structure should retain entry points that do not require a minimum qualification. It is noted that the evidence of the employer lay witnesses and the recommendations of Royal Commission support introduction of a minimum qualification for direct care employees.[43] However, on balance, and with regard to the modern awards objective, the Joint Employers support recognition of the Certificate III within the classification structure, but not as a prerequisite to entry.

66. Retaining an entry level position is consistent with the modern awards objective to improve access to secure work across the economy, as well as promote increased workforce participation by stipulating prior industry experience is not required.[44]

67. To emphasise and clarify the transitory nature of the *"level 1"*, in JE-DD1 the Joint Employers propose:

    (a) consistent with approach adopted in Schedule A of the *HIGA*, the transitory level is entitled *"introductory level"*;

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[41] *Stage 1 decision* at [885], citing Joint Employers closing submissions dated 22 July 2022 at [9.8]; Transcript, 1 September 2022, PN15670.
[42] *Aged Care Award* Schedule B, cl B.1.1.
[43] See Royal Commission Final Report Vol 2 at 215; Royal Commission Final Report Vol 1 at 261, Recommendation 78; Witness statement of Mark Sewell dated 3 March 2022 at [92]; Witness statement of Johannes Brockhaus dated 3 March 2022 at [14]; Witness statement of Anna-Maria Wade dated 23 May 2022 at [46].
[44] *Fair Work Act 2009* (Cth) s 134(1)(aa), s134(1)(c).

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(b) instead of a vague reference to *"basic duties"*, the classification definition provides a clear indication of the competencies required to be met in order to progress to ongoing employment, namely:

(i) an *"Introductory level"* employee is *"undertaking and satisfactorily completing any required in-house training on their role, on the employer's operations and on working in the aged care industry, while demonstrating the competency requirements of a [Grade 1 employee]"*; and

(ii) the competency requirements in *"Grade 1"* (for each stream) includes a definition of the relevant duties an employee is to perform.

(c) instead of an imprecise reference to *"less than three months' work experience"*, the classification definition provides a clear indication of the timing and assessment expectations in order to proceed to ongoing employment:

(i) *"The employee remains at Introductory Level for* ***up to 500 hours*** *while undertaking appropriate training and being assessed for competency to move to Grade 1"* (emphasis added); and

(ii) *"At the end of that period, the employee progresses to Grade 1 unless the employer decides that further training of up to 500 hours is required for the employee to achieve the necessary competency"*.

68. The reference to *"500 hours"* was chosen to ensure that the transitory period is of fair and equal application to all new employees. This avoids arguments about inequity of application in circumstances where some employees may work substantially less hours over a three month period.

69. For avoidance of doubt, an introductory level is included at the outset of each stream. Although this results in some duplication, such repetition serves the beneficial purpose of highlighting that each employment stream within the *Aged Care Award* has an access point for persons new to the workforce.

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(d) Direct care employees—Grades 1 to 5

70. Based on a combination of the evidence before the Commission and the findings of the Full Bench in Stage 1, the following conclusions are available as to the *"the essential elements of qualifications, displayed competence and acquired experience and responsibility"*[45] of direct care employees.

The work performed and minimum qualification requirements

Grade 1

71. The non-exhaustive description of *"direct care duties"* is consistent with the evidence in Stage 1,[46] it is also broad enough to incorporate and have regard to the expansion of direct care duties to include some ancillary work which may be performed. All levels of direct care employee (including the introductory level) are required to perform *direct care duties*.

Grade 2

72. The reference *"additional care duties subject to direction and supervision"* is consistent with the evidence in Stage 1, including:

(a) the increased responsibilities of direct care employees at the instruction and direction of a RN (and following satisfactory competition of training);[47]

(b) additional care duties include, but are not limited to:

(i) simple wound dressing,[48]

(ii) changing catheter bags,[49] and

[45] See *Independent Education Union of Australia* [2021] FWCFB 2051 at [647] (**Teachers Decision**).
[46] See Report to Full Bench (Commissioner O'Neill, 20 June 2022) at [104], citing 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.
[47] See generally, *Stage 1 Decision* [2022] FWCFB 200 at [648]-[663]. See example, Transcript, 11 May 2022, PN12830 (Kim Bradshaw): Ms Bradshaw gave evidence that *"simple wound dressing"* appeared in the job description of a *"care services employee 2"* and all wounds reviewed by RN.
[48] Witness statement of Christine Spangler, dated 29 October 2021 at [24]: Ms Spangler will attend to replacing a bandage which she considers is simple wound care. If it is complex, or a new wound, then the RN or EN deal with the wound. The RN or EN will advise Ms Spangler what needs to be done with a wound. See also, Witness statement of Linda Hardman, dated 29 October 2021 at [62]; Transcript dated 3 May 2022 PN4369 (Alison Curry); Witness statement of Sanu Ghimire at [43]; Transcript, dated 11 May 2022 at PN11860, Transcript, dated 11 May 2022 at PN11863 (Geronima Bowers).
[49] See example, Transcript, 6 May 2022 at PN8585 (Rose Nasemena); Transcript, dated 9 May 2022 at PN9480 (Dianne Power); Transcript, dated 9 May 2022 at PN9979 (Sheree Clarke); Witness statement of Virginia Ellis, dated 20 April 2022 at [70]; Witness statement of Alison Curry, dated 21 April 2022 at [33]; Witness statement of Sally Fox, dated 29 March 2021 at [94].

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(iii) attending to blood sugar level checks;[50]

(c) these particular tasks attract greater complexity (notably by the requirement that further training, which can be in-house is required).[51]

73. The evidence did not suggest that persons in training or relatively new to the aged care industry were expected to perform such *additional care duties*.[52] It is an appropriate marker of increased competency between Grade 1 and Grade 2.

Grade 3 – Certificate III

74. Consistent with the evidence about Certificate III, an essential qualification at Grade 3 is holding a Certificate III in Individual Support (or equivalent),[53] together with the following displays of competency:

(a) meeting the requirements of a Grade 2 employee; and

(b) in addition to exercising the competencies of a Grade 2, exercise the competencies obtained through the Certificate III or equivalent.

This clarification ensures that both employee and employer understand the competencies (and not just the minimum qualification) required to be classified as Grade 3.[54]

Grade 4 – Certificate III (Experienced)

75. The evidence in *Stage 1* supports a finding that Certificate III qualified personal care workers with 3-years post qualification experience display increased levels of competency in their performance of direct care duties.[55] As such, this is an appropriate marker of advancement between Grade 3 and 4.

76. The Grade 4 classification also serves to recognise the experience that is acquired through exercising competencies obtained through a Certificate III over a defined period, and without obtaining a further qualification (e.g. Certificate IV). It is an appropriate intermediary marker

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[50] See example, Witness statement of Virginia Ellis, dated 20 April 2022 at [70]; Witness statement of Antoinette Schmidt, dated 30 March 2021 at [82] - [83]; Witness statement of Marion Jennings, dated 26 March 2021 at [156].

[51] See generally, *Stage 1 Decision* [2022] FWCFB 200 at [648]-[652]-[657], [662].

[52] See also, Transcript, 11 May 2022, PN12830 (Kim Bradshaw): Ms Bradshaw gave evidence that *"simple wound dressing"* appeared in the job description of a *"care services employee 2"* and all wounds reviewed by RN.

[53] See Amended witness statement of Kerrie Boxsell dated 19 May 2022 at [5]; Witness statement of Sally Fox dated 29 March 2021 at [16]; Witness statement of Theresa Heenan dated 20 October 2021 at [107]; Witness statement of Sandra Hufnagel dated 30 March 2021 at [16]; Transcript, 11 May 2022 at PN11597; Witness statement of Sandra O'Donnell dated 25 March 2021at [17]; Transcript, 11 May 2022 at PN11696; Witness statement of Bridget Payton dated 26 October 2021 at [23]; Transcript, 5 May 2022 at PN6409, Witness statement of Tracy Roberts dated 23 March 2021 at [4]; Witness statement of Lorri Seifert dated 10 June 2021 at [122] [124], Witness statement of Susan Toner dated 28 September 2021 at [2]; Witness statement of Veronique Vincent dated 19 May 2022 at [21].

[54] *Fair Work Act 2009* (Cth) s 134(1)(g).

[55] See Transcript, 12 May 2022, PN12995-PN12997 (Mark Sewell); Statement of Mark Sewell dated 3 March 2022 [93].

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of competency between direct care employees who are Certificate III qualified and those who are Certificate IV qualified.

Grade 5 – Certificate IV

77. The Full Bench in the *Stage 1 decision* also recognised the increased prevalence of personal care workers getting Certificate IV qualifications.[56] To assist with a clear indication of career progression for direct care employees, *"Certificate IV in Ageing Support or equivalent"* is included as a minimum qualification at Grade 5, together with the following displays of competency:

(a) meeting the requirements of a Grade 4 employee; and

(b) exercising the competencies of a Grade 4 employee and any additional competencies obtained through the Certificate IV or equivalent.[57]

78. Further, express reference is made to an exclusive Grade 5 responsibility*: "An employee at Grade 5 may assist with the training and support of direct care employees".* Whilst there is plainly a strong *"team"* element to work performed in direct care, this inclusion emphasises a distinct level of responsibility that falls to a Certificate IV qualified employee.[58]

No Specialist/Supervisory Role

79. The Stage 1 evidence does not support recognition of either a *"specialist"* or *"supervisory"* role above a Certificate IV level employee. The following observations are made:

(a) For PCWs in residential aged care, the supervisor role is typically performed by either a registered nurse (**RN**) or an enrolled nurse (**EN**), with the RN retaining accountability for all clinical work.

(b) Whilst a PCW can be a *"team leader"* that level of responsibility is already recognised with a *"leading hand"* allowance within the *Aged Care Award*.[59] The allowance provides a flexible mechanism by which PCWs at Grade 5 (or below) may receive a leading hand allowance, subject to being allocated the responsibility by the RN in charge (or their employer). There is no evidence before the Commission to support a finding that *"team leader"* should be reserved to a higher or strictly *"supervisory"* role within the *Aged Care Award*.

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[56] See generally, *Stage 1 Decision* [2022] FWCFB 200at [685]-[694].

[57] See example, Transcript dated 4 May 2022 at PN5283 (Sanu Ghimire): Ms Ghimire undertook the Certificate IV in Aged Care as she wanted to undertake the medication rounds and to *"enhance my knowledge"*.

[58] See example, Witness statement of Sally Fox, dated 14 April 2022 at [19]: Ms Fox undertook her Certificate IV in training and assessment to "*deliver basic life support training internally to staff, instead of the organisation paying an external provider to deliver the training*".

[59] Aged Care Award clause 15.3.

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(c) The Commission found that the increased prevalence of residents with acuity issues, dementia and complex care needs affects all levels of PCW, including those that do not hold Certificate III qualifications (i.e. that fall below the C10 level) and this was factored into the decision to award a 15% increase to all direct care workers under the *Aged Care Award*.[60]

(d) Equally, whilst all direct care workers in aged care must necessarily perform work that requires interaction with residents that have varying degrees of dementia or require palliative care, some employees are exposed to a greater intensity due to the nature of the shift being within a secure dementia unit. For that reasons, the Joint Employers submit that there is an evidentiary basis for a dedicated dementia allowance (rather than a *"specialised PCW"* classification).[61]

Skills and abilities

80. The *"skills and abilities"* included in JE-DD1 for each classification level are consistent with aged care employee—direct care—levels 2-6. However, based on the observations and findings of the Full Bench in relation to both *"spotlight skills"*[62] and the expanded use of technology,[63] express reference is also made to the following:

(a) *"communication and interpersonal skills*"; and

(b) *"computer literacy"*.

81. Consistent with the progression in the levels of skill and ability within the existing classification descriptions, and the evidence before the Commission, the skill level with respect to *"communication and interpersonal skills"* increases as follows:

(a) Grades 1 and 2: *"**sound** communication and interpersonal skills"*;

(b) Grades 3: *"**good** communication and interpersonal skills"*; and

(c) Grades 4 and 5: *"**well-developed** communication and interpersonal skills"* (emphasis added).

82. That progression reflects the improvement in skill that is acquired through experience working in the aged care industry and performing direct care duties.

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[60] See *Stage 1 Decision* [2022] FWCFB 200 at [932], [965]: *"We are satisfied that the appropriate course is to apply the interim increase to each level of PCW/HCWs (ie at and below the Certificate III level). We are satisfied that the extent of the changes in the work of the employees in the lower classifications is such as to warrant an increase of at least the magnitude we propose to grant as an interim increase"* (at [932]).

[61] See submission advanced below under the heading *"Allowances"*.

[62] See generally, *Stage 1 Decision* [2022] FWCFB 200 at [896].

[63] See *Stage 1 Decision* [2022] FWCFB 200 at [725]-[731].

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Training

83. Consistent with the current construction of the *Aged Care Award*, reference is made to training. To account for the emphasis placed on the completion of mandatory training, express reference was made to the requirement to complete *"any other training required by the employer for this level"*. This inclusion also serves to emphasise the level of ongoing training that direct care employees are required to undertake – even before they hold a Certificate III or IV qualification.[64]

(e) Recreational activities officer—Grades 1 to 3

84. Based on a combination of the evidence before the Commission and the findings of the Full Bench in Stage 1, the following conclusions are available as to *"the essential elements of qualifications, displayed competence and acquired experience and responsibility"*[65] of recreational activities officers (**RAO**).

The work performed and minimum qualification requirements

Grades 1 and 2

85. The non-exhaustive description of *"leisure and lifestyle duties"* is consistent with the evidence in Stage 1.[66]

86. The evidence in Stage 1 suggests that the career path for a RAO typically commences with an individual that has prior experience within the aged care industry.[67] The evidence also suggests that the relevant qualification for a *"qualified"* RAO under the *Aged Care Award* is the Certificate IV in Leisure and Lifestyle (or equivalent).[68]

87. To better crystalise the career path for a RAO under the *Aged Care Award*, JE-DD1 recognises two '*entry*' points for the career development of a RAO:

(a) *First*, Grade 1 enables an entry point for persons with prior experience and receiving on the job training in relation to provision of leisure and lifestyle duties.[69]

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[64] See references to induction and onboarding training in Witness Statement of Johannes Brockhaus dated October 2023 at [8]-[25] and Witness Statement of Louanne Riboldi October 2023.
[65] See *Independent Education Union of Australia* [2021] FWCFB 2051 at [647] (**Teachers Decision**).
[66] See example, Witness statement of Josephine Peacock, 30 March 2021; Witness statement of Sanu Ghimire. See also Report to Full Bench (Commissioner O'Neill, 20 June 2022) at [173]-[180]
[67] See example, Witness statement of Michelle Harden, dated 30 March 2021 at [4]-[5].
[68] See Witness statement of Michelle Harden, dated 30 March 2021 at [6]; Transcript dated 4 May 2022, at PN4884 (Michelle Harden).
[69] See Witness Statement of Josephine Peacock, dated 30 March 2021 at [21]; Transcript dated 4 May 2022, at PN4676 (Josephine Peacock).

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(b) *Second*, the weight of the evidence recognised the value of the competencies attained via a Certificate III in Individual Support when working with residents (for example, learning de-escalation skills, etc).[70] As such, Grade 2 recognises a RAO that commences with prior experience in aged care, and holds a Certificate III in Individual Support, whilst receiving on-the-job training in relation to provision of leisure and lifestyle duties.

Grade 3

88. The evidence provides an overwhelming basis to recognise Certificate IV as the qualification for a RAO.[71] Any subsequent tertiary qualification is not required unless the RAO is seeking to be employed as a Diversional Therapist (which is a professional qualification not covered by the *Aged Care Award*).[72]

Skills and abilities

89. The *"skills and abilities"* are consistent with aged care employee—direct care—levels 3-5. Consistent with the evidence in Stage 1, reference to *"interpersonal skills*" and *"computer literacy"* is included.

Training

90. Consistent with the current construction of the *Aged Care Award*, reference is made to training. To account for the emphasis placed on the completion of mandatory training, express reference was made to the requirement to complete *"any other training required by the employer for this level"*.

[70] See example, Witness statement of Sanu Ghimire at [11]-[12].
[71] See generally, Report to Full Bench (Commissioner O'Neill, 20 June 2022) at [173]-[180].
[72] See Statement of Johannes Brockhaus dated 3 March 2022 [109].

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(f) General services employee—Grades 1 to 3

91. Based on a combination of the evidence before the Commission and the findings of the Full Bench in Stage 1, the following conclusions are available as to the *"the essential elements of qualifications, displayed competence and acquired experience and responsibility"*[73] of laundry employees, cleaning employees and drivers.

The work performed and minimum qualification requirements

Grade 1

92. The non-exhaustive description of *"laundry duties"* and *"cleaning duties"* is consistent with the evidence in Stage 1.[74] The *"driving duties"* are inserted to provide an indication of the scope of duties of this established role in residential aged care facilities. Limited evidence was called in relation to drivers.[75]

Grade 2

93. The evidence did not suggest that the work performed by either laundry or cleaning employees undergoes material change as the worker acquires experience.[76] Rather, the employee continues to perform the same duties and their level of skill and ability improves with experience (see below).

94. For drivers, the *"indicative tasks"* included in the *Aged Care Award* stipulates that a driver is to hold a *"St John Ambulance first aid certificate"*.[77] In JE-DD1, that stipulation has been included as a minimum requirement for a Grade 2 driver. However, to ensure that first aid certificates from other RTOs are recognised, the Joint Employers have inserted *"or equivalent"*.

Grade 3

95. JE-DD1 proposes recognition of holding a Certificate III (or equivalent) as a marker of competency for a Grade 3 laundry or cleaning employee, together with exercising the relevant competence relevant to the work being performed.[78] Although none of the laundry employees

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[73] See *Independent Education Union of Australia* [2021] FWCFB 2051 at [647] (**Teachers Decision**).

[74] See Report to Full Bench (Commissioner O'Neill, 20 June 2022) at [224] (laundry employee), citing Witness statement of Sandra O'Donnell, 25 March 2021 at [32] and [38]; Transcript, 6 May 2022, PN7817-7821; Transcript, 5 May 2022, PN6604. See Report to Full Bench (Commissioner O'Neill, 20 June 2022) at [252] (cleaner), citing Witness statement of Ross Heyen, 31 March 2021 at [12] and [13]; Transcript, 11 May 2022, PN11554, PN11556 and PN11558.

[75] See Witness statement of Virginia Ellis, 28 March 2021 at [125], referred to being the *"only bus driver"* on staff, and driving the bus *"when we have an external trip planned"*.

[76] See evidence of Sandra O'Donnell and Anita Field, summarised in the Report to Full Bench (Commissioner O'Neill, 20 June 2022) at [222]-[230].

[77] See *Aged Care Award* Schedule B, clause B.1.3

[78] See example, Witness Statement of Ross Heyan dated 31 March 2021 [11]; Transcript, 11 May 2022, PN11538-PN11540 (Ross Heyan): Mr Heyan held a Certificate III in Cleaning Operations, during cross-examination he said the course taught *"basic cleaning"* such as *"infection control"*.

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before the Commission held a Certificate III in Laundry Operations, this option for skills advancement exists for laundry employees.[79]

96. As to the role of the driver, consistent with the drafting of the current award, the operation of a *"3 ton and over"* vehicle is retained as the basis to differentiate between a Grade 2 and Grade 3 driver.[80] This inclusion recognises the skills differentiation between operating a vehicle that is less than 3 tonnes and operating a vehicle that is 3 tonnes and over.

No Specialist/Supervisory Role

97. The evidence in *Stage 1* did not include reference to a general services classification level above Certificate III. Further, each witness referred to their supervisor as being the facility manager, client services manager or operations manager (each a managerial and non-award position).[81] Upon that basis, no specialist or supervisory role was included within the general services stream in JE-DD1.

Skills and abilities

98. The *"skills and abilities"* include reference to the level of responsibility and accountability at Grades 1 and 2, and are consistent with the descriptions used in both the *Cleaning Services Award 2020* and *Dry Cleaning and Laundry Industry Award 2020.*

99. That construction is equally supported by the evidence in Stage 1, that suggested the requisite skills at a minimum commenced at:

(a) be responsible for their own work subject to detailed instructions;

(b) work under routine supervision;

(c) carry out duties in a safe, responsible and efficient manner; and

(d) basic communication and interpersonal skills.[82]

100. The evidence did not reveal that the nature of the work of an employee that performs either laundry or cleaning duties changes over time or otherwise increases in complexity. Rather, the employee's skillset and abilities improve from acquired experience. Hence for the purpose of marking the progression from Grade 1 to Grade 2, as a result of acquired experience, the following additional skills and abilities are included in JE-DD1 to indicate a marker of progression, namely, the ability to:

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[79] MST30622 - Certificate III in Laundry Operations.

[80] See *Aged Care Award* Schedule B, clauses B.1.2, B.1.3, B.1.4.

[81] See example, Witness statement of Anita Field, 30 March 2021 at [31]; Witness Statement of Ross Heyan dated 31 March 2021 [30].

[82] See Report to Full Bench (Commissioner O'Neill, 20 June 2022) at [222]-[230] (laundry employee), [250]-[256] (cleaner),

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(a) operate with a minimum of supervision;

(b) recognise and report obvious faults in the equipment they use;

(c) be responsible for the maintenance of the quality and quantity of their own output; and

(d) provide on-the-job training to other general services employees as required;

(e) sound communication and interpersonal skills.

101. Additionally, consistent with the evidence in Stage 1, express reference has been made to a level of *"communication and interpersonal skills"* being required. However, the required level does not exceed *"sound communication and interpersonal skills"*.

(g) Maintenance service employee—Grades 1 to 4

102. Based on a combination of the evidence before the Commission and the findings of the Full Bench in Stage 1, the following conclusions are available as to the *"the essential elements of qualifications, displayed competence and acquired experience and responsibility"*[83] of maintenance and gardening employees.

The work performed and minimum qualification requirements

103. The definitions of *"gardening duties"* and *"maintenance duties"* are consistent with the evidence in Stage 1.[84]

104. The Stage 1 evidence highlighted that both gardening and maintenance employees often hold qualifications, such as a recognised Trade Certificate or Certificate III.[85] In the proceedings, the Commission had the benefit of Mr Mills who held trade qualification in greenkeeping and Mr Basciuk who held trade qualification as an electrician. The application of those additional competencies is appropriately recognised as a higher classification above an *"unqualified"* gardener or maintenance officer.

105. Also, some of the work performed at residential aged care facilities may require post-trade qualifications (if an employee did not have the requisite competency, they may engage contractors).[86] A similar recognition of trade and post-trade qualifications is observed in both

[83] See *Independent Education Union of Australia* [2021] FWCFB 2051 at [647] (**Teachers Decision**).

[84] See Report to Full Bench (Commissioner O'Neill, 20 June 2022) at [234] (gardening duties), citing 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). See Report to Full Bench (Commissioner O'Neill, 20 June 2022) at [246] (maintenance duties), citing Witness statement of Eugene Basciuk, 28 May 2022 at [16]-[31], [51], [56].

[85] See Witness Statement of Kevin Mills dated 30 March 2021 [7]-[8] (trade certificate in greenkeeping); Witness Statement of Eugene Basciuk, dated 28 May 2022 at [12] (Electrical Fitter/Mechanical Trade Certificate).

[86] See Transcript, 29 April 2022, PN2329 (Pamela Little); Transcript, 9 May 2022, PN10119- PN10125, Transcript, 9 May 2022, PN10147- PN10148, Transcript, 9 May 2022, PN10205 (Kevin Mills identified "landscapers" as a common contractor

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the *Gardening and Landscaping Services Award 2020* and *Manufacturing and Associated Industries and Occupations Award 2020.*

106. Upon that basis:

(a) Grade 3 includes express recognition of the qualification a maintenance or gardening employees is required to hold.

(b) Grade 4 states that the employee *"works about and beyond a Grade 3 employee"* and may be required to hold *"post-trade qualifications or equivalent"*. Together with reference to the skills and abilities (see below).

107. Both inclusions provide clarity with the distinction between Grade 3 and 4.

Skills and abilities

108. The *"skills and abilities"* include reference to the level of responsibility and accountability at Grades 1 to 4, and are consistent with the descriptions used in both the *Gardening and Landscaping Services Award 2020* and *Manufacturing and Associated Industries and Occupations Award 2020.*

109. That construction is equally supported by the evidence in Stage 1, that suggested the requisite skills at a minimum commenced at:

(a) be responsible for their own work subject to detailed instructions;

(b) work under routine supervision;

(c) carry out duties in a safe, responsible and efficient manner; and

(d) basic communication and interpersonal skills.[87]

110. Similarly to the development of skills and abilities of cleaning and laundry employees, the evidence did not reveal that the nature of the work of either a gardener or maintenance employee changed over time or increased in complexity. Rather, the employee's skillset and abilities improve from acquired experience. Hence for the purpose of marking the progression from Grade 1 to Grade 2, as a result of acquired experience, the following additional skills and abilities will indicate a marker of progression, namely, the ability to:

(a) operate with a minimum of supervision;

(b) recognise and report obvious faults in the equipment they use;

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engaged); Transcript, 10 May 2022, PN11218 (Jane Wahl gave evidence that a contractor may be engaged to do gravelling or put in paving and irrigation); Witness Statement of Eugene Basciuk, dated 28 May 2022 at [16]-[19]; Transcript dated 2 June 2022 at PN14170 (Eugene Basciuk).

[87] See Report to Full Bench (Commissioner O'Neill, 20 June 2022) at [243] (gardener) and [244]-[249] (maintenance).

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(c) be responsible for the maintenance of the quality and quantity of their own output; and

(d) provide on-the-job training to other general services employees as required;

(e) sound communication and interpersonal skills.[88]

111. The evidence also revealed the employees within maintenance services may possess additional skills and abilities as they acquire additional experience in their role and/or acquire post-trade qualifications. This may also arise in facilities that have larger maintenance divisions. In JE-DD1, those additional skills and abilities for a Grade 4 employees are as follows:

(a) understands and applies quality control techniques;

(b) exercises good interpersonal and communications skills;

(c) exercises discretion within the scope of this classification level;

(d) performs work under limited supervision either individually or in a team environment;

(e) performs non-trade work that is incidental or peripheral to the primary task and facilitates the completion of the whole task (such incidental or peripheral work would not require additional formal technical training);

(f) is able to inspect products and/or materials for conformity with established operational standards; and

(g) provides support and assistance to Maintenance services employees—Grades 1-3.

112. The additional list of required skills and abilities also further helps to delineate between Grades 3 and 4.

113. For completeness, consistent with the evidence in Stage 1,[89] express reference has been made to a level of *"communication and interpersonal skills"* being required. However, the required level does not exceed *"good communication and interpersonal skills"*.

[88] See Report to Full Bench (Commissioner O'Neill, 20 June 2022) at [243] (gardener) and [244]-[249] (maintenance).

[89] See example, Report to Full Bench (Commissioner O'Neill, 20 June 2022) at [248]-[249], citing Witness statement of Eugene Basciuk, 28 May 2022 at [38]-[43], [50]; Transcript, 2 June 2022 at PN14032-14036 (Eugene Basciuk).

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(h) Administration services employee—Grades 1 to 4

114. Based on a combination of the evidence before the Commission and the findings of the Full Bench in Stage 1, the following conclusions are available as to the *"the essential elements of qualifications, displayed competence and acquired experience and responsibility"*[90] of administration employees.

The work performed and minimum qualification requirements

115. The non-exhaustive definition of *"administration duties"* is consistent with the evidence in Stage 1.[91] The definition is also flexible enough to cover the multitude of administrative roles that can exist, particularly in larger aged care facilities.

116. In circumstances where the nature of the work is not subject to material change beyond Grade 2,[92] the Joint Employers propose express recognition of the additional qualifications administrative employees may obtain to exercise additional competencies in the work they perform, namely:

(a) Grade 3: Certificate III in Business or equivalent;[93] and

(b) Grade 4: Certificate IV in Business or equivalent.[94]

Skills and abilities

117. The *"skills and abilities"* include reference to the level of responsibility and accountability at Grades 1 and 2, and follow the format applied to other indirect care worker classifications.

118. Despite administrative and clerical classifications typically focusing on the tasks performed (see for example, *Clerks—Private Sector Award 2020* and *Hospitality Industry (General) Award 2020*), the inclusion of the minimum skills and abilities required is included to help with clarity as to the distinction between Grades 1 and 2.

119. Additionally, consistent with the evidence in Stage 1, express reference has been made to a level of *"communication and interpersonal skills"* being required.[95] Whilst the required level does not exceed *"good communication and interpersonal skills"* within the terms of the award, it is noted that higher levels of interpersonal skills would fall within the competencies of both the Certificate III and Certificate IV.

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[90] See *Independent Education Union of Australia* [2021] FWCFB 2051 at [647] (**Teachers Decision**).
[91] See Report to Full Bench (Commissioner O'Neill, 20 June 2022) at [184].
[92] See generally, Report to Full Bench (Commissioner O'Neill, 20 June 2022) at [184]-[201].
[93] See example, Transcript, 5 May 2022, PN7046 (Kathy Sweeney); Witness Statement of Pamela Little dated 30 March 2021 [19]-[20].
[94] See example, Witness Statement of Fiona Gauci dated 29 March 2021 [24].
[95] See example, Transcript, 5 May 2022, PN6846-PN6847 (Charlene Glass); Witness Statement of Kathy Sweeney dated 1 April 2021 [31].

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(i) Food assistant employee—Grades 1 to 3

120. Based on a combination of the evidence before the Commission and the findings of the Full Bench in Stage 1, the following conclusions are available as to the *"the essential elements of qualifications, displayed competence and acquired experience and responsibility"*[96] of food assistant employees.

The work performed and minimum qualification requirements

Grade 1

121. The non-exhaustive definition of *"kitchen and servery duties"* is consistent with the evidence in Stage 1.[97] All levels of food assistant employee (including the introductory level) are required to perform *kitchen and servery duties*.

Grade 2

122. The evidence did not suggest that the work performed by either food assistants (or kitchen hands) undergoes material change as the worker acquires experience. Rather, the employee continues to perform the same duties and their level of skill and ability improves (see below).

Grade 3

123. JE-DD1 proposes recognition of holding a Certificate III in Commercial Cookery (or equivalent) as a marker of competency for a Grade 3 food assistant, together with exercising the relevant competence relevant to the work being performed.[98]

124. The competencies included in a Certificate III in Commercial Cookery (or equivalent) include additional skills that provide the food assistant employee with a foundation to take on greater responsibilities in the kitchen in the context of food preparation and also supports the career trajectory of a food assistant employee to cook within the facility. For those reasons, recognition of a Certificate III as a minimum training requirement for Grade 3 for the food assistant role – and not just the cook – is an appropriate marker of competency to include.[99]

Skills and abilities

125. The evidence did not reveal that the nature of the work of an employee that performs kitchen and servery duties changes over time or otherwise increases in complexity. Rather, the

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[96] See *Independent Education Union of Australia* [2021] FWCFB 2051 at [647] (**Teachers Decision**).
[97] See Statement of Donna Cappelluti dated 21 April 2022 [21]-[40]; Witness Statement of Tracy Roberts dated 23 March 2021 [54]-[60]; Witness Statement of Carol Austen dated 29 March 2021 [17].
[98] See Witness Statement of Tracy Roberts dated 23 March 2021 [12]: Ms Roberts is employed as a kitchenhand and holds a Certificate III in Commercial Cookery.
[99] See also, Witness Statement of Carol Austen dated 29 March 2021 [8]; PN2401: Ms Austen gave evidence she holds a Certificate III in Aged Care and Certificate III in Hospitality and that from 2019 all Uniting employees are required to hold a Certificate III qualification.

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employee's skillset and abilities improve from application of Grade 1 competencies and acquired experience. Hence for the purpose of marking the progression from Grade 1 to Grade 2, as a result of acquired experience, the following additional skills and abilities will indicate a marker of progression, namely, the ability to:

(a) operate with a minimum of supervision;

(b) recognise and report obvious faults in the equipment they use;

(c) be responsible for the maintenance of the quality and quantity of their own output; and

(d) provide on-the-job training to other food assistant employees as required;

(e) sound communication and interpersonal skills.

126. The next shift in competency for a food assistant employee is indicated by the attainment of a Certificate III or equivalent. Upon attainment of this qualification (or equivalent) the skillset of the food assistant employee in relation to food preparation is enhanced.

(j) Cook and Chef—Grades 1 to 3

127. Based on a combination of the evidence before the Commission and the findings of the Full Bench in Stage 1, the following conclusions are available as to the *"the essential elements of qualifications, displayed competence and acquired experience and responsibility"*[100] of cook and chef classifications.

The work performed and minimum qualification requirements

128. The non-exhaustive definition of *"cooking duties"* is consistent with the evidence in Stage 1.[101]

129. Given that employees may transition into the role of cook without qualification, possibly after working as a food assistant or an unrelated field,[102] JE-DD1 retains an *"unqualified"* cook classification at Cook Grade 1.

130. In addition to meeting the requirement of Cook Grade 1, entry or progress to Cook Grade 2 requires the employee to hold a Certificate III in Commercial Cookery (or equivalent), and to exercise the competencies attained through that qualification.[103]

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[100] See *Independent Education Union of Australia* [2021] FWCFB 2051 at [647] (**Teachers Decision**).
[101] See generally, Report to Full Bench (Commissioner O'Neill, 20 June 2022) at [202].
[102] See example, Witness Statement of Anita Field dated 30 March 2021. She entered the aged care industry as an AIN an now worker part time as a Cook. She was not required to have a Certificate III in Catering (or equivalent) to commence in the tole, however, after she got qualified she said her pay was increased (at [26]).
[103] See Witness Statement of Anita Field dated 30 March 2021 at [26].

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131. The evidence in Stage 1 did not include reference to a chef classification above the *"Head Chef"*, a role which is now recognised with a separate set of minimum weekly wages.[104] Other supervisory roles referred to appear to fall outside of the award, being a facility manager.[105] Upon that basis, no further supervisory role beyond Chef—Grade 3 is included within the food services stream in JE-DD1.

Skills and abilities

132. The skills required of a Cook were the subject of evidence, it is apparent that a marker in progression between Grade 1 and 2 requires the employee to possess the following skills and abilities:

(a) operate with a minimum of supervision, individually or as part of a team;

(b) recognise and report obvious faults in the equipment they use;

(c) be responsible for the maintenance of the quality and quantity of their own output;

(d) be responsible for ensuing requests for texture-modified food and thickened liquids are met;

(e) provide support, assistance and on-the-job training to other food services employees as required; and

(f) sound communication and interpersonal skills.

133. The evidence revealed a further distinction between *"cook"* and *"chef"*. This is maintained with classification level *"Chef—Grade 3"*. An employee at that level works *"above and beyond the skills of a Cook—Grade 2"* and to the level of their skills, competence and training:

(a) performs work under limited supervision either individually or in a team environment;

(b) exercises broad discretion and understands and applies quality control techniques;

(c) provides support, assistance and on-the-job training to other food services employees; and

(d) exercises good interpersonal and communications skills.

134. Additionally, the Chef has the following distinct responsibilities:

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[104] *Aged Care Award* clause 14.2: *"most senior food services employee"*; *Reasons for Decision – s 158—Application to vary or revoke a modern award* [2023] FWCFB 93 (18 May 2023) (**Stage 2 Decision**).

[105] See Transcript, 6 May 2022, PN7335-PN7336 (Darren Kent): Mr Kent reports to the *"general manager at the facility"*. The General Manager is responsible for running the entire facility. See also Witness Statement of Mark Castieau dated 29 March 2021 [13].

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(a) the maintenance of the quality and quantity of their own output and that produced by food assistants and cooks at the facility;

(b) running the kitchen at a facility, including supervision of one or more Cooks—Grades 1 – 2 and the planning of menus and liaising with a dietician and/or nutritionist to ensure the dietary requirements of residents are met.

135. That distinction is supported by the evidence. For example, Anita Field was a Cook. Whilst she worked alone in the kitchen, she did not supervise kitchen staff or have the responsibility of planning a menu.[106] That evidence may be contrast with the account of Mr Kent who supervises 23 employees within the catering services department, which include a cook that makes sandwiches and salads, and 22 kitchen assistants.[107]

136. The additional responsibilities of a Chef are also consistent with the evidence of Mr Castieau.[108]

Allowances

Medication Administration Allowance

137. The evidence in Stage 1 suggests that PCWs are now administering medications, provided they are *"medication competent".*[109] As this competency is not tied to a specific qualification but requires satisfaction of a particular unit of competency,[110] this should be recognised as an allowance and not resting with a particular classification level.

138. In JE-DD1, the Joint Employers propose the following allowance:

> *"**Medication administration allowance***
>
> *An allowance of **$2.77 per week** will be paid to a direct care employee if they are:*
>
> *(a) engaged in direct care duties;*

[106] See Witness Statement of Anita Field dated 30 March 2021 [36]-[38].
[107] See Witness Statement of Darren Kent dated 31 March 2021 [24], [25] and [28] (supervision), [83]-[87] (meal planning).
[108] See Witness Statement of Mark Castieau dated 29 March 2021 at [14], [30], [41]-[43]; Transcript, 29 April 2022, PN1040 (Mark Castieau).
[109] See example, Transcript dated 3 May 2022, PN4784 (Helen Platt). See also Statement of Mark Sewell dated 3 March 2022 [127]; Statement of Paul Sadler dated 1 March 2022 [80]; See generally, evidence of PCWs administering Schedule 4 mediation and following the *"six right of safe medication administration"* (or similar protocol). Cf Transcript dated 6 May 2022, at PN8413 (Virginia Mashford): Ms Mashford had not undertaken any internal or external medication training, she was not *"medication competent"*. She has worked as an AIN for 38 years and has an Advanced Certificate in Special Care.
[110] See Unit of Competency HLTHPS007. See example, Witness statement of Alison Curry, dated 30 March 2021 at [9]; Transcript dated 4 May 2022 at PN6762 (Charlene Glass gave evidence that she chose to undertake a Certificate IV as it *"gives you more ability to administer medications, so it gives you a wider scope to do more things at facilities".* See also Statement of Mark Sewell dated 3 March 2022 [125].

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(b) satisfactorily completed HLTHPS007 Administer and monitor medications or equivalent; and

(c) approved by their employer to administer and monitor medications (which may include utilising dose administration aids) under supervision."[111]

139. The allowance proposed is consistent with the medication administration allowance in the *Aboriginal and Torres Strait Islander Health Workers and Practitioners and Aboriginal Community Controlled Health Services Award 2020*, which provides:

> *"Aboriginal and/or Torres Strait Islander Health Workers who are qualified and permitted under law to administer medications in the performance of their duties are entitled to an allowance of **$2.77** per week."*[112]

140. This construction may also encourage additional direct care employees to seek to upskill in order to benefit from this allowance.

Specialised Dementia Unit Allowance

141. The position of the Joint Employers was highlighted in the *Stage 1 decision* at [883]-[884].[113]

142. The findings of the Full Bench recognised that the increased prevalence of residents with dementia has increased the intensity of the work for direct care employees in residential aged care.[114] The evidence also suggests that workers in specialised dementia units are exposed to a higher intensity during those shifts.[115] For that reason, the Joint Employers continue to submit a specialised dementia allowance should be inserted into the award. Not a separate specialised classification as proposed by the unions.

143. In JE-DD1, the Joint Employers propose the following allowance:

> *"**Specialised dementia unit allowance***
>
> *An allowance of **$0.76 per hour** will be paid to a direct care employee if they are:*
>
> *(a) engaged in direct care duties; and*
>
> *(b) appointed by their employer to work in a specialised dementia unit.*

---

[111] JE-DD1.

[112] *Aboriginal and Torres Strait Islander Health Workers and Practitioners and Aboriginal Community Controlled Health Services Award 2020* clause 18.2(c).

[113] See also Joint Employers closing submissions dated 22 July 2022 at [9.24]–[9.25].

[114] See Stage 1 Decision at [569], [602], [608], [809].

[115] See Witness statement of Antoinette Schmidt, 30 March 2021, at [44]-[83]; Witness Statement of Geromina Bowers, 1 April 2021 at [30].

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*A **specialised dementia unit** is a secure or dedicated dementia unit for residents with advanced dementia."*

144. The comparator for the dementia allowance is taken from the *Manufacturing Award*, specifically the *"hot places"* allowance, which is extracted below:[116]

> *"**(d) Hot places***
>
> ***(i)** An employee who works for more than one hour in the shade in places where the temperature is raised by artificial means must be paid:*
>
> · ***$0.76** per hour where the temperature is between 46 and 54 degrees Celsius;*
>
> · ***$0.99** per hour where the temperature is in excess of 54 degrees Celsius.**(ii)** In addition, where work continues for more than 2 hours in temperatures exceeding 54 degrees Celsius, the employee is entitled to 20 minutes rest after every 2 hours work without loss of pay.*
>
> ***(iii)** The temperature is to be determined by the supervisor after consultation with the employee who claims the extra rate."*

145. The basis for that comparison is that both *"heat"* and *the increased proportion of residents in aged care with dementia* are environmental factors that the Commission have recognised can contributed an intensification of work,

146. In circumstances where the Commission has found that the increased prevalence of residents with dementia (and dementia-associated conditions has increased) contributed to the 15% work value increase,[117] it follows that working in a secure or dedicated dementia unit for residents with advanced dementia must contribute to an intensification of the work performed by those direct care employees covered by the *Aged Care Award*.

147. In circumstances where the intensification of the work is not of equal application, the Joint Employers propose an allowance is an appropriate mechanism.

Conclusion

148. The classification structure and definitions proposed in JE-DD1 are consistent with the evidence in Stage 1 and the modern awards objective. In particular, the inclusion of distinct employment streams, together with descriptions of the work performed, skills and minimum qualification

[116] *Manufacturing Award* clause 30.4(d).
[117] See *Stage 1 Decision* [2022] FWCFB 200 at [602], [809], [899]-[900].

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requirements of each role provides much needed clarity to the *Aged Care Award*. The proposal in JE-DD1 introduces essential detail into the classification structure to ensure that all aged care employers and employees can easily understand the minimum terms and conditions that apply to classifications in the aged care industry.

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PART II: DRAFT DETERMINATION – *SCHADS AWARD* (JE-DD2)

C10 Metals Framework Alignment Approach

Step 1: Key Classification

149. Consistent with the approach set out in *ACT Child Care Decision*, the *"key classification"* in Schedule E of the *SCHADS Award* was identified as *"home care employee—aged care—level 3"* pay point 1.[118]

150. The *"home care employee—aged care—level 3"* pay point 1 aligns to the C10 level in the *Manufacturing Award*, with a minimum weekly wage of $995. Factoring the operation of the 15% increase, the *"home care employee—aged care—level 3"* pay point 1 aligns to the C10 level (+ 15%), with a minimum weekly wage of $1144.20.

151. By reference to the replies to Background Document 10 filed by the HSU and UWU, identification of the key classification in the *SCHADS Award* appears to be uncontroversial.[119]

Steps 2 & 3: Analysis of Internal Relativities

152. As the key classification was already properly fixed, an analysis of the internal relativities was conducted by reference the following:

(a) the existing internal relativities; and

(b) the minimum award weekly wages in the *Manufacturing Award* that align to the home care classifications by reference to the minimum training requirements and competencies set out in that award (i.e. **the C10 framework**).

Preliminary Considerations

153. Prior to turning to that analysis, Table I provide an overview of the C10 framework and its alignment with the *SCHADS Award*, with reference to minimum training requirements referred to in classification descriptions.

Table I – Minimum Training Requirements in *SCHADS Award*

SCHADS Level	SCHADS Descriptions	Stage 1 Evidence	C10 Level
1	On-the-job training which may include an induction course		C14

[118] ACT Child Care Decision at [155].

[119] See HSU Reply to Background Document 10 dated 7 March 2023; UWU Reply to Background Document 10 dated 7 March 2023.

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SCHADS Level	SCHADS Descriptions	Stage 1 Evidence	C10 Level
2	*"Home Care Certificate"* or equivalent or relevant experience/on-the-job training commensurate with the requirements of work in this level	No reference to *"home care certificate"*	C12 – C11
3	Certificate III or equivalent	Certificate III	C10
4	Certificate III + relevant experience	Certificate IV[120]	C9 – C7
5	Beyond completion of a TAFE certificate or associate diploma. They might be acquired through completion of a degree or diploma course with little or no relevant work experience, or through lesser formal qualifications with relevant work skills, or through relevant experience and work skills commensurate with the requirements of work in this level.	Diploma in Business Studies[121]	C5 – C1

Analysis of the internal relativities

154. Table J provides a side-by-side comparison of the existing internal relativities in the *SCHADS Award* for the home care employee—aged care.

Table J – Home care employee—aged care

SCHADS		C10 framework		SCHADS Minimum Wage Difference
Level 1 – Pay Point 1	1059.90	C14	859.30	SCHADS ↑ 23%
Level 2 – Pay Point 1	1121.20	C12	914.90	SCHADS ↑ 23%
Level 2 – Pay Point 2	1128.80	C11	945.00	SCHADS ↑ 19%
Level 3 – Pay Point 1	**1144.20**	**C10**	**995.00**	**SCHADS ↑ 15%**

[120] See example, Statement of Bridget Payton dated 26 October 2021 [5]; Statement of Karen Roe dated 30 September 2021 [7]; Statement of Teresa Hetherington date 19 October 2021 [36]; Witness statement of Lorri Seifert, dated 6 October 2021 at [12]-[14].

[121] See Witness Statement of Peter Doherty, dated 28 October 2021 at [16] (Coordinator).

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SCHADS		C10 framework		SCHADS Minimum Wage Difference
(Certificate III)				
Level 3 – Pay Point 2	1179.50	C9	1026.20	SCHADS ↑ 15%
Level 4 – Pay Point 1	1248.40	C8	1057.40	SCHADS ↑ 18%
Level 4 – Pay Point 2	1273.30	C7	1085.60	SCHADS ↑ 17%
Level 5 – Pay Point 1 (Degree or diploma)	1338.50	C5 C3	1164.10 1257.90	SCHADS ↑ 15% SCHADS ↑ 6.4%
Level 5 – Pay Point 2	1391.20	C5 C3	1164.10 1257.90	SCHADS ↑ 19.5% SCHADS ↑ 10.5%

155. The following observations are made:

(a) For home care employees (**HCEs**) working in aged care, the existing award minimum wages (which incorporate a 15% work value increase) for all levels is significantly higher than the corresponding rates in the C10 framework in each instance. Notably:

(i) the existing award minimum wages for HCE levels 1-3 are **15-23% higher** than the corresponding rates in the C10 framework; and

(ii) the existing award minimum wages for HCE level 4 are **17-18% higher** than the corresponding rates in the C10 framework.

(b) Table K serves to further contextualise the impact of that difference within the modern award system, by identifying the classification level in the C10 framework that aligns to the existing award minimum wage in the *SCHADS Award*.

Table K – Home care employee—aged care

SCHADS		Comparative C10 level and minimum wage	
Level 1 – Pay Point 1	1059.90	1057.40	(C14) ↑ C8
Level 2 – Pay Point 1	1121.20	1140.70	(C12) ↑ C6
Level 2 – Pay Point 2	1128.80	1140.70	(C11) ↑ C6
Level 3 – Pay Point 1 (Certificate III)	**1144.20**	1140.70	(C10) ↑ C6
Level 3 – Pay Point 2	1179.50	1164.10	(C9) ↑ C5

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SCHADS		Comparative C10 level and minimum wage	
Level 4 – Pay Point 1	1248.40	1257.90	(C8) ↑ C3
Level 4 – Pay Point 2	1273.30	1257.90	(C7) ↑ C3
Level 5 – Pay Point 1 (Degree or diploma)	1338.50	1345.70	(C5-C3) ↑ C2(b)
Level 5 – Pay Point 2	1391.20	1345.70	(C5-C3) ↑ C2(b)

(c) Despite this non-alignment, to ensure no home care employee working in aged care is worse off by a work value determination, as a starting point, the Joint Employers propose that the existing rates be *"maintained"*.[122] For this reason, no variation is proposed to the minimum weekly wages in JE-DD2.

156. The decision to retain the existing structure is supported by the following additional considerations:

(a) **Pay points:** Whilst there is an element of the *"years of service"* progression within the *SCHADS Award* in clause 13.3, with "*12 months*" identified as the relevant period to consider progression, the construction of the progression clause in the *SCHADS Award* highlights that the progression between pay points is not intended to be automatic, but subject to an assessment of competency and skills and a determination by the employer.

(b) **Internal consistency:** The same pay and classification structure currently applies to all home care employees, save that home care employees working in aged care benefit from a 15% increase. In circumstances where it is commonplace for employees to work in both *"aged care"* and *"disability"*, caution should be taken to not disrupt the internal consistency within the award. This is more of a matter for any proposed variation to the classification structure, however, to ensure the award remains easy to read and apply in practice, this practical reality should be borne in mind when making decision to vary the *SCHADS Award* (noting the current application does not permit corresponding variations to be made to the disability components of the award).

Conclusion

157. By reference to the preceding analysis, the Joint Employers position is that the award minimum weekly wage for home care employees (providing services to an aged person) levels 1-5 should

[122] See *ACT Child Care Decision* at [155(2)].

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be maintained. In the event the Commission determines that a further increase is justified by work value reasons, such an increase should apply to the existing minimum wage.

Classification Structure & Definitions

Classification Structure

158. In contrast to the *Aged Care Award*, the classification structure and definitions in the *SCHADS Award* include more detail as the *"the essential elements of qualifications, displayed competence and acquired experience and responsibility"* of each classification level.[123] Each classification level addresses the following matters:

(a) accountability and extent of authority;

(b) judgment and decision-making;

(c) specialist knowledge and skills;

(d) interpersonal skills; and

(e) qualifications and experience.

159. For this reason, JE-DD2 proposes only minimal variation to the existing classification structure and definitions. *First*, Schedule E is to expressly distinguish between home care employees (**HCE**) in aged care and disability:

(i) *"home care employee—aged care—levels 1-5"*; and

(ii) *"home care employee—disability—aged care levels 1-5"*.

160. *Second*, with a view to enhance the usability and clarity of Schedule E (to the extent it applies to home care employees in aged care), the classification definitions for *"home care employee—aged care—levels 1-5"* include a series of minor amendments.

161. Whilst the Joint Employers suggest that the usability and clarity of the classification definitions for *"home care employee—disability—aged care levels 1-5"* would also benefit from amendment, that consideration falls outside the scope of the current applications. The appropriate forum to return to such issues may arise in the context of the *Modern Awards Review 2023–24*.

162. Additionally, it is uncontroversial that HCEs and home care providers often provide services to both aged care and disability clients. For this reason, retaining internal consistency between the

[123] See *Independent Education Union of Australia* [2021] FWCFB 2051 at [647] (**Teachers Decision**).

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two sets of HCEs was prioritised in order to not complicate the identification of classifications, especially in circumstances where different minimum weekly wages apply.

Classification Definitions

163. For the assistance of the Commission, the Joint Employers annex a marked-up extract of Schedule E from the SCHADS Award, to highlight the nature of the amendments proposed in JE-DD3 (see **Annexure B**).

Specialist knowledge and skills

164. As mentioned above, each HCE classification level includes a paragraph setting out *"specialist knowledge and skills"*. For the majority of classification levels this is currently presented as a list. To enhance the readability and clarity of each list of *"indicative but not exclusive tasks"*, in JE-DD1 the Joint Employers propose identifying the broad category of duties to which the tasks belong and reformatting the list. The effect of that proposal appears in the Table L below.

165. The following submissions are advanced in support of the variations proposed:

(a) The terms chosen to describe each category of indicative task (or duties) was primarily based on the existing descriptions in the *SCHADS Award*. For example:

(i) Clause E.1.2: *"An employee in this level performs broad tasks involving the utilisation of a range of basic skills in **the provision of domestic assistance and support** and is responsible for the quality of their work"* (emphasis added);

(ii) Clause E.2.3: *"the provision of **personal care**..."* (emphasis added);

(iii) Clause E.4.1: *"Positions in this level may provide direction, leadership, **administration** and rostering of direct care employees"* (emphasis added);

(iv) Clause E.5.1: *"Employees with **co-ordination responsibilities** are also required to..."* (emphasis added).

(b) The use of the term *"social support duties"* is consistent with the description used throughout the evidence in Stage 1.[124]

(c) The duties that appear listed in each classification level are created using the existing lists in Schedule E and with minimal amendment (see Table L below). One exception is the replacement of *"fitting and changing of catheters"* (in clause E.2.3) to *"changing*

[124] See example, Statement of Susan Digney dated 27 October 2021 [21]; Statement of Bridget Payton dated 26 October 2021 [32]; Transcript, 4 May 2022, PN5567 (Jennifer Wood); Statement of Julie Kupke dated 28 October 2021 [107]; Statement of Susan Toner dated 28 September 2021 [15].

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of catheter bags". The evidence in Stage 1 from both HCEs and nursing employees did not suggest that a HCE was required to *"fit"* a catheter.[125]

(d) In addition to the insertion of duty categories, two additional duties were included for *"home care employee—aged care—level 5"* as part of "co-ordination duties:

(i) *"overseeing the preparation and finalisation of care plans for clients"*; and

(ii) *"overseeing the provision of domestic services"*.

(e) The evidence in Stage 1 made clear that the role of the care co-ordinator is to oversee the entirety of the services delivered, with particular emphasis on care plans and the services provided in the homes of clients.[126]

Table L – Classification Definition Comparison: *"Specialist knowledge and skills"*

HCE	Current Clause in Schedule E	JE-DD2 categories	JE-DD2 proposal
1	*"Indicative but not exclusive tasks include: the undertaking of semi-skilled work, including cleaning, vacuuming, dusting, washing and ironing, shopping, sweeping paths, minor maintenance jobs, preparation and cooking of meals, defrosting refrigerators, emptying and cleaning of commodes, banking and account payment, organising appointments, assistance with care of pets, and care of indoor and outdoor pot plants."* (Clause E.1.4)	*"domestic assistance and support duties"*	Indicative but not exclusive tasks of an employee at this level include the undertaking of ***domestic assistance and support duties***, including: (a) cleaning, vacuuming, dusting, washing and ironing; (b) shopping; (c) sweeping; (d) minor maintenance jobs; (e) preparation and cooking of meals, defrosting refrigerators; (f) emptying and cleaning of commodes; (g) banking and account payment; (h) organising appointments; (i) assistance with care of pets; and (j) care of indoor and outdoor pot plants.

[125] See Report to Full Bench (Commissioner O'Neill, 20 June 2022) at [130], the summary of duties states *"Urinary care (empty/change catheter **but not place catheter**, and report any issues to an RN)"* (emphasis added).

[126] See example, coordinator - care plan and supervision: Transcript, 10 May 2022, PN10792 (Susan Morton); Transcript, 10 May 2022, PN10564- PN10566, Transcript, 10 May 2022, PN10574 (Teresa Hetherington); Transcript, 11 May 2022, PN11648 (Sandra Hafnagel); Transcript, 10 May 2022, PN10707, Transcript, 10 May 2022, PN10693 (Catherine Goh); Statement of Susan Digney dated 27 October 2021 [46].

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HCE	Current Clause in Schedule E	JE-DD2 categories	JE-DD2 proposal
2	*"Indicative but not exclusive tasks include: the provision of personal care, supervising daily hygiene, laying out clothes and assisting in dressing, make beds, tidy rooms, preparation and cooking of meals and assistance with meals, dry cleaning, perform gardening duties, undertake basic repairs, clean, fitting and removal of aids and appliances, monitoring medications, fitting and changing of catheters, assistance with communication, accompanying clients on outings, domestics assistance and organising appointments."* (Clause E.2.3)	*"domestic assistance and support duties"* *"personal care duties"* *"social support duties"*	Indicative but not exclusive tasks of an employee at this level include the undertaking of: **(a)** ***domestic assistance and support duties***, including: (i) make beds, tidy rooms; (ii) preparation and cooking of meals and assistance with meals; (iii) dry cleaning; (iv) perform gardening duties; (v) undertake basic repairs, clean; (vi) fitting and removal of aids and appliances; (vii) assistance with communication; and (viii) domestics assistance and organising appointments. **(b)** ***personal care duties***, including: (i) the provision of personal care; (ii) supervising daily hygiene; (iii) laying out clothes and assisting in dressing; (iv) changing of catheter bags; and (v) monitoring medications. **(c)** ***social support duties***, including accompanying clients on outings.
3	*"Indicative but not exclusive tasks include: computer and other office skills; maintain mail register and records; sort, process and record invoices and correspondence; prepare meals and special*	*"administrative duties"* *"domestic assistance and support duties"*	Indicative but not exclusive tasks of an employee at this level include the undertaking of the following: **(a)** ***administrative duties***, including: (i) computer and other office skills;

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HCE	Current Clause in Schedule E	JE-DD2 categories	JE-DD2 proposal
	functions; provide input into meal planning; order foodstuffs and commodities; liaise with dieticians on special needs; schedule work programs on a routine and regular basis; co-ordinate and direct the work of support staff including maintenance (no more than four); oversee the provision of domestic services; provide personal care to clients with particular emphasis on those requiring extra help due to specific physical problems or frailty; schedule maintenance work programs on a routine and regular basis; plan, develop, and co-ordinate diversional therapy programs and carry out general maintenance falling within the scope of trades skills." (Clause E.3.3)	*"personal care duties"*	(ii) maintain mail register and records; (iii) sort, process and record invoices and correspondence; (iv) order foodstuffs and commodities; (v) liaise with dieticians on special needs; (vi) co-ordinate and direct the work of support staff including maintenance (no more than four); (vii) schedule work programs on a routine and regular basis; (viii) oversee the provision of domestic services; and (ix) schedule maintenance work programs on a routine and regular basis; **(b)** ***domestic assistance and support duties***, including: (i) prepare meals and special functions; (ii) provide input into meal planning; and (iii) carry out general maintenance falling within the scope of trades skills. **(c)** ***personal care duties***, including: (i) provide personal care to clients with particular emphasis on those requiring extra help due to specific physical problems or frailty; and (ii) plan, develop, and co-ordinate diversional therapy programs.
4	*"(a) Employees will be required to plan, direct and train subordinate staff. Employees are also required to have a thorough understanding*	*"administrative duties"*	**(a)** Indicative but not exclusive of the skills required of an employee at this level include the undertaking of ***administrative duties***, including:

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HCE	Current Clause in Schedule E	JE-DD2 categories	JE-DD2 proposal
	of the relevant technology, procedures and processes used within their operating unit. *(b) Indicative but not exclusive of the skills required include: the manipulation of data e.g. modify fields of information and create spreadsheets; create new forms of files or records using a computer based records system; access and extract information from external sources e.g. local authorities; roster staff and direct work programs; oversee the work and training of lower level employees; provide guidance and counselling; assist in the development of budgets; order consumables and routine stock items used in domestic support areas; develop client care plans and oversee the provision of domestic services."* (Clause E.4.3)		(i) the manipulation of data e.g. modify fields of information and create spreadsheets; (ii) create new forms of files or records using a computer-based records system; (iii) access and extract information from external sources e.g. local authorities; (iv) roster staff and direct work programs; (v) oversee the work and training of lower-level employees; (vi) provide guidance and counselling; assist in the development of budgets; (vii) order consumables and routine stock items used in domestic support areas; (viii) develop client care plans diversional therapy and oversee the provision of domestic services. **(b)** An employee at this level must possess the following skills and abilities: (i) the ability to plan, direct and train subordinate staff; and (ii) a thorough understanding of the relevant technology, procedures and processes used within their operating unit.
5	***E.5.3 Specialist knowledge and skills*** *Co-ordinators in this level require a thorough understanding of the relevant technology, procedures and processes used within their operating unit. Co-ordinators are*	*"co-ordination duties"*	**(a)** An employee at this level must possess the following skills and abilities: (i) managing time, setting priorities and planning and organising one's own work and that of supervised employees so as to achieve specific and set objectives in the most efficient way possible within the

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HCE	Current Clause in Schedule E	JE-DD2 categories	JE-DD2 proposal
	required to have an understanding of the function of the position within its organisational context, including relevant policies, regulations and precedents. Positions in this level may provide direction, leadership and structured training or on-the-job training to supervised employees or groups of employees. ***E.5.4 Management skills*** *(a) These positions require skills in managing time, setting priorities and planning and organising one's own work and that of supervised employees so as to achieve specific and set objectives in the most efficient way possible within the resources available and within a set timetable.* *(b) The position requires an understanding of and ability to implement basic personnel policies and practices including those related to equal employment opportunity, occupational health and safety and employees' training and development.*		resources available and within a set timetable; (ii) set objectives in the most efficient way possible within the resources available and within a set timetable; and (iii) the ability to implement basic personnel policies and practices including those related to equal employment opportunity, occupational health and safety and employees' training and development. **(b)** An employee at this level may provide direction, leadership and structured training or on-the-job training to supervised employees or groups of employees. **(c)** Care co-ordinators at this level must also possess the following skills and abilities: (i) a thorough understanding of the relevant technology, procedures and processes used within their operating unit; and (ii) an understanding of the function of the position within its organisational context, including relevant policies, regulations and precedents; **(d)** Care co-ordinators at this level perform ***co-ordination duties***, including: (i) overseeing the preparation and finalisation of care plans for clients; (ii) overseeing the provision of domestic services;

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HCE	Current Clause in Schedule E	JE-DD2 categories	JE-DD2 proposal
			(iii) co-ordinating resources, governed by clear objectives and/or budgets with frequent prior consultation with more senior employees; and (iv) providing support to more senior employees.

Qualifications and experience

166. Based on the evidence in Stage 1, the following minor amendments were made to the *"qualifications and experience"* section of some classification levels:

(a) **Level 1:** Due to the emphasis placed on mandatory training for all employees, in addition to the pre-existing reference to *"induction course"*, the following words were inserted: *"and any other training required by the employer for this level"*.

(b) **Level 2:** Due to the absence of evidence as to the ongoing relevance of a *"Home Care Certificate"* (which also appears to be no longer available or used in practice), that qualification was removed from clause E.2.5. Consistent with the Stage 1 evidence, a reference to *"any other training required by the employer"* was also included.

(c) **Level 3:** Given the level 3 classification includes two pay points, with the first pay point requiring a Certificate III, the Joint Employers have inserted express reference to the *"experience"* acquired at this level.

(d) **Level 4:** Consistent with the evidence about Team Leader roles holding a Certificate IV qualification, insertion of the following sentence is proposed: *"Indicative but not exclusive of the qualifications required at this level is an accredited qualification to the position at the level of Certificate IV or equivalent"*.

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PART III: CLASSIFICATION AND ALLOWANCE ISSUES

167. In addition to the submissions advanced above, the Joint Employers continue to rely on the submissions set out in the position document filed 15 September 2023.

168. The Joint Employers submit that the classification structure, definitions and allowances set out in JE-DD1 and JE-DD2 provide an appropriate starting point as the Commission before it determines whether any further increases are justified by work value reasons, having been constructed with regard to both the applicable legal principles in the *Stage 1 decision*, together with the evidence in the proceedings.

169. The Joint Employers will provide a further response to the draft determinations filed by the HSU and ANMF, pursuant to paragraph 11 of the Directions, following the opportunity to review their submissions in support of their respective draft determinations.

For the Joint Employers

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1 November 2023

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ANNEXURE A – ANALYSIS OF AWARD MINIMUM WAGES

Introduction

170. If the Commission determines that a change to the classification structure and/or minimum award rates is justified by work value reasons, it is also required to be satisfied that any determination outside the system of annual wage reviews is necessary to achieve the modern awards objective and minimum wages objective: s 157(2)(b).[127]

171. The Joint Employers continue to rely on the submissions advanced in Closing Submissions at [23.1]-[23.26].

172. This section is designed to assist the Commission to determine whether an increase to the minimum award rates of indirect care workers, justified by work value reasons, is consistent with the modern awards objective.[128]

173. Specifically, whether such an increase will ensure that the modern awards provide a *"fair and relevant minimum safety net of terms and conditions"* taking into account the need to *"ensure a simple, easy to understand, stable and sustainable modern award system for Australia that avoids unnecessary overlap of modern awards"*.[129]

174. As previously submitted, the equivalent classifications and rates for employees in different occupations and industries remains a relevant consideration under s 134(1)(g) and s 284(1)(d). This submission will consider each *"indirect care"* role covered by the *Aged Care Award* and identify relevant comparative roles within the modern award system.

175. For this purpose, the following indirect care worker roles will be considered:

(a) laundry employee;

(b) cleaning employee;

(c) food services assistant;

(d) cook/chef;

(e) maintenance employee;

(f) gardener;

(g) driver; and

(h) administrative employee.

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[127] *Fair Work Act 2009* (Cth), s 157 (2) refers s 134.
[128] *Fair Work Act 2009* (Cth) s 157(2)(b).
[129] *Fair Work Act 2009* (Cth) s 134(1)(g).

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176. The accompanying analysis will identify and compare the equivalent classifications and their corresponding minimum weekly wages in tabular form by reference to the following modern awards (to the extent they are relevant):

(a) *Clerks—Private Sector Award 2020* (***Clerks Award***);

(b) *Cleaning Services Award 2020* (***Cleaning Award***);

(c) *Dry Cleaning and Laundry Industry Award 2020* (***DCL Award***);

(d) *Gardening and Landscaping Services Award 2020* (**Gardening Award**);

(e) *Hospitality Industry (General) Award 2020* (***HIGA***); and

(f) *Road Transport and Distribution Award 2020* (**RTD Award**).

177. The analysis will also identify the difference in minimum award rates by comparison to the minimum weekly wage in the *Aged Care Award.* This is to highlight whether the minimum rates of pay in the *Aged Care Award* are higher, lower or equivalent to the minimum rates of pay for equivalent work in different industries.

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(a) Laundry employee

Observations

Aged Care Award

178. A laundry employee working in the aged care industry is classified as a *"aged care employee—general"*. Whilst there are seven levels of *"general"* aged care employee, it is noted that *"laundry hand"* is only identified as an *"indicative"* role at level 1 and level 2.

DCL Award

179. The following matters are noted:

(a) The *DCL Award* covers employees in the *"dry cleaning and laundry industry"*.

(b) The *DCL Award* includes four classification levels for *"laundry employee"* which are defined in Schedule B.

(c) *"Laundry employee Level 1"* is a transitory level of employment, as indicated by the following definition: *"An employee in the first 6 months of employment with no previous experience in the industry"*.[130]

(d) The classification descriptions in Schedule B of the *DCL Award* do not include reference to any form of qualification.

(e) Progression points between classifications are primarily determined by reference to:

(i) the application of certain competencies (example, *"operate with a minimum of supervision"*);

(ii) the ability to perform certain skills (example, *"zip replacement"*, *"alternations"*, etc); and/or

(iii) the level of responsibility (example, *"be responsible for the maintenance of the quality and quantity of their own output"*).

Analysis of Minimum Rates

180. Table A provides a side-by-side comparison of the classification levels and minimum weekly rates for a laundry employee covered under the *Aged Care Award* (**ACA**) and *DCL Award.*

Table A: Laundry employee side-by-side comparison

[130] *Dry Cleaning and Laundry Industry Award 2020* Schedule B, clause B.1.1.

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Employee Classification		Minimum Weekly Wage ($)		Difference under ACA
ACA	**DCL**	**ACA**	**DCL**	
Level 1	Level 1	910.90	870.70	↑ 4.6%
Level 2	Level 2	947.00	900.50	↑ 5.2%
Level 3	Level 3	983.40	936.50	↑ 5
Level 4	Level 4	995.00	960.40	↑ 3.6%
Level 5	*N/A*	*1028.70*	*N/A*	*N/A*
Level 6	*N/A*	*1084.10*	*N/A*	*N/A*
Level 7	*N/A*	*1103.60*	*N/A*	*N/A*

181. The above comparison reveals that the minimum weekly wage of laundry employees working in the aged care industry is on average **4.6% more** than the minimum weekly wage of a laundry employee performing a comparative role in the dry cleaning and laundry industry.

Other matters

182. Both industry awards also include an allowance for handling either *"linen of a nauseous nature"*[131] or *"foul laundry (as defined)"*[132]. The *DCL Award* defines *"foul laundry"* as *"laundry that contains human excreta"*.[133] The allowance is determined by reference to the standard rate under both awards, a comparison appears below.

Award	**ACA**	**DCL**
% of standard rate	0.05%	1.96%
If entitlement, minimum % of standard rate	0.27%	N/A
Standard rate	$1084.10	$995.00
Per hour	$0.54 per hour *(with a minimum of $2.93 per week)*	$0.51 per hour (*up to a maximum of $19.50 per week*)

183. The above comparison reveals the allowance for handling contaminated laundry in the aged care industry is **5.8% higher** than in the dry cleaning and laundry industry. Additionally, it is not capped at a maximum payment of $19.50 per week.

[131] *Aged Care Award* clause 15.5(a)
[132] *Dry Cleaning and Laundry Industry Award 2020* clause 20.2(a).
[133] *Dry Cleaning and Laundry Industry Award 2020* clause 2.

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(b) Cleaning employee

Observations

Aged Care Award

184. A cleaning employee working in the aged care industry is classified as a *"aged care employee—general"*. Whilst there are seven levels of *"general"* aged care employee, it is noted that *"cleaner"* is only identified as an *"indicative"* role at level 1 and level 2.

Cleaning Award

185. The following matters are noted:

(a) The *Cleaning Award* covers employees in the *"contract cleaning services industry"*.

(b) The *Cleaning Award* includes three classification levels for *"cleaning services employee"* (**CSE**), which are defined in Schedule A.

(c) *"CSE Level 1"* is not a transitory role. This is indicated by the absence of reference to a time requirement (example, *"an employee in the first 6 months of employment with no previous experience in the industry"*[134]) or other suggestion that the role is designed to facilitate *"entry"* or *"introduction"* to the industry.

By contrast, *"aged care employee—general—level 1"* is a transitory role. This classification is identified as *"Entry level"* and described as *"[a]n employee who has less than three months' work experience in the industry..."*.[135]

For this reason, CSE Level 1 will be aligned to "*aged care employee—general—level 2"*, the first level of *"ongoing"* employment in the *Aged Care Award.*

(d) The classification descriptions in Schedule A of the *Cleaning Award* do not include reference to any form of qualification.

(e) Clause 12.2 of the *Cleaning Award* provides:

> *"Despite an employee's classification, an employee is to perform all duties incidental to the tasks of the employee that are within the employee's level of skill, competence and training."*

(f) Progression points between classifications are primarily determined by reference to:

(i) the application of certain competencies (example, *"works under routine supervision either individually or in a team"*);

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[134] *Dry Cleaning and Laundry Industry Award 2020* Schedule B, cl B.1.1.

[135] *Aged Care Award* Schedule B, cl B.1.1.

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(ii) the ability to perform certain skills (example, *"routine repair work or building maintenance (of a non-trade nature) in or about the facility"*, etc); and/or

(iii) the level of responsibility (example, *"are responsible for ensuring the quality of their work"*).

Analysis of Minimum Rates

186. Table B provides a side-by-side comparison of the classification levels and minimum weekly rates for a cleaning employee covered under the ACA and *Cleaning Award.*

Table B: Cleaning employee side-by-side comparison

Employee Classification		**Minimum Weekly Wage ($)**		**Difference under ACA**
ACA	**CSA**	**ACA**	**CSA**	
Level 1	*N/A*	910.90	*N/A*	*N/A*
Level 2	CSE Level 1	947.00	914.70	↑ 3.5%
Level 3	CSE Level 2	983.40	945.00	↑ 4%
Level 4	CSE Level 3	995.00	995.00	0%
Level 5	*N/A*	*1028.70*	*N/A*	*N/A*
Level 6	*N/A*	*1084.10*	*N/A*	*N/A*
Level 7	*N/A*	*1103.60*	*N/A*	*N/A*

187. The above comparison reveals that the minimum weekly wage of cleaning employees working in the aged care industry, after they acquire at least 3 months' work experience in the industry, is either **3.5% or 4% higher** than the minimum weekly wage of a cleaning services employee in the contract cleaning services industry. Upon meeting the competencies of a level 3 cleaning services employee, the minimum weekly wage is comparable between the two industries.

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(c) Food services assistant

Observations

Aged Care Award

188. A food services assistant working in the aged care industry is classified as a *"aged care employee—general"*. Whilst there are seven levels of *"general"* aged care employee, it is noted that *"food services assistant"* is only identified as an *"indicative"* role at level 1 and level 2.

HIGA

189. The following matters are noted:

(a) The *HIGA* covers employees in the *"hospitality industry"*.

(b) The *HIGA* includes two positions that are equivalent to the role of *"food services assistant"* in aged care, namely:

(i) *"food beverage attendant"* (grades 1-4), which appear in the *"food and beverage stream"* in Schedule A; and

(ii) *"kitchen attendant"* (grades 1-3), which appear in the *"kitchen stream"* in Schedule A.

(c) For completeness:

(i) in addition to food beverage attendant grades 1-4, the food and beverage stream also includes a *"Food and beverage supervisor"*; and

(ii) in addition to kitchen attendant grades 1-3, the kitchen stream also includes cook grades 1-5.

(d) *"Food and beverage attendant grade 2"* is described as *"an employee who has not achieved the appropriate level of training and who is engaged in any of the following [tasks listed]"* (emphasis added).

(e) *"Food and beverage attendant grade 4"* is identified as a *"tradesperson"* and described as *"an employee who has completed or has passed the appropriate trade test and who carries out specialised skilled duties in a fine dining room or a restaurant"*.

The first reference to trade qualification within the *"general"* stream in the *Aged Care Award* appears at Level 4. The aged care classification description provides that an employee at Level 4 *"may require formal qualifications"*.

(f) Progression points between classifications include reference to the following:

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(i) the application of certain competencies (example, *"assisting in the cellar or bottle department"* or *"supervising food and beverage attendants of a lower grade"*);

(ii) the ability to perform certain skills (example, *"picking up glasses"* or *"mixing a range of sophisticated drinks"*); and

(iii) the level of responsibility (example, *"having full control of a cellar or liquor store (including the receipt, delivery and recording of goods within such an area"*).

(g) The minimum rates in the *HIGA* appear to have been properly set against the C10 framework, with the minimum rates for *"Introductory Level"* and Wage Levels 1-5 aligning to the minimum rates for classification levels C10 to C14 and C8 in the *Manufacturing Award*:

Introductory Level	859.30	C14
Wage Level 1	882.80	C13
Wage Level 2	914.90	C12
Wage Level 3	945.00	C11
Wage Level 4	995.00	C10
Wage Level 5	1057.40	C8

(h) As previously submitted, Levels 1-3 in the *Aged Care Award* are not properly set and do not align to the C10 framework. Further, the rates are set higher. This difference has been taken into account when aligning the separate classification structures for the purpose of comparing minimum rates.

(i) For the purposes of analysis of minimum rates, by reference to descriptions in the *Aged Care Award* classification, the alignment to the C10 framework is as follows:

Aged Care Employee – Level 1	910.90	C14
Aged Care Employee – Level 2	947.00	C13 / C12
Aged Care Employee – Level 3	983.40	C11
Aged Care Employee – Level 4	995.00	C10
Aged Care Employee – Level 5	1028.70	C9
Aged Care Employee – Level 6	1084.10	C7
Aged Care Employee – Level 7	1103.60	C6

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Analysis of Minimum Rates

190. Tables C1 and C2 provide a side-by-side comparison of the classification levels and minimum weekly rates for a food services assistant (or equivalent) covered under the ACA and *HIGA*, by reference to the food and beverage stream (Table C1) and kitchen steam (Table C2).

Table C1: Food services assistant side-by-side comparison with *HIGA* (food and beverage stream)

Employee Classification		**Minimum Weekly Wage ($)**		**Difference**
ACA	***HIGA***	**ACA**	***HIGA***	**under ACA**
Level 1	Introductory Level	910.90	859.30	↑ 6%
Level 2	Grade 1, Wage Level 1	947.00	882.80	↑ 7.3%
Level 2	Grade 2, Wage Level 2	947.00	914.90	↑ 3.5%
Level 3	Grade 3, Wage Level 3	983.40	945.00	↑ 4%
Level 4	Grade 4, Wage Level 4	995.00	995.00	0%
Level 5	*N/A*	*1028.70*	*N/A*	
N/A	Supervisor, Wage Level 5	N/A	1057.40	
Level 6	*N/A*	*1084.10*	*N/A*	
Level 7	*N/A*	*1103.60*	*N/A*	

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Table C2: Food services assistant side-by-side comparison with *HIGA* (kitchen stream)

Employee Classification		Minimum Weekly Wage ($)		Difference under ACA
ACA	***HIGA***	**ACA**	***HIGA***	
Level 1	Introductory Level	910.90	859.30	↑ 6%
Level 2	Grade 1, Wage Level 1	947.00	882.80	↑ 7.3%
Level 2	Grade 2, Wage Level 2	947.00	914.90	↑ 3.5%
Level 3	Grade 3, Wage Level 3	983.40	945.00	↑ 4%
Level 4	*N/A*	*995.00*	*N/A*	
Level 5	*N/A*	*1028.70*	*N/A*	
Level 6	*N/A*	*1084.10*	*N/A*	
Level 7	*N/A*	*1103.60*	*N/A*	

191. Tables C1 and C2 reveal that minimum weekly wage for food services assistants and kitchenhands working in the aged care industry is on average **5.2% more** than the minimum weekly wage of employees working comparative roles in the hospitality industry.

192. The minimum weekly wage for employee with no prior work experience in the relevant industry is **6% higher** if the employee chooses to commence work in the aged care industry.

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(d) Cook/Chef

Observations

Aged Care Award

193. A cook/chef working in the aged care industry is classified as a *"aged care employee—general"*.

194. Relevantly, the following *"indicative tasks"* provide some insight into 'the hierarchy' of cook/chef classifications in the *Aged Care Award*:

Aged care employee—general	**Indicative tasks**
Level 3	Cook
Level 4	Senior cook (trade)
Level 5	Chef
Level 6	Senior chef
Level 7	Chef / Food service supervisor

195. The terminology used in the *Aged Care Award* to describe the role of the cook/chef and is very much *"indicative"*, with the balance of each classification lacking specificity to the role of cook/chef.

HIGA

196. The classification definitions for cook grades 3-5 in the *HIGA* incorporate terms used in the *"Kitchen Brigade System"* for the purpose of differentiating between the different *"cook"* roles, namely:

(a) cook grade 3 (tradesperson): *"commi chef or equivalent"*;

(b) cook grade 4 (tradesperson): *"demi chef or equivalent"*; and

(c) cook grade 5 (tradesperson): *"chef de partie or equivalent"*.

197. The Kitchen Brigade System is form of hierarchy used by culinary professionals and in commercial kitchens. The descriptions and comparison below highlight the limitations of attempting to apply the Kitchen Brigade System to the cook/chef roles in the aged care industry. It is also apparent that the complete hierarchy is not covered (or contemplated) by the cook classifications in the *HIGA*.

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Description	ACA	*HIGA*
Executive Chef / C*hef Executive* This role is typically the most senior kitchen staff. They will typically have a more business-oriented role, overseeing one or more busy restaurants, such as across a hotel group. Their work will often involve high-level oversight of operations as well as marketing and public relations. Some may also have a hand in menu development.[136]	N/A	N/A
Head Chef / *Chef de cuisine* This role is responsible for day-to-day kitchen management. Depending on the size of the business, they may be at the top of the kitchen hierarchy and report directly to the restaurant manager or owner. They have a largely supervisory role, ensuring the kitchen operates smoothly and taking the lead on creating menus.[137]	The single most senior food services employee engaged by any employer, classified at Aged care employee—general—levels 4 to 7. For this role the employee receive an addition 15%.	N/A
Sous Chef de Cuisine The *sous chef* is the chef de cuisine's second-in-command. Typically, they will act as an intermediary between the chef de cuisine and each station within the kitchen. Strong culinary skills and management abilities are vital for a sous chef, as they must be ready to help in all areas of the kitchen as well as monitoring inventory and employee performance. [138]		N/A

[136] Le Cordon Bleu, *"What is the kitchen brigade system?"* (Webpage) <https://www.cordonbleu.edu/news/what-is-the-kitchen-brigade-system/en>.
[137] Ibid.
[138] Ibid.

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Description	ACA	*HIGA*
Line Cook / *Chef de partie* A *chef de partie* will be in charge of one particular station. While they should be equipped to work in any area if need by, a chef de partie will generally oversee a single area of production, and may be titled accordingly. For example, they may be referred to as the saucier (sauce), entremetier (entrees) or pâtissier (pastries/desserts). [139]	N/A	Cook grade 5 (tradesperson) (wage level 6) This is the highest classification level for a Cook in the *HIGA*.
Demi Chef de partie A demi chef is an assistant chef who mostly works in food preparation on their designated station and is supervised by the *chef de partie*.[140]	N/A	Cook grade 4 (tradesperson) (wage level 5)
Commis Chef This is a junior position, sometimes given to recent graduates or those who have completed a period as a stagiaire (intern). A commis chef will often move around the kitchen according to the restaurant's needs, answering directly to the chef de partie of wherever they're assigned. [141]	N/A	Cook grade 3 (tradesperson) (wage level 4)

198. As mentioned earlier, the wage levels in *HIGA* are aligned to the C10 framework. Relevantly, for the cook classifications, they are repeated below:

[139] Le Cordon Bleu, *"What is the kitchen brigade system?"* (Webpage) <https://www.cordonbleu.edu/news/what-is-the-kitchen-brigade-system/en>.
[140] See generally, *"What do you need to become a Demi chef de partie?"* (Webpage) <https://www.caterer.com/advice/what-do-you-need-to-become-a-demi-chef-de-partie>; "Chef Jobs, Training, and Career Paths: Types of Chefs" <https://www.culinaryschools.org/chef-types/#context/api/sponsored-listings>.
[141] Le Cordon Bleu, *"What is the kitchen brigade system?"* (Webpage) <https://www.cordonbleu.edu/news/what-is-the-kitchen-brigade-system/en>.

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Cook Grade 1	**Wage Level 2**	914.90	C12
Cook Grade 2	**Wage Level 3**	945.00	C11
Cook Grade 3	**Wage Level 4**	995.00	C10
Cook Grade 4	**Wage Level 5**	1057.40	C8
Cook Grade 5	**Wage Level 6**	1085.60	C7

Analysis of Minimum Rates

199. Table D provides a side-by-side comparison of the classification levels and minimum weekly rates for a cook / chef covered under the ACA and *HIGA*. However, at the outset, the following limitations are noted:

(a) The classification descriptions are markedly different, with the cook classifications in the *HIGA* including far greater clarity as to markers of progression (i.e. the basis for advancement between the grades).

(b) Having regard to the C10 framework, it appears that *"Cook Grade 3, Wage Level 4"* and *"aged care employee—general—level 5"* align to the C8 and C9 levels, respectively. For this reason, despite aligning in sequence, the difference between those two rates is not calculated. By having regard to the C10 framework throughout this analysis, the Joint Employers minimise the creation of inconsistent or unfair comparators.

(c) The *HIGA* recognises two levels of cook before the trade qualified cook at Grade 3. In contrast, the ACA only recognises one level of cook before the trade qualified cook. Therefore the comparison between *"Level 2"* and *"Cook Grade 1"* aligns to a food services assistant in the aged care industry and a cook in the hospitality industry.

Table D: Cook/Chef side-by-side comparison with *HIGA*

Employee Classification		**Minimum Weekly Wage ($)**		**Difference under ACA**
ACA	***HIGA***	**ACA**	***HIGA***	
Level 1	*N/A*	*910.90*	*N/A*	
Level 2	Cook Grade 1, Wage Level 2	947.00	914.90	↑ 3.5%
Level 3	Cook Grade 2, Wage Level 3	983.40	945.00	↑ 4%

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Employee Classification		Minimum Weekly Wage ($)		Difference under ACA
ACA	***HIGA***	**ACA**	***HIGA***	
Level 4 (trade)	Cook Grade 3, Wage Level 4 (trade)	995.00	995.00	0%
Level 5	--	1028.70	--	
--	Cook Grade 4, Wage Level 5 (trade)	--	1057.40	
Level 6	Cook Grade 5, Wage Level 6 (trade)	1084.10	1085.60	↓ 0.1%
Level 7	*N/A*	*1103.60*	*N/A*	

200. A comparison of the classification structures in the *HIGA* and *Aged Care Award* highlights the lack of description included in the *Aged Care Award* with respect to the work performed by the cook/chef. The limitations are particularly apparent when attempting to align and compare the minimum weekly wages above aged care employee—general—level 5. For those reasons, analysis of the minimum of rates provided limited insight for the purposes of s 134(1)(g).

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(e) Maintenance employee

Observations

Aged Care Award

201. A maintenance employee working in the aged care industry is classified as an *"aged care employee—general"*.

202. Relevantly, the following *"indicative tasks"* provide some insight into the types of maintenance employee contemplated within the coverage of the *Aged Care Award*:

Aged care employee—general	Indicative tasks
Level 2	Maintenance/Handyperson (unqualified)
Level 4	Maintenance/Handyperson (qualified)
Level 6	Maintenance tradesperson (advanced)
Level 7	General services supervisor

Manufacturing Award

203. The following matters are noted:

(a) The *Manufacturing Award* covers a wide range of industries, associated industries and occupations associated with manufacturing (see cl 4.8), including maintenance.

(b) C14 is a transitory level as indicative by the minimum training requirement of *"up to 38 hours induction training"*.[142]

(c) The classifications that appear in Schedule A are the basis of the C10 framework.

(d) Progression between the classification levels requires satisfaction of the following:

(i) the application of certain competencies (including the minimum training requirement);

(ii) the ability to perform certain skills; and

(iii) the relevant level of responsibility.

HIGA

204. The *HIGA* recognised one *"handyperson"* classification within the *"maintenance and trades—other than the cooking trade"* stream (**maintenance stream**). The description provided is as follows:

[142] *Manufacturing Award* Schedule A, clause A.3.1.

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> ***"Handyperson (wage level 3)*** *means a person who is not a tradesperson and whose duties include performing routine repair work and maintenance in and about the employer's premises."*[143]

205. The balance of the classifications in the maintenance stream concern gardening employees as well as a fork-lift driver.

Analysis of Minimum Rates

206. Tables E1 and E2 provide a side-by-side comparison of the classification levels and minimum weekly rates for a maintenance employees (or equivalent) covered under the ACA, *Manufacturing Award* and *HIGA*.

Table E1: Maintenance employee side-by-side comparison with the *Manufacturing Award*

Employee Classification		Minimum Weekly Wage ($)		Difference under ACA
ACA	**Manufacturing**	**ACA**	**Manufacturing**	
Level 1	C14	910.90	859.30	↑ 6%
Level 2	**C13**	**947.00**	**883.80**	**↑ 3.5**
Level 2	**C12**	**947.00**	**914.90**	**↑ 7%**
Level 3	C11	983.40	945.00	↑ 4%
Level 4	**C10**	**995.00**	**995.00**	**0%**
Level 5	C9	1028.70	1026.20	↑ 0.2%
Level 6	**C7**	**1084.10**	**1085.60**	**↓ 0.1%**
Level 7	**C6**	**1103.60**	**1140.70**	**↓ 3.3%**

(Whilst it is possible for a maintenance employee to be classified at any level in the ACA, levels 2, 4, 6 and 7 are boldened to highlight that maintenance employee roles have been expressly identified as *"indicative tasks"*).

Table E2: Maintenance employee side-by-side comparison with the *HIGA*

Employee Classification		Minimum Weekly Wage ($)		Difference under ACA
ACA	***HIGA***	**ACA**	***HIGA***	
Level 2 (unqualified)	Handyperson Grade 1, Wage Level 2	947.00	945.00	↑ 0.2%

207. A comparison with the *Manufacturing Award* classifications highlights that the minimum weekly wage for maintenance employees classified at Level 1 through to Level 5 on the *Aged Care Award* is either higher or equivalent to the minimum award rates in the *Manufacturing*

[143] *HIGA* Schedule A, clause A.2.8(a) (emphasis added).

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Award. A similar outcome is reached when the unqualified position of maintenance employee is considered under the *HIGA*.

208. Notably, the minimum rates of pay for *"non-trade"* position in the *Aged Care Award* (i.e. Levels 1-3) align to rates of pay for higher qualified positions under the *Manufacturing Award*:

(a) Level 1 – this is an entry level role, which is paid at a rate more closely aligned to a C12 level. The relevant qualification at that level is more than in-house training and includes either a Certificate I or II or equivalent.

(b) Level 2 – this first level of ongoing employment (after 3 months experience in the aged care industry) is paid at a rate more closely aligned to a C11 level. The relevant qualification at that level is a Certificate II or equivalent.

(c) Level 3 – this level is only $11.60 below the minimum weekly wage of a Certificate III qualified employee (i.e. the C10 level). Such that the attainment of the Certificate III qualification results in a marginal increase for employees that progress from Level 3 to Level 4.

209. Turning to Level 6 and 7, the minimum award rates in the *Manufacturing Award* are higher than those that appear in the *Aged Care Award*. This anomaly appears to be a result of the rates in the *Aged Care Award* not being properly fixed in relation to Level 6 and 7.

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(f) Gardener

Observations

Aged Care Award

210. A gardening employee working in the aged care industry is classified as a *"aged care employee—general"*.

211. Relevantly, the following *"indicative tasks"* provide some insight into the types of gardening employee contemplated within the coverage of the *Aged Care Award*:

Aged care employee—general	Indicative tasks
Level 1	Assistant gardener
Level 2	Gardener (non-trade)
Level 4	Gardener (trade or TAFE Certificate III or above)
Level 6	Gardener (advanced)
Level 7	Gardener superintendent

212. Although reference is made to a *"Gardener superintendent"*, it is noted that the evidence in Stage 1 did not include reference that position. Additionally, that role does not appear in either the Gardening Award or *HIGA*.

Gardening Award

213. The following matters are noted:

(a) The Gardening Award covers employees working in the *"gardening and landscaping services industry"*.

(b) The Gardening Award includes six levels of classification, including an introductory level, which are defined in Schedule A.

(c) *"Introductory level"* is a transitory level of employment, as indicated by the classification definition which states:

(i) *"This is an entry level position"*; and

(ii) *"An employee at this level is undertaking training for a period of not more than 3 months... "*.[144]

(d) The classification descriptions include reference to the following qualifications:

(i) Level 3: *"a course in horticulture at a recognised training institution"*;

[144] *Gardening Award* Schedule A, cl A.1.1, cl A.1.2.

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(ii) Level 4: *"a recognised trade qualification"* (together with a requirement to complete *"a satisfactory period of apprenticeship in horticulture"*) or *"a Parks and Gardens Certificate III, a Landscaping Certificate III, a Greenkeeping Certificate III or equivalent"*;

(iii) Level 5: *"post trade training at Certificate IV or Diploma level from a recognised Registered Training Organisation"*.

(e) Progression points between classifications are primarily determined by reference to:

(i) the application of certain competencies (example, *"performs work above and beyond the skills of an employee at Level 1"* or *"performs work under limited supervision either individually or in a team environment"*);

(ii) the ability to perform certain skills (example, *"understands and applies quality control techniques"*, *"exercises good interpersonal and communications skills"*, etc); and/or

(iii) the level of responsibility (example, *"is responsible for assuring the quality of their own work"*).

(f) The *"Introductory Level"* and Levels 1-5 align to the minimum rates in the *Manufacturing Award*, with the exception of Level 3:

Introductory Level	859.30	C14
Level 1	882.80	C13
Level 2	914.90	C12
Level 3	~~945.00~~ ↑ 955.50	~~C11~~ ↑
Level 4	995.00	C10
Level 5	1026.20	C9

The slightly higher rate for Level 3 may be connected to the requirement for an employee at that level to not only have *"completed a course in horticulture"* (which may align to a Certificate II) but also be *"experienced in gardening work"* have *"demonstrated competence in plant and lawn maintenance and development, tree and shrub identification and the use and care of lawn mowers, edging machines and rotary hoes"*.[145]

[145] *Gardening Award* Schedule A cl A.4.

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HIGA

214. The *HIGA* also refers to gardening classifications in the *"maintenance and trades—other than the cooking trade"* stream. The *HIGA* include Gardener Grade 1 to 4.

Analysis of Minimum Rates

215. Tables F1 and F2 provide a side-by-side comparison of the classification levels and minimum weekly rates for a gardening employees covered under the ACA, Gardening Award and *HIGA*.

Table F1: Gardener employee side-by-side comparison with the Gardening Award

Employee Classification		Minimum Weekly Wage ($)		Difference under ACA
ACA	**Gardening**	**ACA**	**Gardening**	
Level 1	Introductory level	910.90	859.30	↑ 6%
Level 2	Level 1	947.00	882.80	↑ 7.3%
Level 2	Level 2	947.00	914.90	↑ 3.5%
Level 3	Level 3	983.40	955.50	↑ 2.9%
Level 4 (trade)	Level 4 (trade)	995.00	995.00	0%
Level 5	Level 5	1028.70	1026.20	↑ 0.2%
Level 6	*N/A*	*1084.10*	*N/A*	
Level 7	*N/A*	*1103.60*	*N/A*	

Table F2: Gardener employee side-by-side comparison with the *HIGA*

Employee Classification		Minimum Weekly Wage ($)		Difference under ACA
ACA	***HIGA***	**ACA**	***HIGA***	
Level 1	*N/A*	*910.90*	*N/A*	
Level 2	Gardner Grade 1, Wage Level 2	947.00	914.90	↑ 3.5%
Level 3	Gardner Grade 2, Wage Level 3	983.40	945.00	↑ 4%
Level 4	Gardner Grade 3 (tradesperson), Wage Level 4	995.00	995.00	0%
Level 5	--	1028.70	--	
	Gardner Grade 4 (tradesperson), Wage Level 5		1057.40	

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Employee Classification		Minimum Weekly Wage ($)		Difference under ACA
ACA	***HIGA***	**ACA**	***HIGA***	
Level 6	--	1084.10	--	
Level 7	*N/A*	*1103.60*	*N/A*	

216. In contrast to the *Aged Care Award*, both the Gardening Award and *HIGA* provide more details about the competencies and skills expected of each classification level. Due to the generalised nature of the classification descriptions in the *Aged Care Award*, it is particularly difficult to align positions such as the Grade 4 gardener from the *HIGA*, save for noting it appears to align to a C8 level in the *Manufacturing Award* for which an equivalent rate does not exist in the *Aged Care Award.*

217. Noting those limitations, the comparisons in Tables F1 and F2 support a conclusion that the minimum weekly wage of a gardener working in aged care is on average **4% higher** than the minimum weekly wage of gardeners covered under the Gardening Award or *HIGA*.

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(g) Driver

Observations

Aged Care Award

218. In the *Aged Care Award*, three distinctions are drawn between driver classifications:

(a) driver of a vehicle less than 3 tons (aged care employee—general—level 2);

(b) driver of a vehicle less than 3 tons + first aid certificate (aged care employee—general—level 3); and

(c) driver of a vehicle 3 tons and over (aged care employee—general—level 4).

Manufacturing Award

219. The *Manufacturing Award* recognises four classification levels of *"vehicle industry driver"*.

220. The primary distinguisher between the classifications in the *Manufacturing Award* is vehicle type:

(a) vehicle industry driver—Level I—D1 means an employee who is a driver Gross Vehicle Mass (GVM) 8 to 11 tonnes;

(b) vehicle industry driver—Level II—D2 means an employee who is a driver GVM 12 tonnes or greater;

(c) vehicle Industry Driver—Level III—D3 means an employee who is a driver of articulated vehicles up to 25 tonnes; and

(d) vehicle Industry Driver—Level IV—D4 means an employee who is a driver of articulated vehicles over 25 tonnes.

RTD Award

221. The RTD Award covers *"transport workers"* (Grade 1 to 10) working in the road transport and distribution industry.

222. Excluding Grade 1, which applies to couriers, the classifications include the following types of driver:

(a) Grade 2 – Driver of a rigid vehicle (including a motorcycle) not exceeding 4.5 tonnes GVM;

(b) Grade 3 – Driver of a two-axle rigid vehicle on any other rigid vehicle exceeding 4.5 tonnes, but not exceeding 13.9 tonnes GVM unless by special permit or registration such vehicle may be up to 15 tonnes GVM;

(c) Grade 4 – Driver of a 3-axle rigid vehicle exceeding 13.9 tonnes GVM;

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(d) Grade 5 – Driver of a rigid vehicle with 4 or more axles and a GVM exceeding 13.9 tonnes;

(e) Grade 6 – Driver of a rigid vehicle and a heavy trailer combination with more than three axles and a GCM greater than 22.4 tonnes up to and including 53.4 tonnes; and

223. Grade 7 – Driver of a double articulated vehicle up to and including 53.4 tonnes GCM— including B-Doubles.[146]

Analysis of Minimum Rates

224. Tables G1 and G2 provide a side-by-side comparison of the classification levels and minimum weekly rates for drivers covered under the ACA, *Manufacturing Award* and RTD Award.

Table G1: Driver side-by-side comparison with the *Manufacturing Award*

Employee Classification		**Minimum Weekly Wage ($)**		**Difference under ACA**
ACA	**Manufacturing**	**ACA**	**Manufacturing**	
Level 1	*N/A*	*910.90*	*N/A*	
Level 2	--	947.00	--	
Level 3	--	983.40	--	
Level 4 (3 tons or more)	D1 D2 D3 D4	995.00	957.10 968.70 980.20 993.90	↑ 4% ↑ 2.7% ↑ 1.5% ↑ 0.1%
Level 5	*N/A*	*1028.70*	*N/A*	
Level 6	*N/A*	*1084.10*	*N/A*	
Level 7	*N/A*	*1103.60*	*N/A*	

Table G2: Driver side-by-side comparison with the RTD Award

Employee Classification		**Minimum Weekly Wage ($)**		**Difference under ACA**
ACA	**RTD**	**ACA**	**RTD**	
Level 1	*N/A*	*910.90*	*N/A*	
Level 2 (less than 3 tons)	Grade 2	947.00	929.40	↑ 1.9%
Level 3	--	983.40	--	

[146] *Road Transport and Distribution Award 2020* Schedule B.

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Employee Classification		Minimum Weekly Wage ($)		Difference under ACA
ACA	**RTD**	**ACA**	**RTD**	
(less than 3 tons)				
Level 4 (3 tons or more)	Grade 3 Grade 4 Grade 5 Grade 6 Grade 7	995.00	940.20 956.80 968.70 979.70 993.90	↑ 5.8% ↑ 4% ↑ 2.7% ↑1.6% ↑ 0.1%
Level 5	*N/A*	*1028.70*	*N/A*	
Level 6	*N/A*	*1084.10*	*N/A*	
Level 7	*N/A*	*1103.60*	*N/A*	

225. The above comparison shows that the minimum weekly wage for a driver operating a vehicle more than 3 tonnes in the aged care industry is higher than both:

(a) the minimum award rates of all *"vehicle industry driver"* classifications under the *Manufacturing Award*, which include the operation of vehicles ranging from 8-11 tonnes to over 25 tonnes.; and

(b) the minimum award rates of all *"transport worker"* classifications under the RTD Award.

226. Further, the minimum weekly rate for a driver classified as an *"aged care employee—general—level 4"* (i.e. operating a vehicle of 3 tonnes or more) in the aged care industry is equivalent to the pay of the following classifications:

(a) a *"transport worker grade 7"* – driver of a double articulated vehicle up to and including 53.4 tonnes GCM—including B-Doubles; and

(b) a *"vehicle industry driver—level IV—D4"* – driver of articulated vehicles over 25 tonnes.

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(h) Administrative employee

Observations

Aged Care Award

227. An administrative employee working in the aged care industry is classified as a *"aged care employee—general"*.

228. Relevantly, the following *"indicative tasks"* provide some insight into the types of administrative employee contemplated within the coverage of the *Aged Care Award*:

Aged care employee—general	Indicative tasks
Level 1	General clerk
Level 2	General clerk/Typist (between 3 months' and less than 1 year's service)
Level 3	General clerk/Typist (second and subsequent years of service)
Level 4	Senior clerk Senior receptionist
Level 5	Secretary interpreter (unqualified)
Level 7	Clerical supervisor Interpreter (qualified)

229. Although reference is made to a *"Secretary interpreter (unqualified)"* and *"Interpreter (qualified)"*, it is noted that the evidence in Stage 1 did not include reference those positions.

Clerks Award

230. The following matters are noted:

(a) The *Clerks Award* covers employees who are *"wholly or principally engaged in clerical work"* in the private sector.

(b) The *Clerks Award* includes five classification levels for clerical workers, which are defined in Schedule A. For completeness, the *Clerks Award* also includes classification levels for various *"call centre"* roles.

(c) Whilst *"Level 1"* does make reference to including *"initial recruits who have limited relevant experience"* within the scope of the classification level, it is not a transitory level. Further guidance is provided by the note at cl A.1.4:

> *"Level 1 is to be viewed as the level at which employees learn and gain competence in the basic clerical skills required by the employer, which in most*

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cases would lead to progression through the classification structure as their competency and skills increase and are utilised."

(d) At the outset it is noted that the *Clerks Award* states *"the key issue to be looked at in properly classifying an employee is the level of competency and skill that the employee is required to exercise in the work they perform, not the duties they perform as such"*.[147]

(e) The minimum award rates in the *Clerks Award* also includes time-based increments. Such that an employee once *"properly classified"* as a Level 1 or 2 employee, will receive an annual increase.

(f) The minimum award rates in the *Clerks Award* do note align to the C10 framework.

231. Thus, whilst the broad nature of the duties being performed by workers under the *Clerks Award* is comparative to that of administrative employees in the aged care industry, the above observations should be noted as potentially impacting the utility of the comparison.

HIGA

232. The *HIGA* also include an administration stream, which includes *"clerical"* workers grade 1-3, together with a *"clerical supervisor"*.

Analysis of Minimum Rates

233. Tables H1 and H2 provide a side-by-side comparison of the classification levels and minimum weekly rates for administrative employees covered under the ACA, *Clerks Award* and *HIGA*.

Table H1: Administrative employee side-by-side comparison with the *Clerks Award*

Employee Classification		Minimum Weekly Wage ($)		Difference under
ACA	**Clerks**	**ACA**	**Clerks**	**ACA**
Level 1	Level 1, Year 1	910.90	910.90	0%
Level 2	Level 1, Year 2,	947.00	954.00	↓ 0.7%
Level 3	Level 1, Year 3	983.40	983.40	0%
Level 4	Level 2, Year 1	995.00	995.00	0%
Level 5	Level 2,	1028.70	1013.40	↑ 1.5%

[147] *Clerks Award*, Schedule A, clause A.1.4.

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Employee Classification		Minimum Weekly Wage ($)		Difference under ACA
ACA	**Clerks**	**ACA**	**Clerks**	
	Year 2			
Level 6	Level 3	1084.10	1050.90	↑ 3%
Level 7	Level 4	1103.60	1103.60	0%
--	Level 5	--	1148.40	--

Table H2: Administrative employee side-by-side comparison with the *HIGA*

Employee Classification		Minimum Weekly Wage ($)		Difference under ACA
ACA	***HIGA***	**ACA**	***HIGA***	
Level 1	Introductory Level	910.90	859.30	↑ 6%
Level 2	Grade 1, Wage Level 2	947.00	914.90	↑ 3.5%
Level 3	Grade 2, Wage Level 3	983.40	945.00	↑ 4%
Level 4	Grade 3, Wage Level 4	995.00	995.00	0%
Level 5	--	1028.70	--	-
--	Clerical Supervisor, Wage Level 5	--	1057.40	
Level 6	--	1084.10	--	
Level 7	*N/A*	*1103.60*	*N/A*	

234. The above table suggests that the minimum weekly wages for administrative employees under the *Aged Care Award* are very much in line with the minimum weekly wages of private sector employees who are wholly or principally engaged in clerical work (except for ACA level 2 when compared to the Clerks Award). Additionally, as progression between the levels in the *Aged Care Award* are not *"time based"*, there is the possibility of faster progression based on meeting the competencies of a higher level.

235. Further, a comparison with the minimum weekly wages of clerical workers performing comparative work in the hospitality industry highlights that the minimum weekly wage of administrative employees working in the aged care industry is higher.

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Concluding Observations

236. The preceding analysis suggests that in the overwhelming majority of cases, the award minimum weekly wage for indirect care employees performing work in the aged care sector is higher than the award minimum weekly wage of employees performing equivalent roles in other industries. Attention has been drawn to those minority of classifications that are not on a higher rate.

237. In the instances where the award minimum weekly wage of the aged care employee classification was less than the award minimum weekly wage of employees performing equivalent roles in other industries, invariably one or more of the following factors applied:

(a) the discrepancy was marginal in nature;

(b) the discrepancy was a consequence of the minimum rates in the *Aged Care Award* not being properly set; and/or

(c) there was minimal evidence in Stage 1 that the *"indicative"* roles listed under *"aged care employee—general—level 7"* continue to be used in practice under the *Aged Care Award*.

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ANNEXURE B

Marked-up Extract – Schedule E

Schedule E—Classification Definitions—Home Care Employees

E.1 Home Care Employee—Aged Care—Level 1

~~A position in~~An employee at this level has the following characteristics:

E.1.1 A person appointed to this position will have less than 12 months' experience in the industry.

E.1.2 Accountability and extent of authority

An employee ~~in~~ at this level performs broad tasks involving the utilisation of a range of basic skills in the provision of domestic assistance and support and is responsible for the quality of their work.

E.1.3 Judgment and decision-making

Work activities are routine and clearly defined. The tasks to be performed may involve the use of a limited range of techniques and methods within a specified range of work. An employee may resolve minor problems that relate to immediate work tasks.

E.1.4 Specialist knowledge and skills

Indicative but not exclusive tasks of an employee at this level include the undertaking of ***domestic assistance and support duties***, including:

(a) cleaning, vacuuming, dusting, washing and ironing;

(b) shopping;

(c) sweeping;

(d) minor maintenance jobs;

(e) preparation and cooking of meals, defrosting refrigerators;

(f) emptying and cleaning of commodes;

(g) banking and account payment;

(h) organising appointments;

(i) assistance with care of pets; and

(j) care of indoor and outdoor pot plants.

~~include: the undertaking of semi-skilled work, including cleaning, vacuuming, dusting, washing and ironing, shopping, sweeping paths, minor maintenance jobs, preparation and cooking of meals, defrosting refrigerators, emptying and cleaning of commodes, banking and account payment, organising appointments, assistance with care of pets, and care of indoor and outdoor pot plants~~.

E.1.5 Interpersonal skills

An employee at this level requires ~~Positions in this level may require~~ basic oral communication skills and where appropriate written skills, with clients, members of the public and other employees.

E.1.6 Qualifications and experience

An employee ~~in~~ at this level ~~will have commenced~~is required to complete on-the-job training which may include an induction course and any other training required by the employer for this level.

E.2 Home Care Employee—Aged Care—Level 2

~~A position in~~An employee at this this level has the following characteristics:

E.2.1 Accountability and extent of authority

An employee in this level performs broad tasks involving the utilisation of a range of developed skills in the provision of domestic assistance and support. Work performed falls within general guidelines but with scope to exercise discretion in the application of established practices and procedures. May assist others in the supervision of work of the same or lower level and is responsible for assuring the quality of work performed.

E.2.2 Judgment and decision-making

In these positions, the nature of the work is clearly defined with established procedures well understood or clearly documented. Employees in this level are called upon to use some originality in approach with solutions usually attributable to application of previously encountered procedures and practices.

E.2.3 Specialist knowledge and skills

Indicative but not exclusive tasks of an employee at this level include the undertaking of:

(a) ***domestic assistance and support duties***, including:

- **(i)** make beds, tidy rooms;
- **(ii)** preparation and cooking of meals and assistance with meals;
- **(iii)** dry cleaning;
- **(iv)** perform gardening duties;
- **(v)** undertake basic repairs, clean;
- **(vi)** fitting and removal of aids and appliances;
- **(vii)** assistance with communication; and
- **(viii)** domestics assistance and organising appointments.

(b) ***personal care duties***, including:

- **(i)** the provision of personal care;
- **(ii)** supervising daily hygiene;
- **(iii)** laying out clothes and assisting in dressing;
- **(iv)** changing of catheter bags; and
- **(v)** monitoring medications.

(c) ***social support duties***, including accompanying clients on outings.

~~include: the provision of personal care, supervising daily hygiene, laying out clothes and assisting in dressing, make beds, tidy rooms, preparation and cooking of meals and assistance with meals, dry cleaning, perform gardening duties, undertake basic repairs, clean, fitting and removal of aids and appliances, monitoring medications, fitting and changing of catheters, assistance with communication, accompanying clients on outings, domestics assistance and organising appointments~~.

E.2.4 Interpersonal skills

An employee at this level requires ~~Positions in this level require~~ oral communication skills and where appropriate written skills, with clients, members of the public and other employees.

E.2.5 Qualifications and experience

~~As a minimum a~~An employee ~~in~~at this level ~~will have satisfactorily completed the requirements of level 1 or equivalent. Indicative but not exclusive of the qualifications~~is required ~~in this level include Home Care Certificate or equivalent; or~~to complete relevant experience/on-the-job training commensurate with the requirements of work ~~in~~at this level and will participate in any other training required by the employer for in this level.

E.3 Home Care Employee—Aged Care—Level 3

~~A position in~~An employee at this level has the following characteristics:

E.3.1 Accountability and extent of authority

Employees perform work under general supervision. Employees ~~in~~at this level have contact with the public or other employees which involves explanations of specific procedures and practices. Employees ~~in~~ at this level are accountable for the quality, quantity and timeliness of their own work in so far as available resources permit, and for the care of assets entrusted to them.

E.3.2 Judgment and decision-making

These positions require personal judgment. The nature of work is usually specialised with procedures well understood and clearly documented. The particular tasks to be performed will involve selection from a range of techniques, systems, equipment, methods or processes.

E.3.3 Specialist knowledge and skills

Indicative but not exclusive tasks of an employee at this level include the undertaking of the following:

(a) ***administrative duties***, including:

(i) computer and other office skills;

(ii) maintain mail register and records;

(iii) sort, process and record invoices and correspondence;

(iv) order foodstuffs and commodities;

(v) liaise with dieticians on special needs;

(vi) co-ordinate and direct the work of support staff including maintenance (no more than four);

(vii) schedule work programs on a routine and regular basis;

(viii) oversee the provision of domestic services; and

(ix) schedule maintenance work programs on a routine and regular basis;

(b) ***domestic assistance and support duties***, including:

(i) prepare meals and special functions;

(ii) provide input into meal planning; and

(iii) carry out general maintenance falling within the scope of trades skills.

(c) ***personal care duties***, including:

(i) provide personal care to clients with particular emphasis on those requiring extra help due to specific physical problems or frailty; and

(ii) plan, develop, and co-ordinate diversional therapy programs.

~~include: computer and other office skills; maintain mail register and records; sort, process and record invoices and correspondence; prepare meals and special functions; provide input into meal planning; order foodstuffs and commodities; liaise with dieticians on special needs; schedule work programs on a routine and regular basis; co-ordinate and direct the work of support staff including maintenance (no more than four); oversee the provision of domestic services; provide personal care to clients with particular emphasis on those requiring extra help due to specific physical problems or frailty; schedule maintenance work programs on a routine and regular basis; plan, develop, and co-ordinate diversional therapy programs and carry out general maintenance falling within the scope of trades skills~~.

E.3.4 Interpersonal skills

~~Positions in~~ An employee at this level require sound skills in oral and written communication with clients, other employees and members of the public.

E.3.5 Qualifications and experience

Indicative but not exclusive of the qualifications required ~~in~~ at this level is an accredited qualification ~~to the position~~ at the level of Certificate ~~3~~III and/or knowledge and skills gained

through on-the-job training and experience commensurate with the requirements of the work in this level.

E.4 Home Care Employee—Aged Care—Level 4

A position in this level has the following characteristics:

E.4.1 Accountability and extent of authority

Employees are expected to exercise discretion within standard practices and processes, undertaking and implementing quality control measures. Positions in this level may provide direction, leadership, administration and rostering of direct care employees.

E.4.2 Judgment and decision-making

The objectives of the work are well defined but the particular method, process of equipment to be used must be selected from a range of available alternatives. For employees undertaking rostering duties, the process often requires the quantification of the amount of resources needed to meet those objectives.

E.4.3 Specialist knowledge and skills

(a) Indicative but not exclusive of the skills required of an employee at this level include the undertaking of ***administrative duties***, including:

(i) the manipulation of data e.g. modify fields of information and create spreadsheets;

(ii) create new forms of files or records using a computer-based records system;

(iii) access and extract information from external sources e.g. local authorities;

(iv) roster staff and direct work programs;

(v) oversee the work and training of lower-level employees;

(vi) provide guidance and counselling; assist in the development of budgets;

(vii) order consumables and routine stock items used in domestic support areas;

(viii) develop client care plans diversional therapy and oversee the provision of domestic services.

(b) An employee at this level must possess the following skills and abilities:

(i) the ability to plan, direct and train subordinate staff; and

(ii) a thorough understanding of the relevant technology, procedures and processes used within their operating unit.

~~**(a)** Employees will be required to plan, direct and train subordinate staff. Employees are also required to have a thorough understanding of the relevant technology, procedures and processes used within their operating unit.~~

~~**(b)**~~**(c)** ~~Indicative but not exclusive of the skills required include: the manipulation of data e.g. modify fields of information and create spreadsheets; create new forms of files or records using a computer based records system; access and extract information from external sources e.g. local authorities; roster staff and direct work programs; oversee the work and training of lower level employees; provide guidance and counselling; assist in the development of budgets; order consumables and routine stock items used in domestic support areas; develop client care plans and oversee the provision of domestic services.~~

E.4.4 Interpersonal skills

Positions in this level require the ability to gain co-operation and assistance from members of the public and other employees in the performance of well defined activities. Employees in this level may also be expected to write reports in their field of expertise.

E.4.5 Qualifications and experience

An employee in this level will have satisfactorily completed the requirements of Level 3 or equivalent as well as have relevant experience. Indicative but not exclusive of the

qualifications required at this level is an accredited qualification to the position at the level of Certificate IV or equivalent.

E.5 Home care employee—Aged Care—level 5

A position in this level includes care co-ordinator, foreperson and maintenance supervisor. A position in this level has the following characteristics:

E.5.1 Accountability and extent of authority

(a) Positions in this level may co-ordinate resources and/or give support to more senior employees or be engaged in duties of a specialist nature.

(b) In positions where the prime responsibility is for resource co-ordination, the freedom to act is governed by clear objectives and/or budgets with frequent prior consultation with more senior employees and a regular reporting mechanism to ensure adherence to plans.

(c) Whatever the nature of the position, employees in this level are accountable for the quality, effectiveness, cost and timeliness of the programs, projects or work plans under their control and for the safety and security of the assets being managed.

(d) Employees with co-ordination responsibilities are also required to ensure that all employees under their direction are trained in safe working practices and in the safe operation of equipment and are made aware of all occupational health and safety policies and procedures.

E.5.2 Judgment and decision-making

In these positions, the objectives of the work are usually well defined but the particular method, technology, process or equipment to be used must be selected from a range of available alternatives. However, problems in this level are often of a complex or technical nature with solutions not related to previously encountered situations and some creativity and originality is required. Guidance and counsel may be available within the time available to make a choice.

E.5.3 Specialist knowledge and skills

(a) An employee at this level must possess the following skills and abilities:

(i) managing time, setting priorities and planning and organising one's own work and that of supervised employees so as to achieve specific and set objectives in the most efficient way possible within the resources available and within a set timetable;

(ii) set objectives in the most efficient way possible within the resources available and within a set timetable; and

(iii) the ability to implement basic personnel policies and practices including those related to equal employment opportunity, occupational health and safety and employees' training and development.

(b) An employee at this level may provide direction, leadership and structured training or on-the-job training to supervised employees or groups of employees.

(c) Care co-ordinators at this level must also possess the following skills and abilities:

(i) a thorough understanding of the relevant technology, procedures and processes used within their operating unit; and

(ii) an understanding of the function of the position within its organisational context, including relevant policies, regulations and precedents;

(d) Care co-ordinators at this level perform ***co-ordination duties***, including:

(i) overseeing the preparation and finalisation of care plans for clients;

(ii) overseeing the provision of domestic services;

(iii) co-ordinating resources, governed by clear objectives and/or budgets with frequent prior consultation with more senior employees; and

~~**E.5.3**~~**(iv)** providing support to more senior employees.

~~Co-ordinators in this level require a thorough understanding of the relevant technology, procedures and processes used within their operating unit. Co-ordinators are required to have an understanding of the function of the position within its organisational context, including relevant policies, regulations and precedents. Positions in this level may provide direction, leadership and structured training or on-the-job training to supervised employees or groups of employees.~~

~~E.5.4 Management skills~~

~~(a) These positions require skills in managing time, setting priorities and planning and organising one's own work and that of supervised employees so as to achieve specific and set objectives in the most efficient way possible within the resources available and within a set timetable.~~

~~(b)~~(c) ~~The position requires an understanding of and ability to implement basic personnel policies and practices including those related to equal employment opportunity, occupational health and safety and employees' training and development.~~

~~E.5.5~~E.5.4 **Interpersonal skills**

Positions in this level require the ability to gain co-operation and assistance from clients, members of the public and other employees in the administration of defined activities and in the supervision of other employees or groups of employees. Employees in this level are expected to write reports in their field of expertise and to prepare external correspondence of a routine nature.

~~E.5.6~~E.5.5 **Qualifications and experience**

The skills and knowledge needed for entry to this level are beyond those normally acquired through completion of a TAFE certificate or associate diploma alone. They might be acquired through completion of a degree or diploma course with little or no relevant work experience, or through lesser formal qualifications with relevant work skills, or through relevant experience and work skills commensurate with the requirements of work in this level.

E.6 Home Care Employee—Disability—Level 1

An employee at this level has the following characteristics:

E.6.1 A person appointed to this position will have less than 12 months' experience in the industry.

E.6.2 Accountability and extent of authority

An employee at this level performs broad tasks involving the utilisation of a range of basic skills in the provision of domestic assistance and support and is responsible for the quality of their work.

E.6.3 Judgment and decision-making

Work activities are routine and clearly defined. The tasks to be performed may involve the use of a limited range of techniques and methods within a specified range of work. An employee may resolve minor problems that relate to immediate work tasks.

E.6.4 Specialist knowledge and skills

Indicative but not exclusive tasks include: the undertaking of semi-skilled work, including cleaning, vacuuming, dusting, washing and ironing, shopping, sweeping paths, minor maintenance jobs, preparation and cooking of meals, defrosting refrigerators, emptying and cleaning of commodes, banking and account payment, organising appointments, assistance with care of pets, and care of indoor and outdoor pot plants.

E.6.5 Interpersonal skills

Positions at this level may require basic oral communication skills and where appropriate written skills, with clients, members of the public and other employees.

E.6.6 Qualifications and experience

An employee at this level will have commenced on-the-job training which may include an induction course.

E.7 Home Care Employee—Disability—Level 2

An employee at this level has the following characteristics:

E.7.1 Accountability and extent of authority

An employee at this level performs broad tasks involving the utilisation of a range of developed skills in the provision of domestic assistance and support. Work performed falls within general guidelines but with scope to exercise discretion in the application of established practices and procedures. May assist others in the supervision of work of the same or lower level and is responsible for assuring the quality of work performed.

E.7.2 Judgment and decision-making

In these positions, the nature of the work is clearly defined with established procedures well understood or clearly documented. Employees at this level are called upon to use some originality in approach with solutions usually attributable to application of previously encountered procedures and practices.

E.7.3 Specialist knowledge and skills

Indicative but not exclusive tasks include: the provision of personal care, supervising daily hygiene, laying out clothes and assisting in dressing, make beds, tidy rooms, preparation and cooking of meals and assistance with meals, dry cleaning, perform gardening duties, undertake basic repairs, clean, fitting and removal of aids and appliances, monitoring medications, fitting and changing of catheters, assistance with communication, accompanying clients on outings, domestics assistance and organising appointments.

E.7.4 Interpersonal skills

Positions at this level require oral communication skills and where appropriate written skills, with clients, members of the public and other employees.

E.7.5 Qualifications and experience

As a minimum an employee at this level will have satisfactorily completed the requirements of level 1 or equivalent. Indicative but not exclusive of the qualifications required at this level include Home Care Certificate or equivalent; or relevant experience/on-the-job training commensurate with the requirements of work at this level.

E.8 Home Care Employee—Disability—Level 3

An employee at this level has the following characteristics:

E.8.1 Accountability and extent of authority

Employees perform work under general supervision. Employees at this level have contact with the public or other employees which involves explanations of specific procedures and practices. Employees at this level are accountable for the quality, quantity and timeliness of their own work in so far as available resources permit, and for the care of assets entrusted to them.

E.8.2 Judgment and decision-making

These positions require personal judgment. The nature of work is usually specialised with procedures well understood and clearly documented. The particular tasks to be performed will involve selection from a range of techniques, systems, equipment, methods or processes.

E.8.3 Specialist knowledge and skills

Indicative but not exclusive tasks include: computer and other office skills; maintain mail register and records; sort, process and record invoices and correspondence; prepare meals and special functions; provide input into meal planning; order foodstuffs and commodities; liaise with dieticians on special needs; schedule work programs on a routine and regular basis; co-

ordinate and direct the work of support staff including maintenance (no more than four); oversee the provision of domestic services; provide personal care to clients with particular emphasis on those requiring extra help due to specific physical problems or frailty; schedule maintenance work programs on a routine and regular basis; plan, develop, and co-ordinate diversional therapy programs and carry out general maintenance falling within the scope of trades skills.

E.8.4 Interpersonal skills

Positions at this level require skills in oral and written communication with clients, other employees and members of the public.

E.8.5 Qualifications and experience

Indicative but not exclusive of the qualifications required at this level is an accredited qualification to the position at the level of Certificate 3 and/or knowledge and skills gained through on-the-job training commensurate with the requirements of the work at this level.

E.9 Home Care Employee—Disability—Level 4

A position in this level has the following characteristics:

E.9.1 Accountability and extent of authority

Employees are expected to exercise discretion within standard practices and processes, undertaking and implementing quality control measures. Positions in this level may provide direction, leadership, administration and rostering of direct care employees.

E.9.2 Judgment and decision-making

The objectives of the work are well defined but the particular method, process of equipment to be used must be selected from a range of available alternatives. For employees undertaking rostering duties, the process often requires the quantification of the amount of resources needed to meet those objectives.

E.9.3 Specialist knowledge and skills

(a) Employees will be required to plan, direct and train subordinate staff. Employees are also required to have a thorough understanding of the relevant technology, procedures and processes used within their operating unit

(b) Indicative but not exclusive of the skills required include: the manipulation of data e.g. modify fields of information and create spreadsheets; create new forms of files or records using a computer based records system; access and extract information from external sources e.g. local authorities; roster staff and direct work programs; oversee the work and training of lower level employees; provide guidance and counselling; assist in the development of budgets; order consumables and routine stock items used in domestic support areas; develop client care plans and oversee the provision of domestic services.

E.9.4 Interpersonal skills

Positions in this level require the ability to gain co-operation and assistance from members of the public and other employees in the performance of well defined activities. Employees in this level may also be expected to write reports in their field of expertise.

E.9.5 Qualifications and experience

An employee in this level will have satisfactorily completed the requirements of level 3 or equivalent as well as have relevant experience.

E.10 Home Care Employee—Disability—Level 5

A position in this level includes care co-ordinator, foreperson and maintenance supervisor. A position in this level has the following characteristics:

E.10.1 Accountability and extent of authority

(a) Positions in this level may co-ordinate resources and/or give support to more senior employees or be engaged in duties of a specialist nature.

(b) In positions where the prime responsibility is for resource co-ordination, the freedom to act is governed by clear objectives and/or budgets with frequent prior consultation with more senior employees and a regular reporting mechanism to ensure adherence to plans.

(c) Whatever the nature of the position, employees in this level are accountable for the quality, effectiveness, cost and timeliness of the programs, projects or work plans under their control and for the safety and security of the assets being managed.

(d) Employees with co-ordination responsibilities are also required to ensure that all employees under their direction are trained in safe working practices and in the safe operation of equipment and are made aware of all occupational health and safety policies and procedures.

E.10.2 Judgment and decision-making

In these positions, the objectives of the work are usually well defined but the particular method, technology, process or equipment to be used must be selected from a range of available alternatives. However, problems in this level are often of a complex or technical nature with solutions not related to previously encountered situations and some creativity and originality is required. Guidance and counsel may be available within the time available to make a choice.

E.10.3 Specialist knowledge and skills

Co-ordinators in this level require a thorough understanding of the relevant technology, procedures and processes used within their operating unit. Co-ordinators are required to have an understanding of the function of the position within its organisational context, including relevant policies, regulations and precedents. Positions in this level may provide direction, leadership and structured training or on-the-job training to supervised employees or groups of employees.

E.10.4 Management skills

(a) These positions require skills in managing time, setting priorities and planning and organising one's own work and that of supervised employees so as to achieve specific and set objectives in the most efficient way possible within the resources available and within a set timetable.

(b) The position requires an understanding of and ability to implement basic personnel policies and practices including those related to equal employment opportunity, occupational health and safety and employees' training and development.

E.10.5 Interpersonal skills

Positions in this level require the ability to gain co-operation and assistance from clients, members of the public and other employees in the administration of defined activities and in the supervision of other employees or groups of employees. Employees in this level are expected to write reports in their field of expertise and to prepare external correspondence of a routine nature.

E.10.6 Qualifications and experience

The skills and knowledge needed for entry to this level are beyond those normally acquired through completion of a TAFE certificate or associate diploma alone. They might be acquired through completion of a degree or diploma course with little or no relevant work experience, or through lesser formal qualifications with relevant work skills, or through relevant experience and work skills commensurate with the requirements of work in this level.

IN THE FAIR WORK COMMISSION

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

Re Application by: Virginia Ellis, Mark Castieau, Sanu Ghimire, Paul Jones and Health Services Union; Australian Nursing and Midwifery Federation; Health Services Union

WITNESS STATEMENT OF JOHANNES BROCKHAUS
DATED 31 OCTOBER 2023

I, Johannes Brockhaus of 39 Hawkesbury Road, Springwood, New South Wales state as follows:

Background

1. I am a witness in these proceedings.

2. I have previously provided two statements in respect of these proceedings dated 3 March 2022 (**First Statement**) and 9 February 2023 (**Second Statement**).

3. I now provide the following information in addition to my earlier evidence.

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

5. I continue to be employed as the Chief Executive Officer (**CEO**) of Buckland Aged Care Services (**Buckland**), 39 Hawkesbury Rd, Springwood NSW 2777. A position I have held since 2020.

Staff

6. Buckland employs a full suite of employees, including:

   (a) assistant in nursing, personal care worker, home care worker – these employees make up roughly 85% of our total workforce (**carer**);

   (b) registered nurses (**RN**);

   (c) enrolled nurses (**EN**);

   (d) diversional therapists;

   (e) chaplains;

   (f) general support officers (**GSO**), which consists of the following roles: catering, kitchen, cleaning, laundry – these employees make up roughly 8-10% of our total workforce;

Lodged by: Joint Employers | **Telephone:** 0482 181 223

Address for Service: Level 7, 8 Chifley Square, Sydney, NSW 2000 | **Email:** Nigel.Ward@ablawyers.com.au; Alana.Rafter@ablawyers.com.au

(g) maintenance team, which consists of the following roles: plumbers, gardeners, and handymen; and

(h) administrative employees

(Collectively, **Buckland employees**).

7. Buckland also employs two fulltime infection prevention and control (**IPC**) leads. Both IPC leads are RNs. The primary responsibility of the IPC lead is to continuously monitor and correct behaviour of Buckland employees in relation to IPC, and perform on the spot training as needed.

Training

8. All Buckland employees receive training and information at the start of their employment and over the course of their employment at Buckland. That training and information provided consists of the following:

(a) induction training;

(b) buddy-shifts;

(c) mandatory training (including IPC and outbreak management);

(d) policies, employee handbook and codes of conduct.

9. Through that training and information, I am able to communicate the expectations of Buckland to each employee.

Induction

10. Induction at Buckland is a 5-hour in-person orientation, which I deliver to the new staff.

11. All staff undergo the same induction training, however, subject to whether the orientation is for carers or GSOs, parts of the orientation may be tailored to that group. For example, during the orientation for GSOs I will identify any specific policies and training modules relevant to those roles.

12. A list of the training modules offered at Buckland was attached to my First Statement.

Buddy-shifts

13. Employees that are new to Buckland are assigned a *"buddy"* for their first few shifts to ensure they understand and can confidently perform the work before being allocated individual shifts.

14. This is a form of on-the-job training that enables each new Buckland employee to work alongside an experienced team member, who can take them through the established

procedures and practices at Buckland. It also provides the new employee an opportunity to ask any questions of their *"buddy"*.

15. Even employees that have prior experience working in aged care will be assigned a buddy-shift when they commence at Buckland. It is an important process to ensure understanding of Buckland's practices.

Mandatory Training

16. All Buckland employees receive access to training modules via an online internal platform. This platform can be accessed via the employee's mobile device or a computer.

17. The mandatory online modules that address the following topics:

    (a) Aged Care Quality Standards (**ACQS**) (what they are and how to apply them);

    (b) customer service;

    (c) elder abuse;

    (d) mandatory reporting;

    (e) whistle blower polices;

    (f) feedback and complaint handling;

    (g) IPC; and

    (h) manual handling deals with safe lifting.

18. All Buckland employees will have at least some level of interaction with residents and possibly their family members, that is why they are required to complete modules about customer service and feedback and complaint handling.

19. The duration of the online training modules ranges from 15-90 minutes. Some modules include a short online assessment/quiz to confirm understanding.

20. Employees receive annual refresher training in mandatory modules.

21. Additionally, Buckland employees received annual IPC training that is provided in-person. That training is facilitated by the IPC leads. The training session takes around 20-minutes.

22. The IPC training provided at Buckland also incorporates reference to the procedures set out in our Outbreak Management Plan. That plan addresses the processes and procedures that apply during an *"outbreak"* at Buckland.

Other Training

23. Buckland employees are provided access to 600+ training modules which may not apply to their specific role. However, all employees are welcome to complete additional modules to gain additional understanding about the aged care industry or areas of interest.

24. Some of the online training modules target specific roles. For example:

    (a) Further IPC training for GSOs performing cleaning or laundry duties. The cleaning module will include information about what chemicals are to be used during an outbreak (i.e. information directly relevant to the work performed by the cleaner, but would not be relevant to our carer workers). The laundry module will address the handling of infectious material. Both modules were provided prior to the COVID-19 pandemic.

    (b) Another example is the manual handing training module for carers. Whilst all roles will do a form of manual handling training, if they are not a carer, the information in that training will not address manual handling techniques required for moving a resident.

25. Buckland retains a record of all training undertaken and completed by its employees.

Information provided to Buckland employees

26. All Buckland employees receive the following material:

    (a) Buckland Employee Policies. During orientation, each employee is signed up to the internal platform, where Buckland employees can access employee training modules and policies;

    (b) Code of Conduct for Aged Care;

    A COPY OF THE BUCKLAND AGED CARE CODE OF CONDUCT ACKNOWLEDGEMENT FORM IS ANNEXED AND MARKED JB-1

    (c) Buckland Code of Conduct;

    A COPY OF THE BUCKLAND CODE OF CONDUCT IS ANNEXED AND MARKED JB-2

    (d) Buckland employee handbook; and

    A COPY OF THE BUCKLAND STAFF INFORMATION HANDBOOK IS ANNEXED AND MARKED JB-3

    (e) Buckland Outbreak Management Plan.

A COPY OF THE BUCKLAND COVID-19 + ACUTE RESPIRATORY INFECTION (ARI) RESPONSE AND PREPARATION PLAN IS ANNEXED AND MARKED JB-4

27. All material is accessible via an internal platform that Buckland employees have access to via either their mobile phone or computers. We also have computers in the workplace.

Buckland Expectations and Established Procedures for GSOs

28. The training and information provided to GSOs also addresses the following scenarios:

    (a) interaction with residents;

    (b) responding to incidents;

    (c) responding to preferences;

    (d) interaction with families; and

    (e) meetings with the Home Support Coordinator.

Interaction with Residents

29. Prior to starting work at Buckland, all GSOs are instructed that their work environment is the resident's home, and they must treat it as such. For example, before entering a resident's room they should knock on the door and ask for permission to enter. They must be respectful and kind.

30. Equally, we also communicate to GSOs what is not acceptable behaviour. This includes that they have should not be expected to experience verbal or physical abuse during their workday. If this occurs, they are to remove themselves from the situation and inform management. The safety of our employees is a priority.

31. Buckland employees are required to read and copy with the Code of Conduct, which sets out the expectations with respect to interactions with residents (together with other matters). Each employee must acknowledge they have read and understood the Code of Conduct by returning a signed copy.

32. The expectations about interaction with residents is also embedded into Buckland's Vision, Mission & Values Statement. For example, the Buckland missions is: *"To provide respectful and dignified care and services that acknowledge the value of each individual".*

33. GSOs are in a position to get to know a resident and build up some familiarity. For example, the cleaner that attends to a resident's room each day might have a short conversation each time. If they observe something to be off with a resident, maybe their mood has changed, they are encouraged to let the care staff know. Of course, there is no expectation that the cleaner makes a clinical assessment or takes note of each resident's demeanour during each visit, but just like a GSO would not ignore a resident that has a fall – if they spot an issue or a potential issue, the expectation is they raise it with the care staff who can then assess the situation.

Responding to Incidents

34. No Buckland employee is expected to act outside the scope of their level of skill, responsibility or competency. For example, GSOs are not trained in mobility aids or supporting residents with mobility because that falls outside their role. Additionally, they lack the foundational training that a care worker is expected to hold.

35. If a Buckland employee was to attempt duties that fell outside their level of competency or within their role that could put residents (and potentially the worker) at risk of harm. An obvious example would be a GSO attempting to provide clinical care to a resident. This is actively discouraged.

36. If a GSO discovers that a resident has had a fall, consistent with the Code of Conduct and WHS training, GSOs are trained to speak up and report incidents to the care team. They can do this by either pressing the internal call bell system or approaching an RN or member of the care team directly. They are not to intervene by moving the resident because they do not have the training or requisite expertise to make a clinical assessment about whether it is safe to do so.

37. The processes practices at Buckland ensure that GSOs are not put in a position to inadvertently cause more harm to a resident.

Responding to Preferences

38. Consistent with the Code of Conduct, all employees are encouraged to listen to the preferences of residents. Buckland employees are working in the resident's home: the resident is in charge of the experience and service they receive.

39. For privacy reasons, GSOs do not have access a resident's care plan. Rather, only the information that is relevant to each department (i.e. kitchen, cleaning, maintenance etc) is made available. For example, the kitchen staff, will have an extract from the care plan that deals with nutrition, hydration and allergies. They only have access to select

portion of the resident's information, which is limited to details that they need to be aware of in their role (**the resident's information**).

40. That extract of the resident's information is relevant to requests and expressions of preference by residents. For kitchen staff, a key determiner for whether they can action a resident request is whether there are any relevant clinical contraindications listed in the resident's information. For example, if a resident requests a meal that contains nuts – the food assistant is trained to check the resident's information, which sets out the resident's allergens (if any). If that resident is not allergic to nuts, they are instructed to provide what the resident wants.

41. At Buckland, we also train our employees to assess the evidence of risk in requests made by residents. If the matter is minor, for example a change in ironing preference communicated to the laundry employees – they are instructed to cater to the request because there is no risk of harm there. It is different if the request introduces a risk of harm, which requires involvement of the care team to conduct a risk assessment. The GSO (along with all staff at Buckland) is trained and expected to recognise situations that could put a resident at risk – but they are not expected to make the decision about whether to grant or deny such requests if they fall outside their role.

42. Relatedly, we have a protocol consistent with the *"dignity of risk"* principle. This is of course a much more documented process, but it can involve a resident of sound mind making a choice that does involve some risk, which could involve consuming a food allergen. Requests of this nature are escalated to the care team.

Interaction with Families

43. Consistent with the Code of Conduct, all employees are expected to communicate respectfully with family members of the residents.

44. Additionally, if a family member makes a request or inquiry that falls within their specific field of training they are encouraged to provide an answer. For example, if a cleaner engages in conversation with a family member who comments *"my mom's toilet wasn't clean enough"* – they can action that request. However, if the request was of a clinical nature, consistent with Buckland policy, they are expected to refer that communication immediately to a care staff member.

45. All Buckland employees also receive training in feedback and complaints handling. If the GSO is the recipient of a complaint (which may or may not be directed towards them), they are trained to listen to the complaint and then communicate it to management so it can be addressed.

Meetings with the Home Support Coordinator

46. The Home Support Coordinator (**HSC**) is the manager of the cleaning, catering and laundry employees at Buckland.

47. The HSC meet with the cleaning, catering and laundry employees twice per day as the start and end of the shift. The primary purpose of this meeting if to communicate updates. For example:

    (a) The meeting at the start of the shift commences at around 7:30am. This meeting is directed at work distribution and provides the HSC the opportunity to alert the cleaning, catering and laundry employees about any matters that might be out of the ordinary or resident issues that may be relevant. For example, a resident is unwell or there is a COVID-19 outbreak.

    (b) The meeting at the end of the shift commences at around 3:30pm. This meeting provides the cleaning, catering and laundry employees the opportunity to communicate any questions or note any matter that was out of the ordinary. For example, if an issue was discovered at the end of their shift – such as a resident's toilet was broken.

48. This meeting is not the same as a *"handover".* As there is only one cleaning shift each day between 7.30am and 3.30pm.

Infection Prevention and Control

Pre-covid

49. Prior to the COVID-19 pandemic, Buckland was required to have and maintain an outbreak management plan that set out the protocol to be followed during an outbreak of an infectious disease (for example, influenza or gastroenteritis).

50. Buckland's outbreak management includes a definition of *"outbreak"*. For example, if 3 or more residents are diagnosed with the influenza, that will be classified as an influenza outbreak. Buckland's outbreak management plan applies to all forms of outbreak.

51. The outbreak management plan is an evolving document that is updated from time-to-time based on advice provided by the NSW Ministry of Health.

52. The use of personal protective equipment (**PPE**) has always featured in the management of infectious outbreaks at Buckland. For example, during a pre-pandemic outbreak of either influenza or gastroenteritis, Buckland's outbreak management plan included requirements for wearing masks.

The pandemic

53. During the pandemic, Buckland had to frequently update its outbreak management plan and IPC protocols to be consistent with the latest advice released by the NSW Ministry of Health. This included advice relating to facility lockdowns, the donning and doffing of masks, and requirements to provide notification of positive cases.

54. The increased levels and frequency of both information and training in relation to COVID-19 was a learning curve for all staff at Buckland.

Impact of pandemic as at 2023

55. At Buckland we continue to follow the state-based guidance published by NSW Ministry of Health (**NSW Guidelines**).

56. The risk-based approach in relation to COVID-19 is now built into Buckland's outbreak management plan.

57. Following the update to NSW Guidelines in September 2023, we reviewed and updated out outbreak management plan to ensure it is consistent with the latest advice.

58. Buckland's outbreak management plan reflects the latest advice.

59. Immediate differences in practice between now and the pandemic in 2020-2021 are as follows:

    (a) Entire facility lockdowns are avoided unless absolutely necessary. Whereas during the pandemic it was a mandatory requirement during an outbreak. The advice provided to providers emphasises the psychological toll such approaches can have on residents due to the isolation it creates.

    (b) Mandatory mask wearing is not required at all times. Mask wearing protocols set out in the outbreak management plan continue to apply during outbreaks (which has always featured in outbreak management). However, subject to the location of the outbreak, this may not impact all staff in the facility.

    (c) The increased frequency of IPC training (e.g. donning and doffing of PPE) for all staff has returned to be consistent with other forms of mandatory training provided by Buckland. It is provided in two formats annually: online modules, together with a 20-minute face-to-face training session led by the IPC lead.

    (d) The increased frequency of cleaning of *"touch points"* by the cleaner with the use of stronger chemicals is now reserved for outbreaks. It does not otherwise operate at a sustained intensity.

60. A permanent change that arose as a result of the pandemic is the requirement to appoint IPC leads. This is an entirely new responsibility for two of our RNs. The IPC leads are responsible for the delivery of IPC education and on-the-spot training and education. The observe and monitor all Buckland employees IPC practices – whether they are care staff, kitchen, cleaning, administration, etc – to ensure they are following their training and meeting the requisite standard.

Staffing Shortage

61. Buckland is experiencing a staffing shortage with respect to permanent employees. For that reason, to ensure we continue to meet the care needs of our residents we have had to supplement our permanent workforce with agency staff.

62. Engaging agency workers ensures that the care needs of each resident are met without compromise. It also helps Buckland to meet its mandatory care minutes.

63. Engaging agency workers costs Buckland on average around $250,0000 per month.

64. Additionally, we have explored the avenue of migration pathways. This includes partnering with a University in the Philippines to develop a training program and bring staff over.

65. Buckland is able to guarantee the care needs of its residents will be met with a combination or permanent employees and agency staff. We have never experienced a shortage of availability of aged care employees supplied from agencies.

66. In most cases, agency workers are paid at higher rates. It is easy to see why an aged care worker may prefer to be directly employed via an agency provide as opposed to the residential aged care provider.

Star Ratings

67. Star Ratings were introduced in December 2022.

68. Each provider receives are rating in relation to four categories:

    (a) Compliance;

    (b) Quality Measures;

    (c) Residents' Experience; and

    (d) Staffing.

69. The rating system is as follows:

    (a) 1 star = significant improvement needed;

    (b) 2 stars = improvement needed;

(c) 3 stars = acceptable;

(d) 4 stars = good; and

(e) 5 stars = excellent.

70. Each category is rated individually and then combined to provider an *"Overall Star Rating".*

71. The results are published on the My Aged Care website.

72. The Star Ratings for Buckland (as at 7 August 2023) are as follows:

(a) Overall Star Rating: 4 stars = good;

(b) Compliance: 5 stars = excellent;

(c) Quality Measures: 4 stars = good;

(d) Residents' Experience: 3 stars = acceptable; and

(e) Staffing: 3 stars = acceptable.

Staffing Rating

73. The Staffing Rating considers the amount of care provided by RNs, ENs and PCWs/AINs at Buckland.

74. In December 2022, Buckland received an average quarterly target for care time from the Australian Government, which was as follows:

(a) 194 minutes for total nursing and personal care (which includes care provided by RN, EN and PCW/AIN); and

(b) 39 minutes for care from a RN.

75. That target is based on the number of residents at Buckland and their care needs. That means the care target for another provider may vary depending on the specific care needs of their residents.

76. Buckland is required to submit a Quarterly Financial Report, which sets out the direct and indirect care provided to residents. For the purpose of the Star Rating, the Australian Government is concerned with whether Buckland meets the direct care target.

77. For the past four consecutive quatres, Buckland has exceeded our care minute targets. This means the care staff at Buckland provided more care than the minimum requirement set by the Government.

Signed: _____

Johannes Brockhaus

Date: 31 October 2023

12

THE BUCKLAND CONVALESCENT HOSPITAL Trading as
Buckland
AGED CARE SERVICES

ACN 000 243 863 ABN 82 517 110 268
39 HAWKESBURY ROAD
SPRINGWOOD NSW 2777
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PO BOX 117, SPRINGWOOD NSW 2777
TELEPHONE: 02 4752 2500
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...we care

Aged Care Code of Conduct Acknowledgement Form

Purpose and Aim

The purpose of the Code is to create expectations of foundational behaviour that all consumers can expect from their providers, aged care workers and governing persons, place obligations relating to behaviour on individuals, thereby giving the Aged Care Quality and Safety Commission (the Commission) a mechanism by which to respond to behaviour that falls below what is expected by the Code and to directly engage with aged care workers and governing persons about their conduct.

The Code is aimed at ensuring that all consumers can have confidence in the quality of the aged care and can expect the same level of high quality and safe care regardless of who provides their aged care services.

The Code - 'When providing care, supports and services to people, I must:

a. act with respect for people's rights to freedom of expression, self-determination and decision-making in accordance with applicable laws and conventions;
b. act in a way that treats people with dignity and respect, and values their diversity;
c. act with respect for the privacy of people;
d. provide care, supports and services in a safe and competent manner, with care and skill;
e. act with integrity, honesty and transparency;
f. promptly take steps to raise and act on concerns about matters that may impact the quality and safety of care, supports and services;
g. provide care, supports and services free from:
   i. all forms of violence, discrimination, exploitation, neglect and abuse; and
   ii. sexual misconduct; and
h. take all reasonable steps to prevent and respond to:
   i. all forms of violence, discrimination, exploitation, neglect and abuse; and
   ii. sexual misconduct.

Declaration
(Governing Person, Employee, Contractor, Supplier)

- I have read and understand the Code of Conduct is a minimum behaviour expectation.
- I understand that any adverse findings in the delivery of care, supports and services or any other breach of the code must be disclosed to my prospective employer prior to accepting a role or commencing work.
- I understand that any adverse findings in the delivery of care, support and services or any other breach of the code must be disclosed during my employment.
- I understand if I do not disclose information relating to a breach of the Code of Conduct this may result in immediate disciplinary action, and my employment could be terminated.
- I understand that if I do not comply with the Code of Conduct or I do not disclose a breach of the Code of Conduct, civil penalties may apply per the Quality and Safety Commission role in determining breaches. Maximum individual penalty $55,000 can apply.
- I understand a breach to the Code of Conduct will undergo investigations and may result in restrictions being placed on my practice.

First Name: Last Name:

Designation:

Signature:

Date:

Please circle which applies (Governing Person | Manager | Employee | Contractor | Supplier)

Witnessed

First Name Last Name

Signature:

Designation:

Date:

Please circle which applies (Governing Person | Manager I RN I HR)

Code of Conduct

Version: 4
Published: 25 Feb 2022, 9:27 AM
Last edited: 25 Feb 2022, 9:26 AM
Approved: 25 Feb 2022, Johannes Brockhaus

Overview

This document outlines Buckland's code of conduct and applies to all staff and management.

This code of conduct has been developed to assist staff by providing a framework for day to day decisions and actions while working for Buckland.

Specifically, this document aims to:

- Promote a positive work environment where the contribution of all staff is acknowledged and valued, and in achieving this effective teamwork and respectful relationships are nurtured.
- Acknowledge that each staff member is treated, and must treat others, with dignity, fairness and respect.
- Provide the basis for maintaining a positive workplace culture, where Buckland values of
    - Honesty, loyalty and integrity are upheld,
    - All people are treated with respect,
    - Professionalism maintained,
    - Effective, ethical leadership is demonstrated, and that there is
    - Pride in everything we do
- Assist in the prevention of corruption, maladministration and serious and substantial waste by alerting staff to behaviours that could potentially be corrupt or involve maladministration or waste.

Outcome

- Residents get quality care and services when they need them from people who are knowledgeable, capable and caring
- Residents are treated with dignity and respect, and can maintain their identity. Residents can make informed choices about their care and services, and live the life they choose.

Buckland statement

- Buckland provides a safe and comfortable service environment that promotes the residents independence, function and enjoyment.
- Buckland has a workforce that is sufficient, and is skilled and qualified, to provide safe, respectful and quality care and services
- Buckland's governing body is accountable for the delivery of safe and quality care and services

Documents relevant to this policy

- A guide to Australian discrimination laws
- Accountability Principles 2014
- Age Discimination Act 2004
- Aged Care Act 1997
- Australian Human Rights Comission State and Territory Anti-Discrimination Legislation
- Behaviour in the workplace and grievance resolution
- Code of conduct
- Customer protection policy
- Fair Work Act 2009
- Privacy Act 1988 - Part III, Division 2 Australian Privacy Principles
- Sex Discrimination Act 1984
- Standard 1 - Requirement (3) (a) Each consumer is treated with dignity and respect, with their identity, culture and diversity valued
- Standard 7 - Requirement (3) (b) Workforce interactions with consumers are kind, caring and respectful of each consumer's identity, culture and diversity

1.0 Introduction

All Buckland staff are required to fully comply with all aspects of this policy. Any breach or non-compliance with any aspect of this policy may lead to disciplinary action including the termination of employment.

This document outlines Buckland's code of conduct and applies to all staff and management.

This code of conduct has been developed to assist staff by providing a framework for day to day decisions and actions while working for Buckland.

Specifically, this document aims to:

- Promote a positive work environment where the contribution of all staff is acknowledged and valued, and in achieving this effective teamwork and respectful relationships are nurtured.
- Acknowledge that each staff member is treated, and must treat others, with dignity, fairness and respect.
- Provide the basis for maintaining a positive workplace culture, where Buckland values of
    - Honesty, loyalty and integrity are upheld,
    - All people are treated with respect,
    - Professionalism maintained,
    - Effective, ethical leadership is demonstrated, and that there is
    - Pride in everything we do.
- Assist in the prevention of corruption, maladministration and serious and substantial waste by alerting staff to behaviours that could potentially be corrupt or involve maladministration or waste.

1.1 Principles underpinning this code of conduct

The staff of Buckland must conduct themselves in a way that promotes public confidence and trust in the organisation.

Staff have a duty of care to the residents as well as to other staff. Staff must ensure that, as far as practicable, the best interests of residents are maintained in decision-making and when undertaking duties, have regard to the duty of care that Buckland has to staff as well as residents.

The reputation of Buckland and its standing in the community are built on the following principles and these principles must be incorporated into the decisions, actions and behaviour of all staff:

- Acting ethically
- Acting in the public interest
- Avoiding corrupt conduct
- Avoiding conflicts of interest
- Disclosing wrongdoing
- Respecting differences
- Complying with the law, directions and policies
- Providing quality services
- Acting fairly
- Resolving conflicts and handling complaints
- Accepting scrutiny
- Acting transparently
- Managing risk
- Using resources effectively
- Efficiency and effectiveness

(from NSW Ombudsman, *Good Conduct and Administrative Practice*, April 2017)

https://www.ombo.nsw.gov.au/news-and-publications/publications/guidelines/state-and-local-government/good-conduct-and-administrative-practice

1.2 Key definitions

Corrupt conduct – is broadly defined as the misuse of office. Commonly this involves the dishonest or partial use of power or position that results in one person being advantaged over another.

Corruption can take many forms including (but not limited to):

- Official misconduct
- Bribery and blackmail
- Unauthorised use of confidential information
- Fraud and
- Theft

Maladministration - is defined as conduct that involves action or inaction of a serious nature that is:

- Contrary to law;
- Unreasonable, unjust, oppressive or improperly discriminatory, or
- Based wholly or partly on improper motives.

Serious and substantial waste - is defined as any uneconomical, inefficient or ineffective use of resources, authorised or unauthorised, which results in significant loss / wastage of funds or resources.

Violence – is defined as any incident in which an individual is abused, threatened or assaulted and includes verbal, physical or psychological abuse, threats or other intimidating behaviours, intentional physical attacks, aggravated assault, threats with an offensive weapon, sexual harassment and sexual assault. (Also see the organisation's "Inappropriate behaviour in the workplace" policy).

2.0 Competence and professionalism

Overview

Staff have a responsibility to carry out their roles in a competent and professional way which demonstrates:

- Respect for residents, relatives, visitors, other staff and the public in general;
- Fairness and impartiality in decision making, and
- Efficiency and effectiveness.

Staff must exercise due care in going about their duties and must always present themselves for work in a fit and proper condition. In particular, staff must not present for work under the influence of alcohol, drugs or other substances that could detrimentally affect their ability to perform their duties.

While the code of conduct outlines standards of conduct, there may be situations that arise in the course of employment where staff may find it useful to apply the following six points as a guide to ethical decision making and behaviour:

1. Is my decision or behaviour unlawful?
2. Is my decision or behaviour in line with the policies of the organisation?
3. What will be the outcome of my decision or behaviour for me, work colleagues, the residents, Buckland and other stakeholders?
4. How will my decision be viewed by my Registration Board and / or my Professional Association (if applicable)?
5. Is my decision or behaviour a conflict of interest, or could it be perceived as a conflict of interest, and / or will it lead to private gain at Buckland's expense?
6. Can my decision or behaviour be justified in terms of public interest and could it withstand public examination?

2.1 Personal and professional behaviour

When carrying out duties, staff will:

- Comply with any legislation and professional codes of conduct and ethics relevant to their profession;

- Obey any lawful direction from a person who has the authority to give the direction. If a staff member has a concern about carrying out a lawful direction, they may appeal through existing complaint / grievance procedures or to the chief executive officer (CEO);
- Behave honestly and with integrity. This includes a duty to report other staff who are behaving in a way that is a breach of this code of conduct;
- Report any circumstance that may compromise clinical or professional standards to the Facility Manager or CEO;
- Endeavour to carry out work as efficiently and effectively as possible and to a standard that reflects favourably on Buckland;
- Follow the policies of the organisation, whether or not they agree with these policies. Should a situation arise in which a staff member cannot comply with a policy because of personal or clinical views, the matter must be discussed with the Facility Manager or Care Manager, with a view to resolving the situation, and
- Act in good faith.

2.2 Good faith

Staff must exercise their duties in good faith and avoid acting in 'bad faith'.

Acting in 'good faith' means that a duty or function is performed by a staff member:

- Honestly,
- For the proper purpose,
- On relevant grounds, and
- Without exceeding the power or authority of the position.

2.3 Professional standards

In the event of any conflict between professional standards and the provisions of this code of conduct, the matter must be taken up with the CEO.

Staff have a professional responsibility to maintain and enhance their skills, knowledge and competence while undertaking duties within the organisation.

2.4 Personal relationships with residents

Staff must not have personal relationships with residents that result in any form of exploitation, obligation or sexual gratification.

All staff must be aware of the power of imbalance and unconscious processes within any resident relationship, including relationships with carers of residents. Staff must remain aware of the particular vulnerability of residents and their carers.

Personal relationships with residents or their carers, as referred to in this section, may be social, sexual or other types of relationships (e.g. financial) and may not be acceptable conduct. Any of these kinds of relationships may result in some form

of exploitation of a resident or their carer, or involve some form of obligation or expectation being created in the resident or their carer.

Where a family member / spouse / partner becomes a resident of a Buckland facility where the staff member works, the staff member must report this to the Care and Facility Managers regarding any conflict of interest issues.

2.5 Conducting financial transactions and / or dealing with money / property for residents

As a general rule, staff should not become formally or informally involved in any transaction for or with a resident which involves dealing with cash, bank accounts, credit cards or property.

Where a resident requires such services and cannot conduct such transactions themselves, staff should discuss with the resident, low risk alternatives and, with their consent:

- Contact relatives.
- Contact other agencies that assist in such matters (e.g. NSW Trustee and Guardian).
- Contact the residents' bank, etc and advise of situation and make appropriate accountable arrangements

2.6 Providing advice to decision makers

Staff must, to the best of their ability, provide advice and reports (in relation to their employment role) to the Facility and Care Managers when appropriate or required. The advice provided must be materially accurate, frank and honest, cover all issues relevant to the matter (including the consultation undertaken) and contain relevant and appropriate recommendations. This advice and information must be as complete as possible in the circumstances and within the resources available.

2.7 Quality service

Staff must provide a relevant and responsive service to the residents, colleagues and the public.

All staff share responsibility for creating and maintaining a service that provides safe, high quality care.

Care and attention

Staff must ensure that, while at work, attention is focused on their duties.

Ensuring timeliness

Staff must carry out their duties and functions within the agreed timeframes, having regard to available resources. If timeframes or duties cannot be met, due to resource issues or other circumstances, staff must report this to the Facility or

Care Managers for advice and action.

3.0 Conflicts of interest

Overview

Staff are expected to perform duties in a fair and unbiased way and not make decisions which are influenced by self-interest or personal gain.

The integrity and fairness of decisions and actions taken by staff could be undermined if, when performing their duties, a conflict between work and private interest exists or appears to exist. To protect the integrity of Buckland and its staff, situations that give rise to conflicts of interest should be avoided by staff members and properly managed when they do occur.

Conflicts of interest exist when it is likely that a staff member could be influenced, or perceived to be influenced, by personal interest when carrying out their duties. Conflicts of interest that lead to biased decision making may constitute corrupt conduct.

Conflicts of interest can be actual, perceived or potential:

- An **actual conflict of interest** involves a direct conflict between a staff member's current duties and responsibilities and existing private interests.
- A **perceived or apparent conflict of interest** can exist where it could be perceived, or appears, that a staff member's private interests could improperly influence the performance of their duties – whether or not this is in fact the case.
- A **potential conflict of interest** arises when a staff member has private interests that could conflict with other duties in the future.

Interest can be pecuniary (financial) or non-pecuniary (do not relate to money).

Some situations that may potentially give rise to a conflict of interest include:

- Financial interests in a matter Buckland deals with or where staff are aware that friends or relatives have financial interest in the matter,
- A personal belief or attitude is not openly declared, that may influence the impartiality of advice given or decisions made by Buckland,
- Personal relationships with the people Buckland is dealing with or investigating which go beyond the level of a professional working relationship,
- Authorising appointments, transfers, reclassification, or changes in employment details or employment status, award classifications or allowances for relatives or close personal friends, and
- Access to information that can be used for personal gain, whether that personal gain be that of the staff member or their relatives or friends.

3.1 Managing conflicts of interest

Conflicts of interest must be dealt with in an open and transparent way.

A staff member may often be the only person aware of the potential for conflict. Therefore, it is their responsibility to avoid any situation that could compromise their ability to perform duties impartially. It is also their responsibility to report any potential or actual conflicts of interest to the CEO. Disclosure must be made at the first available opportunity, preferably in writing, for a decision as to what action should be taken to avoid or to deal with the conflict.

If staff are uncertain whether a conflict exists, the matter must be discussed with the CEO in an attempt to resolve the matter.

If staff are aware that another staff member has a potential conflict of interest they should report the matter to the CEO.

To resolve any conflicts of interest that occur, or could occur, a range of options is available depending on the significance of the conflict, the nature of the situation and sensitivity of the issue.

The options include:

- Taking no action because the conflict is assessed as being minor in nature or is eliminated by disclosure or effective supervision,
- Allow limited involvement (e.g. Participate in discussions but not in decision making),
- Prohibit any involvement, or
- Request the individual concerned relinquish or divest the personal interest which creates the conflict.

3.2 Bribes, gifts and benefits

Staff must not seek or accept any gift or benefit intended or likely to influence, or be reasonably perceived to influence, the staff member to:

- Act in a particular way,
- To fail to act in a particular circumstance, or
- To otherwise deviate from the proper exercise of their official duties.

Gifts of cash should not be accepted. As a general rule, no gifts or benefits should be accepted by staff members without them being fully disclosed to the CEO or Facility Manager, prior to acceptance.

Staff must take all reasonable steps to ensure that neither they nor their immediate family members are the recipients of gifts or benefits which could give the appearance, to an impartial observer, of an indirect attempt to secure their influence or favour.

3.3 Token gifts

Token gifts offered as a gesture of appreciation and not to secure favour may be accepted and retained by staff however, they are required to report the acceptance of the gift to the CEO and gain their agreement to retain the gift.

Generally speaking, **token** gifts and moderate acts of hospitality would include:

- Gifts of bottles of reasonably priced alcohol (e.g. under $50.00).
- Free or subsidised meals and / or beverages provided infrequently (and / or reciprocally).
- A box of chocolates or flowers.

The Australian Macquarie Dictionary defines 'token' as anything of nominal value.

3.4 Non-token gifts

As a general principle, staff must not accept non-token gifts. If staff do receive a non-token gift, they are required to declare it to the CEO straight away.

Gifts or other benefits not essentially token or inconsequential should only be accepted:

- Where they are not given because of the person's job or status.
- Where the gift is given to a staff member in a public forum in appreciation of the work, assistance or involvement of the staff member and refusal to accept the gift would cause embarrassment or affront.
- If there is no possibility that the recipient might be, or might appear to be, compromised in the process.
- In circumstances generally approved by the CEO.

Approval by the CEO must only be given where the acceptance of the gift is unlikely to be seen by a reasonable 'impartial observer' to create a conflict of interest, or influence the performance of duties or functions.

In any offer or where a suggestion of a bribe is made directly or indirectly to a staff member, the facts must be reported to the CEO at the first opportunity.

If staff are dealing with, or have access to sensitive information, they must be particularly alert to inappropriate attempts to influence them.

3.5 Gifts register

A gifts and benefits register is maintained by the CEO. All staff must ensure that non token gifts received are reported by them to the CEO at the time of receiving the gift or as soon as they are made aware of the offer of a gift.

4.0 External business activities

Participation in voluntary community organisations, charities and professional associations

Buckland encourages all staff in their contribution to society and as such, staff are free to participate in voluntary community organisations and charities and in professional associations, so long as it does not conflict with their primary role within Buckland or any other requirement under this code of conduct (e.g. use of official resources, information etc).

Staff wishing to join the Rural Fire Service or the State Emergency Services are required to consult the CEO, prior to any affiliation being made to such organisations.

5.0 Use of Buckland resources

Overview

Buckland resources refers to the organisation funds, staff, facilities, equipment and materials. Some examples of resources include (but are not limited to) telephones, facsimiles, email, internet, photocopiers, scanners, typing facilities, computers, motor vehicles, office stationery and general stock inventory.

Use of resources must be appropriate, lawful, efficient, proper and ethical. Inappropriate use includes, but is not limited to any use of resources (primarily communication devices) to intentionally transmit, communicate or access pornographic or sexually explicit material, images, text or other offensive material.

Staff must not use resources to transmit, communicate or access any material which may discriminate against, harass or vilify colleagues, residents or others.

Requests to use resources for non-official purposes must be referred to the CEO or Facility Manager for approval. Unless permission is granted, staff must not use the resources of the organisation for non-official purposes.

If a staff member is authorised to use resources for non-official purposes, they must:

- Take responsibility for maintaining, replacing and safeguarding the property and following any special directions or conditions that apply during the time they are being used for non-official purposes, and
- Ensure the resources are under their control or used by them effectively and economically.

Staff using resources for non-official purposes without gaining prior approval could face disciplinary and / or criminal action.

Buckland resources are not to be used for any private commercial purposes, under any circumstances.

6.0 Use of official information

Overview

Official information must not be disclosed or used without proper authority.

Official information is any recorded information, in any form including data in computer systems, created or received and maintained by Buckland in the transaction of business or the conduct of affairs and kept as evidence of such activity.

Current privacy legislation outlines requirements related to the disclosure of personal and personal health information.

Staff must not use or disclose official information acquired in the course of their employment outside their workplace or professional relationships other than as required by law or where proper authority has been given.

6.1 Personal health information

Personal health information includes the identity and personal and health information about individuals, including staff and includes confidential data and information collected for purposes of resident care or for administrative, statistical or other purposes.

Staff must:

- Comply with privacy and security procedures in relation to any personal information accessed in the course of their duties,
- Preserve the confidentiality of this information, and
- Inform the appropriate person immediately, if a breach of privacy or security relating to information occurs.

Staff must not:

- Knowingly access any personal information unless such information is essential for the proper and efficient performance of duties (including looking up any records relating to other staff) or
- Misuse any personal information e.g. for personal purposes or for any other purpose which conflicts with the purpose for which the information was generated or obtained.

6.2 Misuse of official information

Staff must not misuse information gained while undertaking their work role. Misuse includes:

- Unauthorised use or disclosure (including in the negotiation of business contracts and agreements – commercial in confidence information must not be divulged to a competing supplier/company)
- Seeking to take advantage, for personal reasons or for another person, of information about a person held in official records or data.
- Gossiping on the basis of personal or other information held in official records.

6.3 Security of official information

Staff must make sure that confidential and / or sensitive official information, in any form (e.g. documents, emails, computer files etc), cannot be readily accessed by unauthorised parties. Confidential and / or sensitive official information must be securely stored overnight or when unattended.

Managers are responsible for ensuring that premises are secure and that suitable arrangements are in place to maintain the security of confidential and / or sensitive official information. This includes transferring documents by hand where necessary.

Staff must make sure that confidential and / or sensitive official information is only discussed with people who are authorised to have access to it. It is considered a serious offence to deliberately release confidential and / or sensitive official information to unauthorised persons.

Where appropriate, managers must make sure that confidential and / or sensitive papers are tabled at meetings rather that circulated and agreement is reached within the meeting about the level of detail to be included in the minutes.

6.4 Staff information

Information about the staff of Buckland is totally confidential, must not be released to external bodies without appropriate legal authority and the authorisation of the CEO.

There are some instances when an external body will be required to provide a written request for information (e.g. insurance matters). In some instances information regarding employment will be provided to external bodies (e.g. the Australian Taxation Office).

Buckland must confirm details held by financial institutions if a staff member is applying for financial assistance. Buckland will validate the bona fide of the caller as a representative of the financial institution (usually with a call back). In all instances, a staff member's permission will be sought prior to confirming the information held.

6.5 Providing referee reports

When providing either verbal / written references for other staff members, or persons outside Buckland, staff have a duty to provide frank and accurate comments.

Staff must also take care to avoid making statements that could be regarded as malicious. Situations which may potentially be regarded as malicious include:

- Where the staff member knowingly includes false or unsubstantiated allegations;
- Where the language used is excessively strong or weak, in a manner which might unreasonably mislead the recipient of the report or misrepresent the staff member who is the subject of the report, or
- Where extraneous material is deliberately introduced or where omissions are deliberately made so as to create a misleading impression.

7.0 Fairness in decision making

Overview

Staff must deal with issues, cases or complaints consistently, promptly, transparently and fairly. This involves dealing with matters in an impartial, non-discriminatory manner and in good faith.

7.1 Fairness

Staff must be fair and reasonable when exercising discretionary power that could affect the rights, interests or legitimate expectations of individuals. Situations must be dealt with in a fair and timely manner.

Staff must avoid all unnecessary delay in making decisions or taking action.

The principles of equal employment opportunity must be followed in employment-related decisions.

Staff must take all reasonable steps to ensure that the information upon which their decisions or actions are based is factually correct and relevant to the decisions or actions. Staff must avoid acting in a way that could be seen as unreasonable or discriminatory.

7.2 Use of discretionary power

Staff must not exercise discretionary powers (i.e. powers to act according to ones own judgement) for improper purposes or on irrelevant grounds. Improper use includes errors such as failing to take all relevant facts into consideration, not having regard to the merits of each particular case or taking into account irrelevant information.

8.0 Policy Statement

This policy supersedes the previous document developed and implemented in June 1998, and all subsequent policy documents as developed by the Executive Director of Nursing / Deputy CEO, Mrs Elizabeth Roberts.

This policy document was developed by the Exec DON/Deputy CEO in September 2005 and then reviewed and endorsed by the members of the Quality Improvement Committee on the 18th October 2005.

It was further reviewed, amended and then endorsed by the Quality Improvement Committee on the:

2nd July 2007

1st December 2007

9th August 2008

30th November 2009

11th October 2010

16th May 2011

20th May 2012

6th April 2015

12th May 2015

25th February 2022

STAFF INFORMATION HANDBOOK

...we care

Buckland
AGED CARE SERVICES

39 Hawkesbury Road | PO Box 117 | SPRINGWOOD NSW 2777 | Telephone (02) 4752 2500

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1. HISTORY OF BUCKLAND

The Buckland Convalescent Hospital was conceived and endowed by the late Sir Thomas Buckland, and commenced operation in 1936.

It originally operated as a hospital, but over the years its role has slowly changed to the present stage, where it now holds Commonwealth funded high and low care licences.

The face of Buckland has continued to change and progress, with the development of a total aged care facility, which presently encompasses self-care units and residential aged care facilities.

As Buckland changes, we the staff will also be called upon to grow, progress and move forward. This will involve willingness by all staff members to consolidate old skills as well as learning and cultivating new ones. It is our objective to provide a supportive environment that is appropriate to the individual needs of the aged, whilst at the same time maintaining their independence and dignity.

2. BUCKLAND VISION, MISSION & VALUES STATEMENT

At Buckland We Care . . .

Our Vision

To be a leader in the provision of care to the aged

Our Mission

To provide respectful and dignified care and services that acknowledges the value of each individual

We Value

Honesty, loyalty and integrity

Respect for people

Professionalism

Effective, ethical leadership

Pride in everything we do

3. CHARTER OF AGED CARE RIGHTS

The Commonwealth Government has enshrined in legislation the following rights for all residents.

Each resident has the right to:

- To safe and high quality care and services;
- To be treated with dignity and respect;
- To have my identity, culture and diversity valued and supported;
- To live without abuse and neglect;
- To be informed about my care and services in a way I understand;
- To access all information about myself, including information about my rights, care and services;
- To have control over and make choices about my care, and personal and social life, including where the choices involve personal risk;
- To have control over, and make decisions about, the personal aspects of my daily life, financial affairs and possessions;
- To my independence;
- To be listened to and understood;
- To have a person of my choice, including an aged care advocate, support me or speak on my behalf;
- To complain free from reprisal, and to have my complaints dealt with fairly and promptly;
- To personal privacy and to have my personal information protected;
- To exercise my rights without it adversely affecting the way I am treated.

Buckland is committed to ensuring that each resident is afforded all his or her rights.

4. STAFF GENERAL

4.1. Orientation

Orientation is a series of learning activities provided by the organisation to enable newly appointed staff to function effectively in a new position as soon as possible.

Each newly appointed member of staff will be required to make themselves available for orientation before commencement of duties. They will be assigned to another staff member who will show them the layout of the facility and will explain the duties they will be expected to perform.

Staff are required to complete an orientation package which will include the completion of an online training package. Staff will be given access to Buckland's online policy platform and are expected to familiarise themselves with the organisations policies and procedures. All staff must make themselves familiar with the day-to-day activities of the organisation.

4.2. Appearance

All staff are required to maintain a high standard of personal hygiene and appearance whilst on duty. In keeping with respective duties it is a requirement that all staff remain neat and tidy.

4.3. Uniforms

As a member of the staff you are representing the organisation at all times. The organisation reserves our right to insist upon the standards of professional dress, grooming and behaviour acceptable to this organisation. Uniforms (including shoes) are provided for staff after 3 months service. Staff can avail themselves of the laundering of their uniforms by the organisation's laundry, this is arranged with the Facility Manager. Buckland requires all staff to comply with the following uniform requirements:

- Uniforms are expected to be no shorter than knee length (dress or skirt).
- Staff identification badges MUST BE WORN AT ALL TIMES WHILST ON DUTY.
- Navy/black lace up nurse's shoes or black/brown boots, clean and in good repair for care staff.
- Navy/black lace up shoes, or brown/black boots; clean and in good repair for other staff, except kitchen staff who must wear black fully closed in, leather shoes or boots with a flat non-slip sole.
- Appropriately coloured, fully closed in shoes either slip on, lace up, strap, or buckle are required for all clerical and administrative staff. These shoes must have a low heel and be fully enclosed at the ankles and toes.
- Stockings are to be flesh coloured or a colour to match your shoes.

- The general wearing of jewellery is not permitted, bracelets, necklaces etc. Staff may not wear a wrist watch, smart watch or fitness tracker unless given permission by management. Staff may wear a single wedding ring/commitment band without stones.
- Those staff with pierced ears may wear one only sleeper/stud in each ear (no stones).
- All face, tongue or head piercing other than single ear piercing are not to be adorned with any other device beside a clear plastic stud.
- Buckland reserves the right to ask staff to cover tattoos. This may occur where the tattoo/s is considered offensive or cause distress to a resident.
- Hair must be kept clean and tidy and if long must be tied back.
- Catering staff must wear hair nets when preparing, handling and serving food.
- The wearing of jeans, tracksuit pants, hipster pants and shorts higher than the knee are not permitted.
- Nails are to be kept clean, tidy and relatively short. **NO** nail polish is to be worn. Nail extensions or overlays are not permitted as they have infection control implications.

4.4. General Service Officers and Food Handlers

- Uniforms and shoes must be clean, and if working in the kitchen changed into once at work and prior to commencing the shift.
- Staff identification badges must be worn at all times unless working in the kitchen as this may pose a risk of food contamination.
- Navy/black lace up shoes or black boots, clean and in good repair with a flat non-slip sole.
- Stockings are to be flesh coloured or a colour to match your shoes.
- The general wearing of jewellery is not permitted. Staff may not wear a wrist watch, smart watch or fitness tracker unless given permission by management. Staff may wear a single wedding ring/commitment band without stones.
- Those staff with pierced ears may wear one only sleeper/stud in each ear (no stones). If working in the kitchen only sleepers are allowed, although it is preferable that no earrings at all are worn.
- All face, tongue or head piercing other than single ear piercing are not to be adorned with any other device beside a clear plastic stud.
- Hair must be kept clean and tidy and if long must be tied back. Hair clips and hair adornments are not permitted to be worn by staff in the kitchen.
- When working in the kitchen or preparing, transporting and serving food all hair must be enclosed and contained within a hair net.

- The wearing of jeans, tracksuit pants, hipster pants and shorts higher than knee length are not permitted.
- Nails are to be kept clean, tidy and relatively short. **NO** nail polish is to be worn. Nail extensions or overlays are not permitted as they pose infection control and food safety implications.

4.5. Hours of Duty

- All staff are employed with the understanding that their contracted hours of duty are "AS ROSTERED", with no commitment by Buckland to particular days or shifts. Staff are required to sight the roster each day at the commencement and completion of each shift to ensure that they are aware of their rostered hours for future roster periods.
- It is essential that staff attend in accord with the hours they are rostered. It is not acceptable to arrive any time after the commencement of a shift or to leave prior to the noted completion time of a shift without having sought approval of the Care or Facility Manager prior to that shift.
- To ensure a high standard of care is delivered to residents and the observance of fair and reasonable workloads for all, staff are expected to attend as rostered. Poor performance in relation to attendance; short notice of an inability to attend, and regular periods of non-attendance have the potential to lead to disciplinary actions including the termination of employment.
- Staff are required to clock on and off at the start and end of each shift using the Humanforce kiosks in each work area. If staff are unable to do so, they are required to notify their manager via Leecare as soon as possible. Failing to do so correctly has the potential to lead to disciplinary action.

4.6. Overtime

- Payment for overtime will be made only when such time has been duly authorised (prior to being undertaken) by the CEO, Facility Manager or Care Manager. Payments of this nature will be as per Buckland Enterprise Agreement provisions.

4.7. Staff Meetings

- This organisation holds regular meetings for all staff and whilst attendance at these meetings is not compulsory, all staff are encouraged to attend. A record of attendance is kept and this is used as a measure of staff commitment and degree of input in regard to policy, practice and procedure.

4.8. Staff Education and Training

- Buckland has a commitment to ongoing staff education. This commitment includes an annual program that includes topics chosen by staff and topics relevant to staff safety and resident care and welfare. Staff are encouraged to attend in-service education and training with the organisation also supporting external training and education, where this training and education will benefit resident care or staff safety and welfare. Self-directed learning

packages applicable to each classification also form part of the education program and the organisation encourages their completion.

- Buckland has a large number of education resource materials available to staff. Staff are required to note in the library register (held at reception) any text, booklets, magazine, or DVD's that they borrow.
- Buckland has access to the Aged Care Channel, where a large range of comprehensive education sessions are offered. These sessions are registered on the organisations education program each year and are available to be viewed by staff at their request, or as broadcast on the home internal education channel.
- Buckland and The College of Nursing are party to a Memorandum of Understanding, which forms the basis of a relationship that allows our registered nursing staff to enjoy the educational and training resources of the College at a reduced rate. Details of these benefits can be obtained from the Facility Manager.

4.9. Competencies

- To ensure that standards of care are maintained, staff are asked to achieve and then maintain competencies. These competencies relate to work practices and are regularly reviewed and documented.

4.10. Performance Appraisals

- Each member of staff will undergo a performance appraisal within 6 months of joining the organisation and this will be followed by regular appraisals. Each staff member will have the opportunity to discuss their appraisal details and to add their own comments if desired. The appraisal is kept on the staff member's personnel file and may be referred to as necessary.

4.11. Staff Comments, Suggestions and Grievances

- It is management's policy to readily accept input on all facets of policy, practice and procedures. Formal comments should be submitted via the Customer Liaison Service forms or Suggestion Box forms. No staff member position will be jeopardised as a result of following this procedure. The organisation also has policies on "Inappropriate Behaviour in the Workplace & Grievance Resolution" and "Sexual Harassment in the Workplace". Both these policies clearly set out the mechanisms available to staff to lodge a complaint or grievance.

4.12. Staff Alert / Emergency

- The staff call system at Buckland can activate a nurse assist button in each residents' room. The assist call will register as the residents' room number followed by the letter A, *e.g. 65 A* All staff becoming aware of this alert must respond immediately. There are also several other staff emergency alert systems in place including the main kitchen, the laundry and on the emergency call out bag.

4.13. Fire and Emergency Procedures

- All staff are to familiarise themselves with the fire procedures set down for this organisation, as well as being aware of the locations of fire extinguishers, fire blankets and hose reels. Exits are to be kept clear at all times.
- In the case of a fire, the fire brigade is to be contacted **by dialling "000",** requesting the fire brigade and clearly stating the details.
- **REMEMBER: EARLY DETECTION AND ACTION CAN SAVE LIVES.** Regular fire drills are undertaken and attendance with involvement is required. Non-attendance may be grounds for dismissal.
- The organisation also has a number of other policies, practices and procedures that relate to emergency and disaster situations. All staff are to be fully familiar with the organisational "Disaster Plan & Procedures in Relation to Threats" document and the "Emergency Procedure Guide" that is located at each phone throughout each facility.

4.14. Employee Assistance Program

- Buckland is committed to assisting staff to maintain high levels of work performance through the provision of an Employee Assistance Program (EAP).

- The objectives for the EAP are:
  - To improve the overall wellbeing of Buckland staff thereby, promoting quality services to the residents and their families;
  - To promote and maintain a healthy and productive working environment;
  - To provide a confidential counselling service at no cost to employees, to address issues which may impact the employee's performance or well-being;

- All existing staff members are entitled to access the EAP for up to three (3) one (1) hours counselling sessions per annum, or as approved by the Chief Executive Officer (CEO). The service is only accessible during the providers opening hours. Staff will be required to attend appointments outside working hours.

- The Buckland EAP enables staff to have access to the services after Management approval. An appointment can be made by directly contacting Riverland's Therapy via telephone on (02) 4731 8111. The appointment booking is the responsibility of the staff member or can be done with the assistance of the Human Resource Manager.

- A staff member claiming current workers compensation or participating in a current work rehabilitation program generally cannot access the EAP, for the same issue. If necessary, alternative counselling arrangements can be made.

- In the case of a traumatic situation or event crisis, counselling could be arranged by the Human Resource Manager, with the approval of the CEO and group sessions can be arranged as required.

- Detailed information relating to staff utilising the EAP is confidential and will not be released to any person without written consent of the staff member or their legal

representative, except to prevent a serious threat to a person's health or life and/or as required by law.

- Buckland will be provided feedback from the providers of the service which will not identify specific individuals. This feedback may include:
  - Number of staff members seen;
  - Number of sessions provided to each staff member;

4.15. Work Health and Safety

- Buckland has an extensive Work Health and Safety program which all staff, residents and visitors are required to adhere to.
- Buckland is obliged under the *NSW Work Health and Safety Act 2011* to provide a safe and healthy environment for all staff, visitors and contractors. Staff also has an obligation under this legislation to perform their duties in a safe manner and to report any unsafe work practices or equipment to management as soon as you become aware of it.
- The organisation has a documented Work Health and Safety policy which all staff are required to read and abide by.
- Buckland has in place an Employee Assistance Program (EAP) that staff can freely access. All staff can access this service for both professional and personal challenges they are attempting to address.

4.16. Workers Compensation

- All staff within this organisation are covered by the provisions of the *Workers Rehabilitation & Compensation Act.* The Act requires the organisation to have in place a fully detailed Return to work program and a Return to work co-ordinator. (All staff are required to read and be familiar with this organisation's "Work Health, Safety and Return to work program"). If a staff member suffers an injury that is covered under the *Workers Rehabilitation & Compensation Act,* they will be fully informed by the return to work co-ordinator as to the steps and processes that they are to follow under this program.

4.17. Minimal Lift Policy

- Buckland has a minimal lift policy that requires staff to adopt the use of mechanical lifters or other relevant equipment for all resident transfers, positioning and lifting. Each resident that requires any form of assistance with transferring, positioning or lifting has been assessed by a physiotherapist and has a plan of management in place that must be followed at all times.

4.18. Illness or Injury on Duty

- **Illness:** If a staff member feels that they are not well enough to continue duties, they should immediately inform the Registered Nurse in charge who will, after arranging sufficient replacement staff, authorise them to leave. The time of leaving the facility should be noted on Leecare as well as the reason for not completing the shift.

- Staff involved in food preparation and working in tasks covered by the food safety program are to comply with the requirements of that program in relation to illness and sickness.
- Any staff member with an infectious illness must not attend work until they are free of all symptoms for the required period of time for the particular infection. A medical certificate must be provided by the doctor stating the nature of the infectious illness and confirmation that the person is now no longer infectious and able to return to work. In some instances Buckland may be required to report instances of staff infectious illnesses to the Public Health Unit.
- **Injury:** If a staff member injures themselves at work, they are required to immediately inform the Registered Nurse in charge and then write a full report on the nature and circumstances of the injury, including details of any witnesses to the incident, on the Buckland Accident /Incident form and in the WorkCover Register. The injured staff member is required to physically report to the Facility Manager at the time of the injury or on their next rostered day of duty. If medical treatment is required, the treating doctor must issue a certificate stating full details of the injury.

4.19. Safety Rules

- All staff are required to comply with the following safety rules:
- Hazards and risks must be reported by utilising the 'Hazard and Risk Management Forms' which are located in each work area.
- Equipment that is deemed to pose a risk to staff, residents or others must undergo an assessment by utilising the "Equipment Risk Assessment Worksheet". These are also located in each work area.
- All safety and warning signs must be observed.
- Safe operation procedures must be followed where a procedure has been developed for a hazardous task.
- Chemicals must be stored in a manner that doesn't place staff, residents or others at risk. All chemicals used by the organisation have a current MSDS (material safety data sheet). Where a chemical is classed as hazardous, it is registered in the hazardous substances register and a risk assessment has been carried out. Staff must abide by the outcomes of the risk assessment for all hazardous substances.
- Security awareness is an essential aspect of your position. All staff are responsible for assisting in providing a safe and secure workplace and living environment. All external doors and windows must be locked at sunset (access can be gained by those with a legitimate need by using the door bells, etc).
- The residential care facility has closed circuit security cameras throughout the buildings. These cameras record movements within and outside the buildings. The cameras have been installed for the safety and security of the residents, staff and others visiting the buildings. Management monitor these cameras on a regular basis to ascertain their correct

functioning. Whilst these cameras are for safety and security purposes, staff are advised where in the course of the regular review and checking of the cameras staff practices are observed that require management attention, staff should have an expectation that the footage viewed can and will be relied on for staff performance management. A number of security cameras are also located within the grounds and record movement across the site including roads and car parks.

- Staff are required to take their designated breaks as listed on their duty statements, to ensure that periods of rest occur for all staff on all shifts.
- Staff should minimise the personal belongings and valuables that they bring into the workplace. Staff are required to use their lockers. Items such as handbags, keys, and mobile phones must be secured in a locker at all times whilst on duty. Staff are issued with a locker key at the time of their employment and this remains the property of Buckland. If staff lose or require another key they can be purchased at the cost of Buckland having one recut.
- Staff are issued with an identification badge at the time of their employment and this remains the property of Buckland, if staff request a replacement badge it will be reissued at the cost that Buckland has in replacing it.
- Staff must ensure that all work areas are kept clean and tidy. Spills must be wiped up and trip hazards removed as soon as they are identified so to reduce the risk of slips, trips and falls.
- Any task that you undertake that is classed as repetitive must be broken into periods that are not deemed as excessive. Where equipment is provided that is adjustable to suit persons of differing heights, etc. this equipment must be adjusted to suit you specifically.
- Staff required to drive a Buckland vehicle as part of their duties are required to:
  - Hold a current drivers licence for the type and class of vehicle.
  - The vehicle must only be used for the purpose it is designed for.
  - Vehicle inspection must have been undertaken for safety purposes prior to driving.
  - All speed limits must be observed.
  - Headlights used at night or in adverse driving conditions.
  - Mobile phones are only used if a hands free kit is fitted to the vehicle.
  - No smoking in vehicles.
  - If any defects are noted with the vehicle they are immediately reported to management.

4.20. Telephones

- All staff are expected to answer the telephone by first giving the name of the organisation “BUCKLAND”, and then their name and position held (e.g. Mrs. Jones, Registered Nurse).
- All messages are to be advised as soon as possible via the Leecare communication system.
- Urgent personal calls can be made by informing the Registered Nurse or the person in charge of the need. These calls should be kept to a minimum.
- **Staff are not permitted to bring a mobile phone into the workplace**. All mobile phones must be left in the staff members’ locker whilst they are on duty.

4.21. Meals

- Staff are allowed meal and tea breaks in accordance with the provisions of the Buckland Aged Care Services Enterprise Agreement. All staff are expected to take these breaks as allotted in their duty statement.
- Staff are required to ensure that they alert and gain permission to go on a break and again alert the Registered Nurse on their return. At no time are staff to eat whilst on duty. The taking of meals must occur in the designated staff rooms or if preferred, the grounds surrounding the facility.

4.22. Smoking

- Smoking is not permitted in any building within the Buckland Complex (with the exception of the Self Care Units and in this case for residents only). Buckland staff are allowed to smoke in the three designated smoking areas which are; outside the nursing home staff room, under the gazebo outside the main laundry and for DCW staff in the outside area off dining room E (known as the waterfall area). Any non-smoking staff member who sees fit to sit with staff members who smoke, do so at their own risk, as management has provided areas within the facility for staff to gather in a smoke free environment. Staff are not permitted to carry cigarettes on their person whilst they are on duty. Cigarettes must be held within the staff members locker or vehicle, where they can be accessed during an allotted tea or meal breaks.

4.23. Parking and Speed Limits

- All staff are expected to observe the speed restriction signs within the grounds and are to park only in the designated parking areas.

4.24. Resignations

- It is a requirement of this organisation that resignations are provided within the terms of the Buckland Aged Care Service Enterprise Agreement. Staff may provide a resignation that is for a longer period than that stated in the Enterprise Agreement, but it cannot be for a lesser period.
- Written references are not issued by this organisation. Staff will be issued with a 'Statement of Service' which will outline the period of employment, hours worked, sick

leave taken, etc. Staff can organise for the Facility Manager or Care Manager to act as a verbal referee if required.

4.25. Children

- No child is permitted to stay in either Buckland, The Donald Coburn Wing or the Buckland Retirement Villages, without the prior approval of the Facility Manager.
- If a staff member has any difficulty in attending their rostered hours of duty due to their need to care for their child/children, please contact the Facility Manager so that appropriate arrangements can be made.

4.26. NDIS Workers Clearance

- Staff need to be aware that before commencing employment an NDIS Workers Clearance is required. This is required as part of Commonwealth legislation, with the person having been convicted of murder or sexual assault, or convicted of, and sentenced to imprisonment for, any other form of assault. If any convictions of this nature appear on the clearance you will be ineligible for employment at Buckland. Please note that you will be responsible for the cost of this initial NDIS Workers Clearance. Details of how to apply for the clearance will be provided to following the interview. Staff are assured that the details of their NDIS Workers Clearance will remain private and confidential. Once employed staff are required to immediately inform management of any conviction that falls inside the requirements as noted above.

4.27. Privacy & Confidentiality

- Buckland does ensure that each staff member's privacy is respected whilst employed by this organisation. Each staff member does have the right to expect that information held by the organisation in relation to their employment is accurate and that this information will be held in confidence where appropriate. At times the organisation does need to share a staff member's information with others to enable the organisation to meet legislative and other requirements. (e.g. Aust. Taxation Office, financial institutions, etc). Buckland has formulated policies, practices and procedures that comply with the legislative requirements of the *Privacy Amendment (Private Sector) Act 2000.* Staff members can obtain an individual copy of the organisations Privacy Policy or alternatively view it in the Buckland policies, practices and procedures manual on desktops throughout the facilities. Staff are required to sign a Confidentiality Agreement at the time of their employment.
- Staff need to be aware that they should have no expectation of confidentiality in relation to communications undertaken within the organisation on its electronic communication systems including Leecare and email. All these systems are managed by Buckland appointed management staff who have administrator rights, which allow them access to all communication within these systems. Where staff and management agree to keep a matter confidential in relation to the terms and conditions of their employment or and disciplinary actions that agreement is binding.
- Closed circuit cameras are in use in the residential aged care facility and the grounds of the site and record the movement of staff, residents and others (Refer to 4.19 Safety Rules).

4.28. Medical Examination of Nurses and vaccination

- At the time of employment, all nursing staff are able to request full protection against tuberculosis including; a PA chest x-ray, a Mantoux test, and where the Mantoux test is negative, immunisation with BCG vaccine, and/or subsequent referral and action, as deemed necessary in response to the Mantoux reaction.
- The organisation will also offer immunisation protection against other communicable diseases including; diphtheria, tetanus, poliomyelitis, measles, mumps, hepatitis and rubella.
- Nursing staff wishing to avail themselves of this screening and/or immunisation process should speak with the Care Manager.
- Buckland will offer free annual influenza vaccinations. All staff are required to be vaccinated under section 7 of the public health act.

4.29. Energy Consumption

- Each member of staff is asked to assist in the reduction and prevention of waste, whether it be paper, water, electricity or other resources. Great savings to both the facility and the environment can be made if staff use these resources wisely. Each staff member is personally responsible for the prevention of all forms of waste.

4.30. Communication

- Communication within the organisation is to be made via the Leecare communication system. Training in this system is provided on orientation. All staff are required to at a minimum to log onto the Leecare communication at the commencement and completion of each shift.
- Buckland issues a monthly newsletter that sets out to inform staff, residents, relatives and other interested parties of the day-to-day activities and functions of the organisation. Staff are asked to avail themselves of a copy each month, so that they are fully aware of the activities and programs that are scheduled as well as keeping up to date with the day to day running of the facility. Noticeboards are located throughout each facility. Information relevant to your work is often displayed on these boards. All staff are responsible for maintaining an awareness of what is on display.
- Staff need to be aware that they should have no expectation of confidentiality in relation to communications undertaken within the organisation on its electronic communication systems including Leecare and email. All these systems are managed by Buckland appointed management staff who have administrator rights, which allow them access to all communication within these systems.

4.31. Poor Performance

- If a staff members' performance or behaviour is deemed after careful assessment to be unsatisfactory, Buckland may take action to terminate your employment. Buckland takes such decisions very seriously and prior to arriving at such a decision, the staff member involved would be advised of the organisations concerns and opportunities would be provided for the staff member to rectify the problem.

4.32. Abandonment of Employment

- A staff member is deemed to have abandoned their employment when they do not report for duty on two consecutive days and have not contacted the Facility Manager, Care Manager or immediate supervisor. Should an employee not turn up for work and not inform the organisation, Buckland will make all reasonable attempts to contact the staff member. It should be noted that this attempted contact is undertaken with the staff members' welfare being the organisation's priority.
- A staff member who leaves the workplace without proper advice to the Care or Facility Manager whilst they are on duty or the Registered Nurse at any other time will be considered to have abandoned their employment.

4.33. Dismissal

- Any incident of misconduct, blatant disregard for safety rules, unsatisfactory work performance (after counselling and further training) etc. may be dealt with by the dismissal of the staff member concerned. Dismissal may be instant or with notice depending on the nature of the incident (see Summary Dismissal).

4.34. Summary Dismissal

Buckland reserves the right to dismiss without notice any staff member who is found to have acted in a manner of gross negligence or wilful misconduct. Examples of behaviour that may warrant summary dismissal include: serious neglect of duty; dishonesty including fraud; drunkenness or substance abuse; serious misbehaviour including fighting; abandonment of employment, actions or comments that damage the reputation of the organisation and serious and wilful disobedience.

4.35. Aged Care Code of Conduct

All staff upon employment are required to familiarise themselves with the Aged Care Code of Conduct. Staff will be given information on this code during orientation and are required to sign an acknowledgement form.

When providing care, supports and services to people, employees must:

a. act with respect for people's rights to freedom of expression, self-determination and decision-making in accordance with applicable laws and conventions;

b. act in a way that treats people with dignity and respect, and values their diversity;

c. act with respect for the privacy of people;

d. provide care, supports and services in a safe and competent manner, with care and skill;

e. act with integrity, honesty and transparency;

f. promptly take steps to raise and act on concerns about matters that may impact the quality and safety of care, supports and services;

g. provide care, supports and services free from:

   i. all forms of violence, discrimination, exploitation, neglect and abuse; and

   ii. sexual misconduct; and

h. take all reasonable steps to prevent and respond to:

   i. all forms of violence, discrimination, exploitation, neglect and abuse; and

   ii. sexual misconduct.

5. LEAVE

5.1. Annual Leave

Although annual leave is provided as per the provisions of the Enterprise Agreement, the law provides for the employer to determine upon the annual rosters for the facility. Whilst every endeavour is made to provide leave at the times requested, the nature of this care and service sector precludes the possibility of excess staff on leave at any one time.

A minimum of two (2) months' notice for leave requests is required however a longer notice period may assist in allowing the leave to be granted.

Staff are required to request annual leave using Humanforce. The requested dates are then submitted to the Hospitality Services Coordinator, Care or Facility Manager for approval.

Once this is received management will review the number of staff off at a given time and then once approved, notify the staff member via a Leecare message or noting it on the roster.

Please note: Do not book holidays until your leave has been approved to avoid disappointment.

Please note: Management, Administration and Retirement Village staff annual leave requests are submitted to the CEO.

5.2. Compassionate Leave

Compassionate leave with pay shall only be granted in accord with the conditions of the Enterprise Agreement and is approved by the CEO, Facility and Care Managers.

5.3. Leave Without Pay

Applications for extended absences of leave without pay must be submitted to the Facility Manager on the same basis as annual leave. Leave without pay will usually only be given if all other leave entitlements have been taken and will be dependent on the circumstances.

5.4. Personal Carers Leave / Sick Leave

All permanent and permanent part time staff are eligible for sick leave on a pro rata basis. Sick leave is fully accumulative from year to year and is calculated at two weeks of the equivalent of usual hours i.e. part/full time. A medical certificate or documented evidence supporting a legitimate reason for non attendance is required for all absences. Where a staff members periods of personal carers or sick leave is considered excessive management will discuss the matter with the staff member to allow them to provide advice on the circumstances, etc.

5.5. Long Service Leave

Long service leave may be taken after an employee has completed ten (10) years of service. Applications for this type of leave must be made in writing with a minimum three (3) months notice. Granting of this leave is totally at the discretion of the CEO.

5.6. Absence from Duty

All staff are required to inform the organisation a minimum of four (4) hours prior to any absence from duty. Longer notice if possible, will enable replacement staff to be found. Failure to notify the organisation of an inability to attend work will be deemed wilful misconduct and may result in the staff member's employment being reconsidered (see 5.3. Abandonment of Employment)

5.7. Leaving Facility during Working Hours

If at any time it is necessary to leave the facility during working hours, the Registered Nurse in Charge must be informed and his/her permission sought. The Registered Nurse is required to note this absence on Leecare.

5.8. Jury Duty

Any member of staff who receives notice that they are required to attend jury duty must inform the Facility or Care Manager. It may be that the lack of suitable replacement staff causes the organisation to request the employee to decline jury duty therefore early notification is essential. Payment for time required, will be the difference between the amount paid by the Court Sheriff and the usual wage earned.

5.35. Parental Leave

An employee other than a casual is entitled to 12 months unpaid parental leave, the provisions for parental leave is provided as per the Enterprise Agreement, and the National Employment Standards. Staff are required to apply for parental leave by completing the parental leave application form and submitting it to the relevant manager.

A minimum of ten (10) weeks' notice is required when applying for parental leave. If a pregnant employee continues to work during the 6 week period before the expected date of birth of the child, Buckland reserves the right to request medical evidence from a staff member that they are fit for work and whether regular duties can continue.

Staff can apply for up to 12 months parental leave however have the opportunity to extend this to a maximum of 24 months. Further extension of parental leave beyond the 12 month period is subject to management's approval. Requests to extend parental leave must be in writing and provided to Buckland a minimum of 4 weeks before the return date.

Requests to reduce or cancel the period of leave is subject to Buckland's agreement, however requests must be in writing with a minimum of 4 weeks' notice.

6. SALARIES AND WAGES

6.1. Wages

Wages will be paid in accordance with the Buckland Aged Care Services Enterprise Agreement.

Pay periods commence on a Wednesday and cover a fourteen (14) day period. Wages are paid by Direct Deposit to a Bank Account nominated by the employee. The Board of Directors reserves the right to alter the method of payment of wages at any time subject to the provisions and guidelines of the industrial agreements.

Buckland is classified as a Public Benevolent Institution and as such is able to offer to staff a tax-free benefit via an Employee Benefits Card. Details on this benefit are provided to you at the time of your employment, with further information being available from the Payroll administration. This benefit is available to staff after three months service. The terms and conditions Buckland extends to the tax free benefit can be reconsidered at any time.

6.2. Pay Enquiries

All enquiries regarding wages must be directed initially to the administration staff member responsible for payroll services. In some circumstances staff may be directed to forward their enquiries to the CEO.

6.3. Change of Address and Personal Details

It is a requirement that all staff members advise the organisation of up to date personal details such as: address, phone numbers, name changes and next of kin contact details. Any updates must be submitted on Humanforce.

6.4. Superannuation

A provision of the Enterprise Agreement under which this organisation operates is the requirement of an Employer Sponsored Occupational Superannuation Scheme. This organisation has an active scheme in process and staff will be advised of the details on commencement of employment. If a staff member wishes to nominate a superannuation fund

other than the default fund they must advise the Payroll administration within 28 days of commencement of employment.

6.5. Registration (Registered and Enrolled Nurses)

Evidence of current Australian Health Practitioner Regulation Agency (AHPRA) registration must be produced prior to the offer of appointment. Registered and Enrolled Nurses are required by legislation to renew their registration annually. The receipt must be presented to the Payroll Administration following receipt of payment and before expiry of registration. Failure to present a current registration will result in removal from the roster until such time as a current registration is produced.

6.6. Salary Sacrifice Provisions

The organisation provides a salary sacrifice scheme for staff after 3 months service. Details of the salary sacrifice system in place are available from the Payroll administration. Buckland reserves the right to alter the conditions of this scheme as it sees fit.

7. RESIDENTS

7.1. Confidentiality of Residents Records

All information contained in resident's records is strictly confidential. Discussions of matters relating to residents should only take place with appropriate medical, nursing/care and allied professions.

7.2. Accidents Involving Residents

Any incident or accident that involves a resident must be documented on the residents electronic file accident /incident form and an alert sent to the Care and Facility Manager.

7.3. Gifts

No staff member is to accept a gift of any nature from a resident (or their family) without first seeking the approval of the Facility Manager or Care Manager. The organisations' policy documents further guide staff in relation to the acceptance of gifts.

Staff are not to borrow or take resident's belongings without first notifying the Facility or Care Manager.

7.4. Witnessing Legal Documents

No staff member is to witness or sign any legal document. Requests of this nature are to be directed to the Facility or Care Manager.

7.5. Chaplain Service

Buckland has a chaplain on staff who provides for the spiritual care and needs of the residents. The chaplain has also agreed to be available to staff by appointment.

Religious services may be held within the facility on the request of the relevant church minister.

Any request by a resident for contact with a religious minister must be directed initially to the chaplain or in her absence to the Care Manager who will make the necessary arrangements.

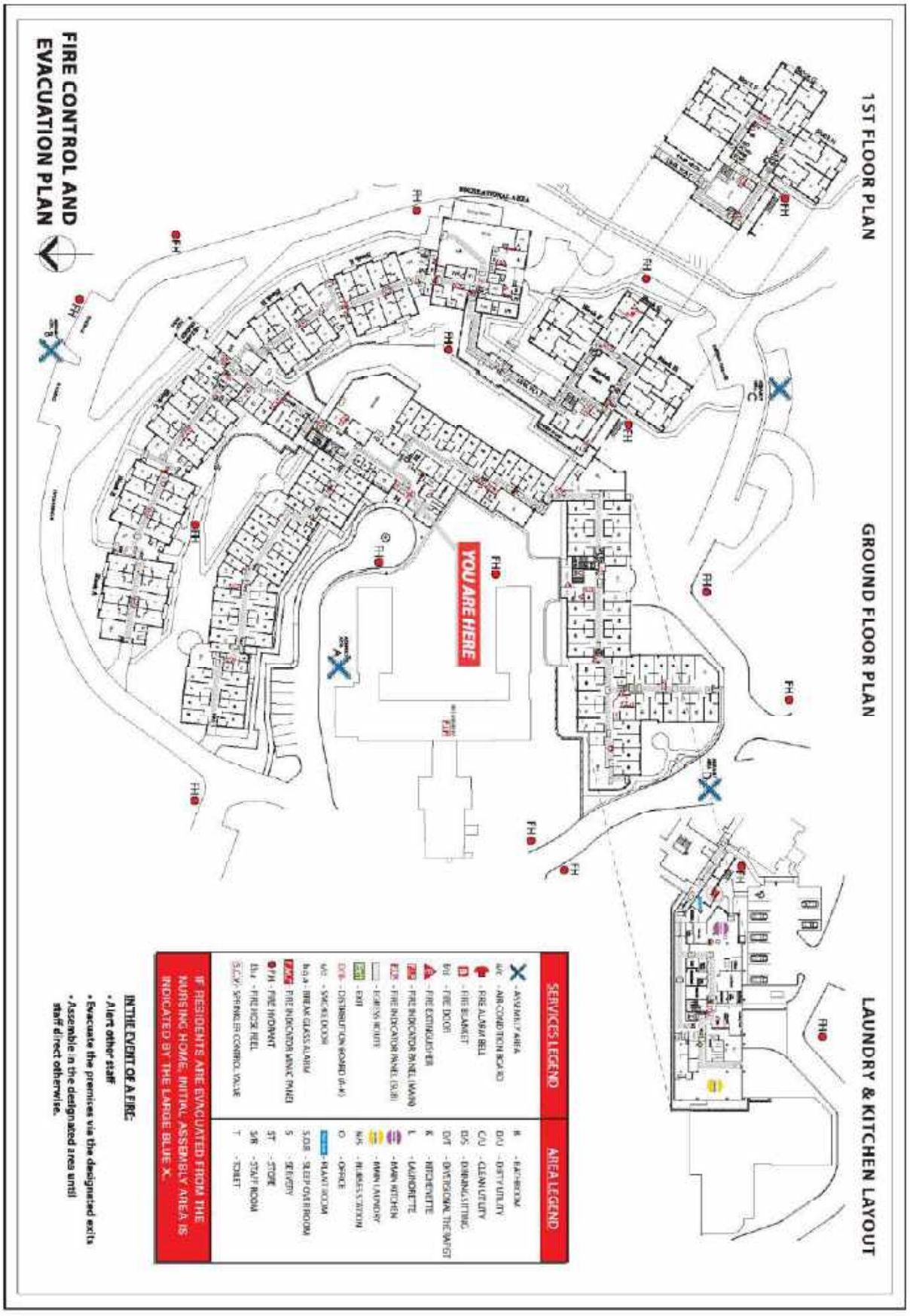
7.6. Professional Standards of Care

All residents and their families are entitled to expect a high standard of professional conduct from staff. Staff are required to treat all residents, their families and visitors to Buckland, with respect. Residents will be afforded a good degree of privacy and dignity in their day-to-day care and interactions with staff. Staff are required to address all residents and their family members by their preferred name. Each resident's wishes, in relation to their preferences, are noted on their care plan.

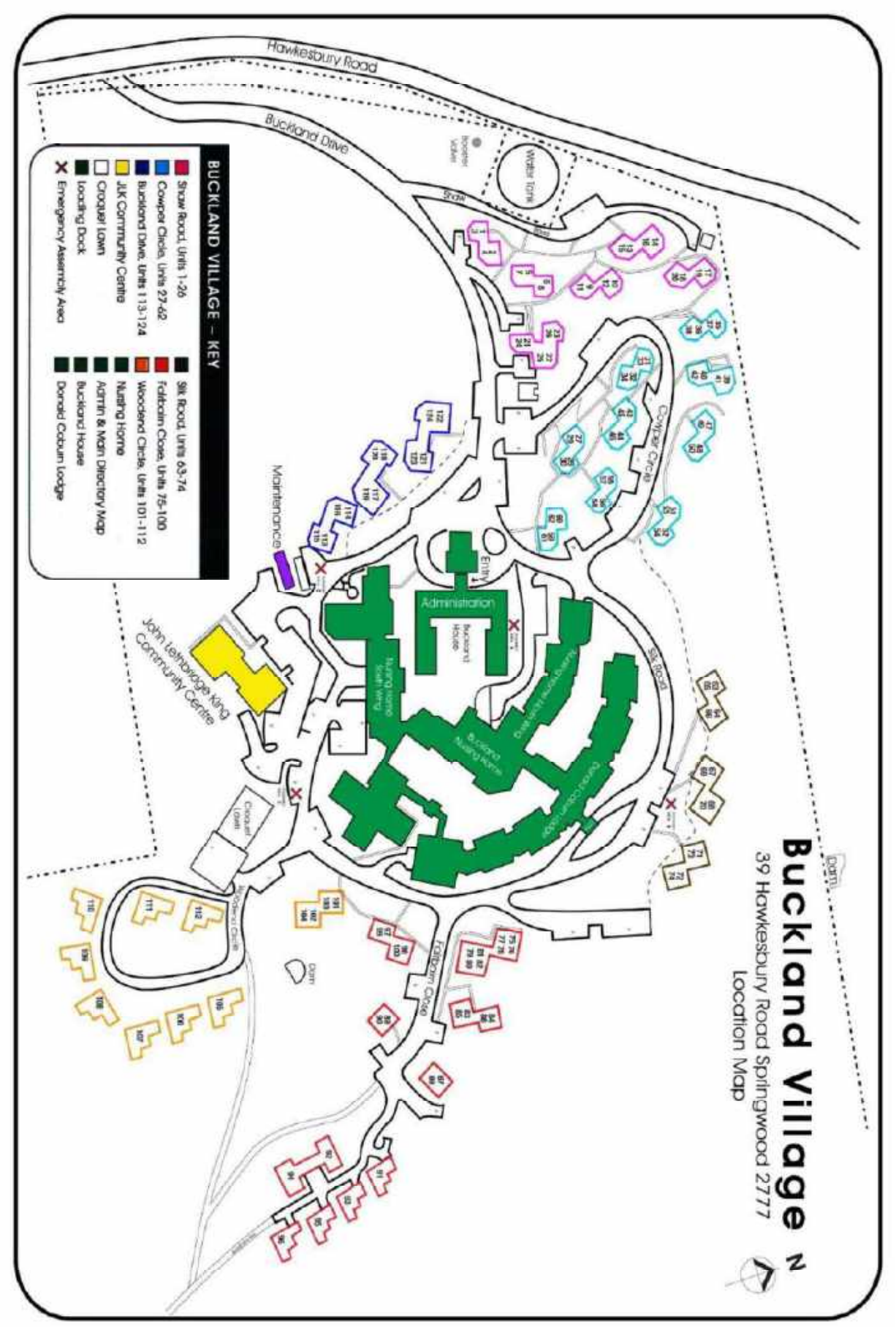
8. APPENDICES

8.1. Personal Notes

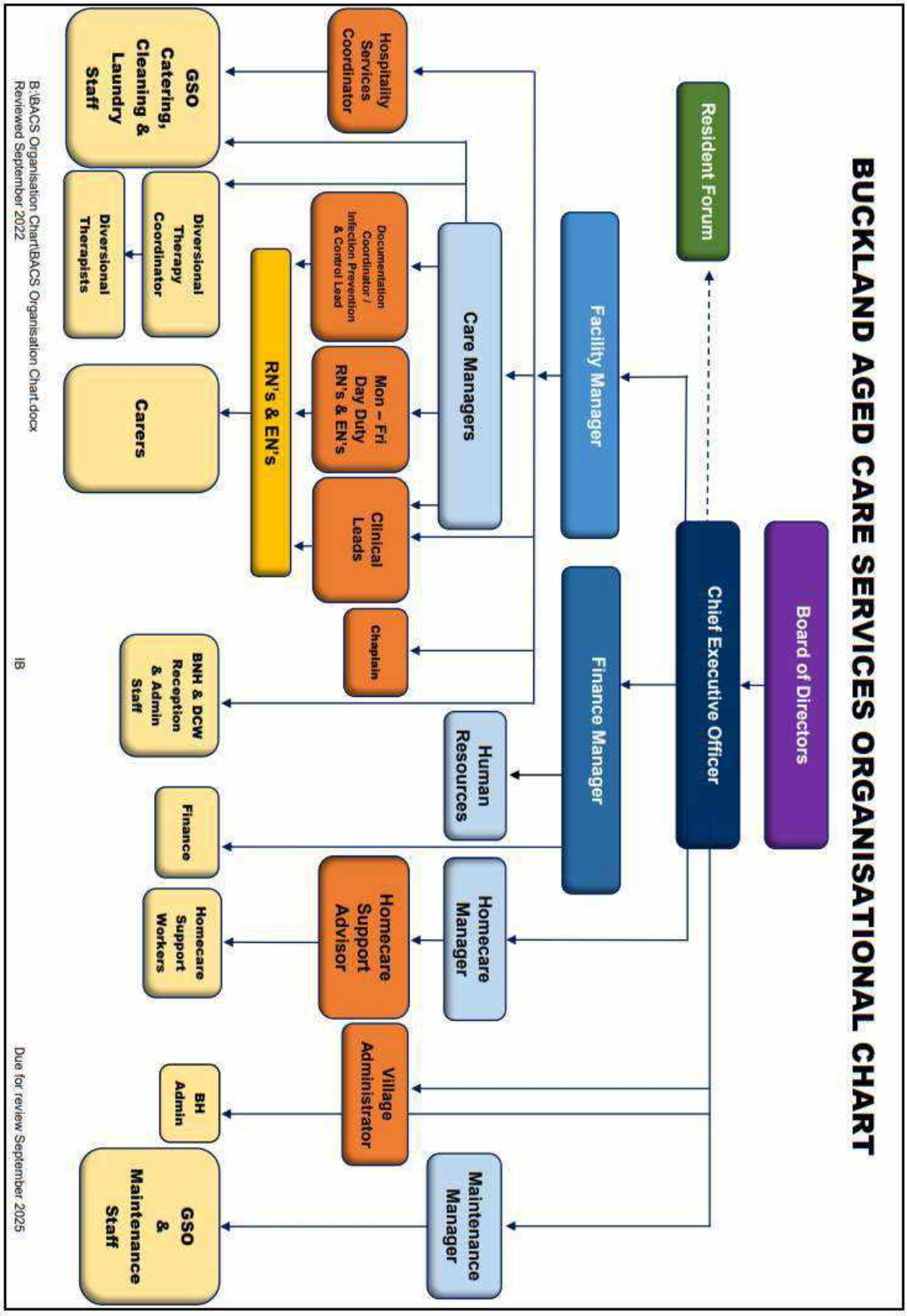
8.2. Buckland Floorplan / Fire Control and Evacuation Plan



8.3. Buckland Retirement Village Location Map



8.4. Buckland Organisation Chart



9. DOCUMENT REVIEW

This Staff Information Handbook was developed by [redacted] on 12th October 1987.

It has been reviewed and updated on:

16th June 1989
27th August 1992
19th April 1994
26th June 1996
4th February 1997
10th November 1999
1st August 2001
3rd February 2003
1st February 2004
24th June 2004
8th August 2005
1st March 2007
20th June 2007
27th May 2009
30th November 2009
29th July 2010
7th October 2010
10th February 2011
15th May 2011
29th July 2011
15th November 2011
13th January 2012
2nd February 2012
10th April 2012
11th February 2013
23rd November 2013
24th April 2014
30th July 2014
30th September 2014
8th May 2015
20th January 2016
26th July 2016
12th December 2016
2nd February 2017
20th May 2017
28th June 2017
7th August 2017
10th November 2018
28th June 2019
14th August 2019
07th February 2020
10th November 2020
10th March 2021
25th October 2021
18th October 2022

COVID – 19
+ Acute Respiratory Infection (ARI)
Response and preparation plan
Buckland Aged Care Services

Contents

The trigger event to activate the response plan is 1 x confirmed case of RESPIRATORY or Influenza (Resident) within the facility. An outbreak is declared if 2 or more residents test positive to COVID-19 or influenza within a 72-hour period. *NOTE: the threshold as per the CDNA guidelines for the he prevention and control of COVID-19 outbreaks in a RACF is 2 or more residents within five days or five or more staff/visitors or residents within 7 days. This threshold will have to be met to access Commonwealth supports*

The plan outlines Buckland's planned response to a COVID-19 and/or influenza outbreak within our facility. The plan will address two fundamental questions:

1. What will be done in response to a RESPIRATORY and/or influenza outbreak at Buckland's?
2. How will we work together to achieve the best possible outcome for our residents, their families and our staff?

Please note: This document should be read in conjunction with our detailed timeline. The timeline refers to each item raised, when and why it was raised and what action was taken.
This document should also be read in conjunction with the most recent CDNA national guidelines for the prevention, control, and public health management of COVID-19 outbreaks in residential care facilities in Australia and NSW health Guidance for Residential Aged Care Facilities on the public health management of Acute Respiratory Infections (including COVID-19 and Influenza)

Outbreak Summary Table

While the definitions below provide guidance, the state/territory PHU will assist the aged care centre in deciding whether to declare an outbreak as jurisdictional public health guidance may vary. Public health units may advise that the centre should take some actions where an outbreak is suspected, whilst awaiting laboratory confirmation.

Note- When the respiratory illness is unknown or under investigation, assume it is COVID-19 until the PCR has shown a negative result. If COVID-19 negative and respiratory illness is still unknown use Standard, Contact and Droplet precautions until cause identified for the duration of illness.

**Note- see illness specific OMP extension pack for detailed precautions, incubation period, treatment requirements, release of isolation for staff, and disease table requirement depending on type of outbreak identified.*

Disease	Outbreak Criteria	Immediate PHU Notification	*Standard Precautions* + Transmission Based Precautions	Release from Isolation Residents & Precaution Duration
Respiratory Infection				
COVID-19	2 or more residents in 72 hours **OR** 5 or more staff, visitors, residents in 7 days	Yes	Contact Droplet Airborne	After day 7 if no symptoms for 24 hours and must wear mask in communal areas until after day 10.
Influenza	*NSW/ACT*: 2 or more residents in 72 hours *QLD*: 3 or more residents in 72 hours	Yes	Contact Droplet	After 5 days from symptom onset, or until they are symptom-free, whichever is longer.
Adenovirus	3 or more cases in 72 hours in staff and residents	*FYI only*	Contact Droplet	Once symptoms resolve.
Rhinovirus	3 or more cases in 72 hours in staff and residents	*FYI only*	Contact Droplet	Duration of illness and or after 3 days (whichever is longer) and must be afebrile and asymptomatic for 24 hours.
Human Parainfluenza Virus (HPIV)	3 or more cases in 72 hours in staff and residents	*FYI only*	Contact Droplet	Duration of illness and or after 5 days (whichever is longer) and must be afebrile and asymptomatic for 24 hours.
Respiratory Infection (continued)				
(HMV) Human Metapneumovirus	3 or more cases in 72 hours in staff and residents	*FYI only*	Contact Droplet	Duration of illness and or after 5 days (whichever is longer) and must be afebrile and asymptomatic for 24 hours.
(RSV) Respiratory syncytial virus	3 or more cases in 72 hours in staff and residents	*QLD- Yes* *FYI only for NSW/ACT*	Contact Droplet	Duration of illness and or after 5 days (whichever is longer) and must be afebrile and asymptomatic for 24 hours.
Parasitic Infestation & Skin Infection				
Scabies	2 or more cases in residents, staff, and visitors in 6 weeks	*FYI only*	Contact	Until 24 hours after treatment commenced
Lice – Head & Body	2 or more cases in residents, staff, and visitors in 6 weeks	No	Contact	Until 24 hours after effective treatment
Monkeypox	PHU to determine	Yes *Immediately once suspected*	Contact Droplet Airborne	When all lesions have crusted, scabs have fallen off and a fresh layer of skin has formed underneath + PHU clearance
Gastroenteritis Infection				
Gastroenteritis Viral	2 or more residents and staff with vomiting or diarrhoea within 24 hours	Yes	Contact Droplet	Until at least 48 hours after cessation of diarrhoea and or vomiting
Gastroenteritis Bacterial & Parasitic	2 or more residents and staff with vomiting or diarrhoea within 24 hours	Yes	Contact	Until at least 48 hours after cessation of diarrhoea and or vomiting
Gastroenteritis Toxin Producing Bacteria & Antibiotic-associated	2 or more residents and staff with vomiting or diarrhoea within 24 hours	Yes	Contact	Until at least 48 hours after cessation of diarrhoea and or vomiting

Preparedness

Buckland has appropriate preparedness plan in place to ensure we promote an early response to an acute respiratory Infection Outbreak. The preparedness plan is as follows:

- Promote vaccinations to all residents, staff, visitors, contractors for seasonal Influenza and COVID-19 vaccination as per ATAGI advice.
- Buckland requests general practitioners (GPs) to regularly review residents to assess vaccination status, arrange a refill pathology form for the respiratory viral testing and assess the suitability for antiviral treatment using the pre-assessment action plan for respiratory infections (Please refer to the attached pre assessment August 2023).
- Buckland maintains the following systems for monitoring and recording of vaccinations status of residents and staff for COVID 19 and Influenza.
    1. *Facility based spreadsheet – IPC Lead (resident and staff)*
    2. *BESTMED - residents (IPC LEAD, Clinical Management)*
    3. *Leecare – (residents) – (IPC LEAD) – These can be found in the Z drive in the infection control folder.*
- A potential cohorting of residents and staff with zoning at Buckland.
- Appropriate infection protection and control strategies.
    1. *Regular staff training.*
    2. *Outbreak Management competency assessment and monitoring (Donning and Doffing Outbreak response).*
- Review stocktake spreadsheet and arrange for PPE, Hand Hygiene and cleaning supplies as well as ensure adequate supply or RATS and identify procurement methods.
- Establish workforce surge capacity.
- Douglas Hanley Moir pathology to be utilised as pathology provider to arrange collection. (Collection and supply of swabs
    1. Phone Number
    2. Login Portal details

service.

First 24 Hours Checklist – Managing COVID-19 in a Residential Aged Care Home

The first 24 hours in managing a confirmed COVID-19 case in a residential aged care home is critical to minimising the spread of the virus and its impact on residents and staff. This checklist is to help residential aged care providers and their staff to manage a COVID-19 positive case or outbreak in the first 24 hours. Please visit the links within the checklist for more information.

The first 24 hours

Aged care providers must take all possible steps to prepare for and manage a COVID-19 outbreak well-rehearsed for immediate activation. Your Outbreak Management Plan should be up to date and -well-rehearsed for immediate activation.

Immediate steps: within 30 minutes – 6 hours

Checklist	Steps to action within 30 minutes to 6 hours
☐	1. Isolate the COVID-19 positive case(s): Staff member: • if onsite, apply a surgical mask, leave the premises and not attend work for at least 7 days or while symptoms persist. • If off site, check rosters to confirm when previously on-site. • refer to the CDNA Guidelines and Winter Plan for guidance on how to manage staff cases. Resident(s): • sensitively inform resident(s) of their diagnosis. • isolate the resident(s) in their room with an ensuite if possible or a commode if no dedicated toilet is available. • perform a clinical assessment, if signs and symptoms are mild, residents can be cared for in the facility with appropriate clinical monitoring and infection prevention control (IPC). • inform the resident's family or representative of the diagnosis and treatment options. • Speak with residents, their families and representatives about the use of oral anti-viral treatments and arrange and record their consent for treatment. • Make sure resident(s) have been assessed by a GP, preferably by the resident's usual GP, for their suitability to receive oral anti-viral treatments. • If clinically required, discuss other accommodation options, such as hospital transfer with your Public Health Unit (PHU) and the relevant acute care support service/outreach service.
☐	2. Implement IPC measures • IPC leads should implement your homes IPC measures, including use of personal protective equipment (PPE) and isolation of any positive case.

Checklist	Steps to action within 30 minutes to 6 hours
	• Implement your homes IPC measures.
☐	3. Activate your Outbreak Management Plan (OMP). • You should activate your OMP when the first resident who has tested positive for COVID-19 and before the definition of an outbreak is met, to prepare for a potential outbreak. • Your IPC lead nurse should be made aware of the outbreak and guide implementation of the OMP. • Notify key personnel identified in your OMP, including senior management, to implement their roles and to coordinate on-site leadership at all times.
☐	4. You will need to notify positive COVID-19 cases to the Commonwealth Department of Health and Aged Care: ○ all cases (staff, resident and visitor) must be reported via the My Aged Care provider portal. This will trigger support from the Commonwealth if needed. ○ your local PHU, only where applicable, and in line with jurisdictional reporting requirements. To find out about whether this reporting requirement applies in your jurisdiction please refer to your state or territory health department. • Report the positive case/s to the Work Safe organisation in your jurisdiction in accordance with any state requirements that may apply.
☐	5. Continue to monitor residents and staff for COVID-19. • You should identify residents and staff who may be considered high risk exposures and/or close contacts and consider your plan for cohorting. • Confirm vaccination status of all residents and workers to assess who is at greatest risk.
☐	6. Control movement of people entering the building • Understand your jurisdiction's COVID-19 screening protocols. • Follow the screening requirements in line with your state or territory public health directions.
☐	7. Enact your communication plan outlined in your Outbreak Management Plan. • Refer to the National COVID-19 Residential Aged Care Emergency Communication Guide for more advice.
☐	8. Continue to monitor residents and staff for COVID-19. • You should identify residents and staff who may be considered high risk exposures and/or close contacts and consider your plan for cohorting.

Checklist	Steps to action within 30 minutes to 6 hours
☐	9. Check your PPE and Rapid Antigen Testing (RAT) kit supplies. • If you need additional PPE, hand hygiene or cleaning products and cannot source these through commercial suppliers, you can request additional stock from the My Aged Care provider portal. • RAT kits are deployed weekly to homes as part of surveillance screening. • Contact existing waste removal suppliers and inform them of the potential increase in clinical waste removal needs.
☐	10. Convene your first Outbreak Management Team (OMT) meeting. • Relevant members of your leadership team should attend and where available and considered necessary, state or territory PHU and representatives from the Commonwealth Department of Health and Aged Care's relevant State Office. • Make sure you have as much information available before the OMT. This will include number of residents and staff onsite, vaccination rates, number of COVID positive cases, if you are cohorting staff and residents, workforce levels and IPC, which includes PPE and waste. • These might continue to be daily meetings during the outbreak. • Regularly notify, report and update your facility's senior leadership and governing body.
☐	11. Plan your staff roster • Review your workforce management plan. • Support and use your existing workforce as efficiently as possible, including roles for isolated staff, Partners-in-Care and volunteers. • Manage staff identified as contacts using guidance in CNDA National Guidelines for the Prevention, Control and Public Health Management of Outbreaks of Acute Respiratory Infection (including COVID-19 and Influenza) in Residential Care Facilities • If you are still unable to fill your roster, access to surge workforce support may be available through the Commonwealth.
☐	12. Arrange for COVID-19 testing. • Test residents and staff for COVID-19, in line with advice from your PHU or broader public guidance. • Follow PHU guidance of the use of PCR and RAT kits to diagnose COVID19. • Report any COVID-19 positive results as per step 4.
☐	13. Clinically monitor and manage COVID-19 positive residents • Manage COVID-19 positive residents based on their clinical needs and in line with jurisdictional public health requirements. This includes detecting and responding to deterioration and decisions on management and hospital transfers.

Checklist	Steps to action within 30 minutes to 6 hours
	• Discuss clinical management and treatment options with in-reach services, GPs, or the PHU as required.
☐	14. Continue ongoing care • Make sure that the ongoing care needs of all residents (irrespective of COVID-19 status) continue to be met (including medication rounds, assistance with meals and hydration, assistance with toileting and access to visitors).

Within 6 – 12 hours

Checklist	Steps to action within 6 hours to 12 hours
☐	15. Cohort, zone and relocate • Separate positive, suspected positive, close contacts and negative residents into zones within the home where possible to protect COVID-19 negative residents from exposure. • Where possible residents should have their own room and bathroom. • Make sure staff comply with restrictions on use of shared areas e.g. breakrooms. • Make sure staff rostering supports cohorting – make sure staff are clear about whether they are caring for residents in isolation. • Discuss cohorting options including those outlined in your Outbreak Management Plan with the PHU.

☐	16. Move to the command-based governance structure outlined in your Outbreak Management Plan
	• Ensure senior leadership is onsite at all times. This should include weekends and public holidays.
	• Provide thorough handovers for new staff for every shift and confirm:
	  • the onsite facility manager and clinical lead
	  • everyone's roles and responsibilities
	  • what to do if there is a problem
	  • what the escalation processes are.

☐	17. Enhance IPC • Determine the on-the-ground infection control lead nurse for each shift. • The IPC lead should check outbreak IPC processes and practices are implemented. • Clean and disinfect COVID-19 positive, suspected or close contact residents' rooms often, as per guidelines on environmental cleaning. • Commence increased cleaning and disinfection of: • any shared areas

Checklist	Steps to action within 6 hours to 12 hours
	• shared equipment • frequently touched surfaces. • Provide orientation, IPC and PPE training for any new support staff.
☐	18. Talk to any residents, their families or representatives who are not up-to date with their COVID-19 vaccination. • Encourage them to consent or re-consider consent to receive vaccination or booster • Organise vaccinations for residents yet to receive their vaccination or boosters for COVID-19: either with the residents GP or Nurse Practitioner. • If you are unable to get a GP or Nurse Practitioner to administer the vaccination, Commonwealth vaccination in-reach clinics are available.

Within 12 – 24 hours

Checklist	Steps to action within 12 hours to 24 hours
☐	19. Review advance care directives • Clinical staff should familiarise themselves with any COVID-19 positive residents' advance care directives and make sure clinical decisions consider these plans and involve residents, families and representatives.
☐	20. Maintain residents' social contact • Action social contact arrangements in your Outbreak Management Plan. • Maintain Partners-in-Care and Named Visitors initiatives. • Arrange for enough staff to assist with IT equipment and technology where required. • Clean shared IT equipment after each use.
☐	21. Follow-up communications • Establish and maintain daily communication for residents, families and staff as per your communication plan. • Provide OPAN information kits to residents, families and staff that include details for advocacy services.
☐	22. Continue primary health care and allied health support • Make sure there is strong ongoing clinical governance of routine care. • Ensure there is access to a GP to support treatment for residents who have tested positive. • Notify the Primary Health Network if there is an exposure or an outbreak, as well as residents' GPs who may contribute to care.
☐	23. Support your staff • Establish fatigue management plans and share support information.

Checklist	Steps to action within 12 hours to 24 hours
	• Continue to offer support to staff who are isolating. • Pre-plan and allocate offsite responsibilities to staff who are asymptomatic. • Consider a “buddy” system for peer support.
☐	24. Stay up-to-date Assign a staff member to monitor relevant state or territory COVID-19 webpages, including updates from the Commonwealth: • New South Wales • Victoria • Queensland • Western Australia • South Australia • Tasmania • Australian Capital Territory • Northern Territory

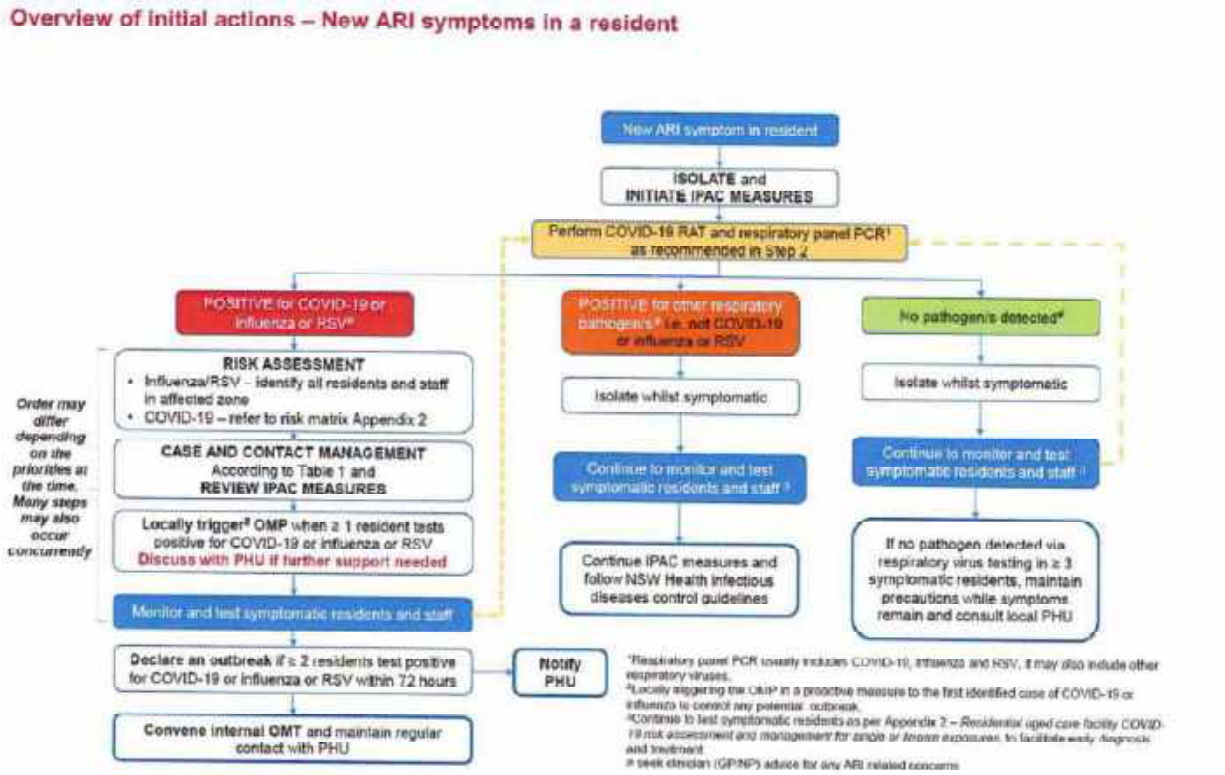
Contact Details

Roles	Proposed Staff member	Contact Numbers	Email Addresses	Contingency
Chairperson	Johannes Brockhaus, CEO	[redacted]	[redacted]	Deputy Chair
Deputy Chair	[redacted]			Chairperson
Outbreak Coordinator				Care Managers
Assistant Care Manager				
Infection prevention and Control leads				Clinical Lead
Environmental officer/HSC				es
Emotional support officers				DT Team
Communication Officer				[redacted]
Reception and Admin Assistant				
Facility Maintenance				
Allied Health Rep				
Registered Nurse on shift				Set up PPE and Zoning

Initial Actions – New ARI symptoms in a resident

The Steps outlined below are a guide only and the Step-by-Step order may differ depending on the priorities at the time. Many Steps may also occur concurrently.

NOTE: please refer to the overview of the initial actions – New ARI symptoms in a **resident flow chart overview.**



CDNA Guidelines - https://www.health.gov.au/sites/default/files/documents/2022/10/coronavirus-covid-19-cdna-national-guidelines-for-public-health-units.pdf

Step 1: ISOLATE the symptomatic resident immediately in their own room if possible and implement initial infection prevention and control (IPAC) measures including airborne and droplet precautions for staff in affected areas.

Step 2: TEST the symptomatic resident as soon as possible.
Early diagnosis of COVID-19, influenza and RSV means earlier treatment and outbreak control.

• Facilities should work with the GP on a process to ensure residents are tested quickly; this may include having pre -
ordered pathology forms (found in Outbreak Kit) in the event a resident is symptomatic.
• The first symptomatic resident in a facility should be tested with both a COVID-19 RAT and full respiratory panel PCR to establish the pathogen (or COVID-19, influenza, and RSV PCR as a minimum). Ensure the pathology order forms include the name of the RACF and the doctor's details.
• Ensure any symptomatic resident remains isolated until initial testing is complete, and a diagnosis is known. Subsequent symptomatic residents during a COVID-19 outbreak should be tested with a COVID-19 RAT.

o If the COVID-19 RAT is negative, the resident should have a respiratory panel PCR test.

o If the COVID-19 RAT is positive, the resident should be managed as a COVID-19 case.

• If a false positive RAT result is suspected, Buckland should consult with the resident's GP and the PHU.

• If no pathogen is detected for three or more symptomatic residents, Buckland should contact their PHU for advice. (Refer to Step 4)

Step 3: RISK ASSESS resident, staff, and visitor contacts.

• Trigger the outbreak management plan with the **first** resident who has tested positive for COVID-19, influenza or RSV while awaiting additional test results of other residents.
• Review contacts of the symptomatic resident for ARI symptoms. Isolate and test symptomatic resident s as per Step 1 and Step 2. For symptomatic staff, test (RAT), (Buckland can provide PCR service) furlough and direct to their GP.
• Establish a red zone, (As per step 6) review the measures that have been implemented and identify and address any gaps.
• Once the diagnosis is known, cases and contacts should be managed.
• If the diagnosis is COVID-19 and the source is unknown, all residents in the affected zone should be tested by RAT or PCR (depending on availability) to find cases, irrespective of whether they have symptoms. Generally, where an exposure is unknown or unclear, residents in the affected zone should be considered high risk.
• COVID-19 risk matrix (Appendix 2 please refer to the below) provides information to support assessment and management of contacts of a positive COVID-19 case for known or single exposures. This matrix should be used where there has been a known exposure, or when there is a single case with a known source. In outbreaks with multiple resident cases, the risk assessment can be discussed with the local PHU upon notification, as the management of contacts may differ.
• In assessing contacts of a positive influenza or RSV case, Buckland identifies all staff and residents in the affected zone and ensure they monitor for symptoms and limit movement in the facility.

Step 4: CASE AND CONTACT MANAGEMENT

Table 1 – Case and contact management for COVID-19, influenza, and other confirmed respiratory pathogens

			COVID-19	Influenza	Another confirmed respiratory pathogen including RSV
CASE	Resident	Case isolation	7 days from symptom onset, or test date if asymptomatic	5 days from symptom onset	While symptoms remain. There may be guidelines available for specific pathogens, available from the NSW control guidelines
		Release from isolation	After day 7 if substantial resolution of acute symptoms and no fever for 24 hours. No testing required†	After 5 days from symptom onset, or until they are symptom-free, whichever is longer, or 72 hours after antivirals commenced regardless of symptoms. No testing required	Once symptoms resolve. No testing required
		Antiviral treatment	COVID-19 antivirals (via treating clinician) See Antiviral guidance	Influenza antivirals (via treating clinician) See Antiviral guidance	Seek guidance from treating clinician
	Staff	Return to work	After day 7 if no symptoms for 24 hours, with no testing required. If symptoms continue, return when substantial resolution of acute respiratory symptoms and no fever for 24 hours*	After 5 days from symptom onset, or until they are symptom-free, whichever is longer or 72 hours after antivirals commenced. No testing required for return to work	Once symptoms resolve. No testing required
	Visitors	Visitors to facility	Can visit facility after day 7 if no symptoms. Visitors are strongly recommended to wear a mask between day 8 and 10. See Advice to RACFs for entry restrictions	After 5 days from symptom onset, or until they are symptom-free, whichever is longer, or 72 hours after antivirals commenced	Exclude if symptomatic
CONTACTS	Resident	Contact testing (initial round of testing)	All residents in the affected zones (likely wing). As per risk matrix at Appendix 2 if single/known exposure	Symptomatic residents in the same zone (likely wing)	Symptomatic residents in the same zone (likely wing)
		Contact isolation	See Appendix 2 risk matrix if single/known exposure	Residents in same zone(s) should avoid communal areas, group activities and moving between different zones	Nil
		Contact post-exposure prophylaxis (PEP)	Nil	Influenza antivirals can be considered in an outbreak See Antiviral guidance	Nil
	Staff	Return to work	See Appendix 2 risk matrix	Immediately if no symptoms. Must wear mask and other PPE when at work	Immediately if no symptoms.
	Visitors	Visitors to facility	Should not visit facility for at least 7 days after close contact with a COVID-19 case or if they are symptomatic. See Advice to RACFs on entry restrictions	If symptomatic, do not visit the facility until 5 days after symptom onset, or until symptom-free, whichever is longer, or 72 hours after antivirals commenced	If symptomatic, should not visit the facility.

• A resident who has tested positive for an ARI should isolate away from other residents. Cases can share a room with another case with the same pathogen. Residents with ARIs should receive ongoing daily care onsite (e.g.,
mobilisation, allied health services, time sensitive pathology tests, routine catheter changes and wound reviews etc).

• Essential off-site appointments also should continue (e.g., dialysis), with negotiation with the service provider if the resident has COVID-19 or influenza or has been exposed to COVID-19 or influenza. Buckland should ensure that residents and transport providers are provided with a mask and appropriate mask wearing advice if they leave Buckland.

• Residents' GPs will continue to provide their routine primary care as needed either onsite and/or virtually.

• Residents in the green zone can attend external appointments.

• Consider (depending on facility occupancy, the ability to relocate a resident who is on a palliative resident who are on a palliative care pathway and require additional supports to an area where they are less at risk of further exposure (or if they are a case, plan for how the resident could be supported with visits).
• Refer to pre assessment form regarding the antiviral medications with the treating GP. See Antiviral guidance. Staff returning to work following a RACF exposure to COVID-19 or influenza should not move between their section and other areas of the facility, in line with basic IPAC principles.
• During a confirmed influenza outbreak, staff who are unvaccinated are at higher risk of acquiring influenza, therefore they are recommended to work only if asymptomatic, wearing a mask, and taking appropriate antiviral prophylaxis, in keeping with the Buckland influenza outbreak policy. Any antiviral use by staff should be documented. Refer to the CDNA National Guidelines for the Prevention, Control and Public Health Management of Outbreaks of Acute Respiratory Infection (including COVID-19 and Influenza) in Residential Care Facilities for more detailed information on influenza prophylaxis and treatment.
• Buckland accommodation set up with single ensuite where more than one resident case is positive (with the same pathogen) With maintaining consumer dignity and choice residents are given the choice to self-isolate while the outbreak is active or to mix with people with similar exposures. Preference should be recorded on their care plan. Please refer to Resident choice around isolation. Residents will be informed that if they choose not to isolate during the Outbreak and risk assessment needs to conduct and that this increases their risk of contracting and transmitting of the infection.
• Where residents cannot be effectively isolated, more frequent testing may be required.

Step 5: NOTIFICATION AND REPORTING

• Buckland is able to discuss with the local PHU (1300 066 055) when one resident has tested positive for COVID-19, influenza, or RSV, if requiring clarification.
• Outbreak Coordinator will notify the Australian Government Department of Health of an OUTBREAK when 2 or more residents test positive to COVID-19, influenza, or RSV, within a 72-hour period.
• Where PCR test results are delayed and a COVID-19 RAT is negative, discuss with the local PHU when 2 or more residents have ARI symptoms in a 72-hour period.
• Notify the Australian Government Department of Health via the My Aged Care provider portal of positive COVID-19 cases. The Buckland will receive an email confirming the level of support available.
• Deputy Chair will notify other care facilities and hospitals where residents have had a high-risk exposure and have subsequently been transferred or require immediate transfer for care.
• Record and report details of each resident and staff who tests positive on a line list.
• preferred PHU line list commences and required information for all affected residents and staff, this includes vaccination status, symptom onset, test results and other identifying information.

Step 6: IMPLEMENT INFECTION PREVENTION AND CONTROL (IPAC) MEASURES

• Vaccination
o Review vaccination status (BESTmed Report and Leecare Report, Staff found in the Z Drive) (COVID-19 and influenza) of residents and staff (e.g., as part of contact reporting).
o Consider supporting vaccination for those who have not received a seasonal influenza vaccine or are not up to date with recommended COVID-19 vaccinations.
• Cohort, zone and relocate to Identify the areas of the facility that are at risk. Where the whole of Buckland is impacted action should be taken. Where only a wing or floor of the Buckland is impacted only that area should be managed as an outbreak site. Identify crossover areas at risk of transmission, such as shared lifts.
o Apply the risk assessment outcomes and test results to confirm areas in the facility that:
▪ are staff only e.g., nurses' station, medication room, kitchen, reception area (Blue zone)
▪ are likely to be completely unaffected and can be staffed with non-exposed staff and managed separately (green zone)

▪ have been affected due to exposures (Blue zone) or
▪ cases (red zone)
o Set up donning/doffing areas as per outbreak management plan. o Allocate staff to colour zone for the duration of the outbreak.
o Cohort staff to work in only one part of the facility.
• PPE
o P2/N95 respirator (mask) and eye protection (Sheild or Goggles) to be worn by staff when caring for residents with ARI symptoms until diagnosis.
o Surgical mask and eye protection to be worn by staff caring for residents with confirmed influenza, RSV, and all other respiratory infections except COVID-19 (P2/N95).
o P2/N95 respirator (mask), eye protection, (gown and gloves as per standard precautions) to be worn by staff caring for residents with confirmed COVID-19.
o Where possible and where able, residents who are isolating should wear a surgical mask particularly when staff members or visitors are in their room.
• Environmental cleaning and disinfection
o Trained staff are allocated for cleaning of affected areas – ensure they are skilled to perform routine, additional, and terminal cleaning.
o Schedule daily cleaning in line with Environmental cleaning and disinfection principles for COVID-19. This cleaning practice is also applicable to RSV, and influenza.
• Refer to COVID-19 Infection Prevention and Control Manual for more information.

Step 7: COMMUNICATE

• Ensure all affected residents are aware of their diagnosis, exposure status, testing and isolation requirements. Individual communication strategies need to be considered for residents who may have difficulty following instructions due to cognitive impairment or language barriers.
• Ensure the residents' family and carers are aware of the exposure/outbreak at Buckland. Ensure family and carers are informed of the status of individual residents with resident's/guardian's consent, including their diagnosis and management. Maintain confidentiality of the identity of any residents who have tested positive as far as possible.
• Ensure staff are aware of the exposure/outbreak at Buckland and remain on high alert monitoring themselves and residents for ARI symptoms. Staff have received training and education to know the steps to take if they or other residents develop symptoms.
• Ensure visitors are aware of the exposure/outbreak at Buckland. Visitors are permitted to continue to visit affected residents, including those residents to be high risk and in designated red zones. Visitors should comply with Buckland entry requirements, as outlined in the Advice to residential aged care facilities (RACFs).
• Notices will be placed regarding the outbreak at all entrances of the facility including any info to minimise the outbreak and unnecessary visits that may lead to inadvertent transmission. Signage should also be displayed outside the room of affected residents on any PPE requirements or other precautions.

Step 8: ACTIVATE OUTBREAK MANAGEMENT PLAN (OMP)

• See Outbreak management planning in aged care for information on how to develop an OMP.
• Buckland would activate their RACF OMP on identification of the first resident who has tested positive for COVID-19, influenza, or RSV while awaiting additional test results of other residents.
• An outbreak should be declared if 2 or more residents test positive within a 72-hour period for:
o COVID-19 OR
o Influenza OR
o RSV
• Once an outbreak has been declared, Buckland will convene a meeting of the internal outbreak management team (OMT) and confirm the:

o Outbreak Coordinator and Infection Prevention Leaders
• Buckland, LHD and/or Australian Government Department of Health representative
will determine if an interagency OMT is required.
The local PHU can be consulted if advice is required.

Step 9: DECLARING AN OUTBREAK OVER

A decision to declare the outbreak over should be made by the internal OMT, in consultation with the PHU. This should be when at least 7 days have passed since the last date of identified transmission. Outbreak closure should not occur if there are pending PCR test results for contacts or symptomatic residents. Where there is extensive or poorly understood transmission, or where there are a significant number of residents non- or under vaccinated, the PHU may advise Buckland to undertake additional testing or measures in the 7 days following an outbreak being declared "over".
• After the outbreak closure, Buckland should remain on high alert and:
o test anyone with new symptoms of carefully monitor residents with high-risk exposure for atypical symptoms such as behavioural changes, lack of appetite/ lethargy, out of range vitals and increase falls and test for COVID-19,
o Ensure visitors are aware that there has been a recent outbreak.
• Individual cases should remain in isolation for the required period (as per Step 4) even if the outbreak has been declared over.
• Once an outbreak is over, Buckland should evaluate the response and management of the outbreak to identify strengths and areas for improvement. Buckland will conduct a facility debrief with all employees and contractors involved.

The OMT may make decisions about ongoing Buckland surveillance after declaring the outbreak over, consider the following needs:

- Maintain general infection control measures.
- Monitor the status of ill residents, communicating with public health authority if their status changes.
- To notify any late, illness related deaths to the PHU
- To alert the PHU to any new cases, signalling either re-introduction of infection or previously undetected on-going transmission.
- To advise relevant state/territory/national agencies of the outbreak in Buckland if applicable.

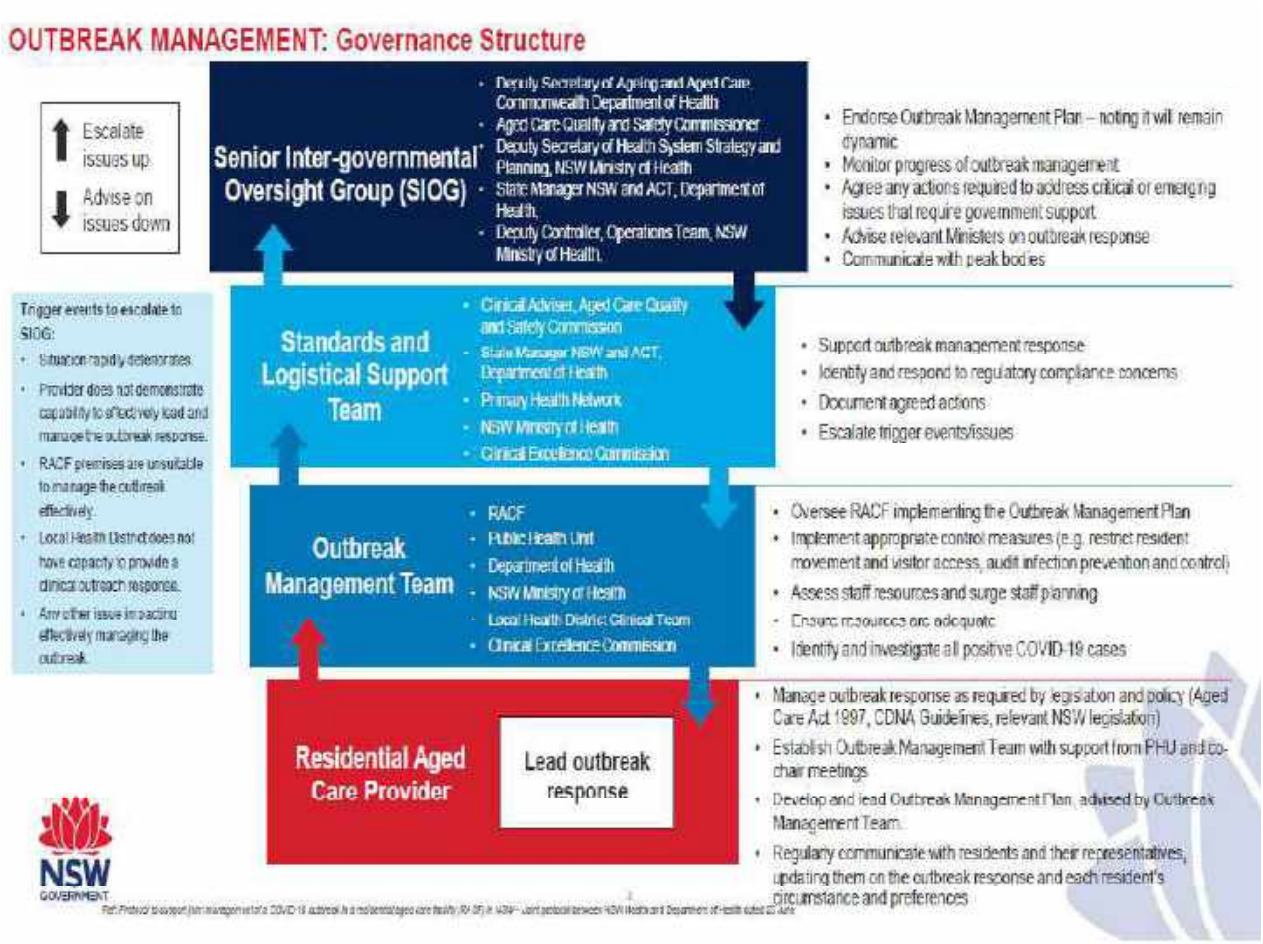
Governance

Trigger events requiring escalation to the senior inter-governmental group:

It is expected with support from the PHU will lead the outbreak response, with support and advise from other parties including the commonwealth government, ASQSC, NSW Government local public health unit (PHU), local health districts, NSW ministry of health public health emergency operations health centre (PHEOC).

The following issues are triggers that would require decision making by the Senior Inter-governmental Oversight Group (described below):

- Rapid deterioration of the situation
- Buckland does not demonstrate capability to effectively lead and manage the outbreak response.
- The aged care centre premises are unsuitable to manage the outbreak effectively.
- The Local Heath District does not have capacity to provide a clinical outreach response.
- Any other issue impacting on the effective management of the outbreak.



2. Responsibilities of Roles

Each role is responsible to action and delegate specific tasks if required. Due to the uncertainty of staff being furloughed by the Nepean Blue Mountains Public Health Unit in the event of an outbreak, no specific names will be assigned to each individual role. Staff may adopt more than one role depending on availability of human resources. The delegation of roles will be carried out by the Chief Executive Officer.

2.1 Chairperson

- Notify all stakeholders.
- Accept and communicate government support as required. (Government support is only available if the Residential Aged Care Facility is deemed to be in an outbreak).
- Issue blanket authorisation for overtime without preapproval. (Payroll Officer and Finance Manager to be notified via email)
- Alert IT to prioritise all requests from facility via email [redacted].
- As needed website updates to be posted and text message sent out to stakeholders.
- As needed updates to residents and staff and text message to be sent to staff.
- Media communication and statements.

- Notify Employee assistance program info@riverlandstherapyservices.com.au
- Liaise with the board of directors.
- Line Listing must be provided to the PHU, an updated copy daily or as instructed.

2.3 Deputy Chair

- Contact Nepean Blue Mountains Public Health Unit via nbmlhd-racfomt@health.nsw.gov.au to advise of positive cases then await risk assessment from PHU.
- Advise Nepean Blue Mountains Virtual Aged Care team (VACS) of positive cases to commence positive residents to be under VACS team care. Contact via email - [redacted] & [redacted]
- Gather Buckland outbreak management team and assign roles.
- Communication with family members with special requirements.
- Gather data and chair Outbreak Management team (OMT) meetings with PHU, Department of health, Aged Care Quality and Safety Commission and Nepean Blue Mountains Virtual Aged Care team (VACS)
- Action any tasks or recommendations discussed in OMT.
- Post OMT – provide update to internal key personnel and delegate tasks if required.
- Assume all responsibilities of Chairperson as required.
- Line Listing must be provided to the PHU, an updated copy daily or as instructed.

2.4 Outbreak Coordinator

- Review positive residents Advanced Care Directive s and action any identified anomalies. -
- Review positive residents progress notes and vital observations.
- Assist with testing and liaising with the RN, CM, CL (RAT & PCR) for staff and residents and testing regime per risk assessment. (Please refer to the attached Risk Assessment Template)
- Follow up pathology results.
- Liaise with the Registered Nurse, Care Manager, Clinical Lead and Communicate with GP's and pharmacies.
- Liaise with the IPC & RN, to notify the GP of positive cases and ask GP for antiviral to be commenced. (Must check Antiviral Consent form).
- Review emergency stock medication and ensure optimal levels.

- Maintain a list of residents and NOK attending compassionate visits and advise internal key personnel accordingly.
- Maintain line listing of positive residents and staff. -Care Managers

2.5 Care Manager

- Action all tasks as directed by Outbreak coordinator.
- Assume all responsibilities in the absence of outbreak coordinator.
- Review positive residents progress notes and vital observations and address any out-of-range vital observations.
- Conduct spot checks with staff PPE compliance and provide education on the spot if required.
- Check and top up PPE supplies where applicable
- Assist with testing (RAT & PCR) for staff and residents and testing regime.
- Follow up pathology results.
- Ensure staff are aware of strategies in place for positive residents and unvaccinated residents – such strategies as per template.
- Allocate passwords for clinical management systems.

2.6 IPC Lead

- Conduct Spot check on staff PPE compliance and provide training (Please refer to the attached)
- Place droplet, contact and airborne precaution signage and donning and doffing throughout the building.
- Set up PPE station and droplet, contact and airborne precaution signs on affected resident room(s).
- Placing PPE waste bins inside affected resident room(s) and PPE stations.
- Enforce existing screening protocols.
- Reinforce standard precautions via face-to-face education prioritising the infected wings and via internal messaging system.
- Daily random infection control/ donning and doffing spot checks and provide education on the spot. Staff to sign education sheet.
- Check and top up PPE supplies where applicable
- Assist with testing (RAT & PCR) for staff/residents and testing regime as per risk assessment completed by PHU.
- Induction of agency staff daily, surge workforce and volunteer staff. Liaise with Educator, Clinical Lead and Care Manager.
- Ensure staff are aware of strategies in place for positive residents and unvaccinated residents.
- Conduct spot checks with staff PPE compliance and provide education on the spot if required.
- Check and top up PPE supplies where applicable and commence Burn Rate Calculator.
- Line Listing must be provided to the PHU, an updated copy daily or as instructed.

2.7 Hospitality Service Coordinator

- Ensure that twice daily full, environmental surface clean (Actichlor 2 step clean) is being conducted with rapid disinfectant and Clinell Wipes.
- Allocate designated staff members to attend to positive residents' room cleaning – these staff members should not attend to unvaccinated residents' rooms.
- Ensure Cleaning staff are attending to positive residents' room post cleaning all the other rooms. Wiping down laundry Racks, Burlodge Trolley and Bins.
- Ensure GSO support is following infection control precautions.
- Responsible for Burlodge trolley redirection if required.
- Review current active GSO roster and cohort staff as much as possible.

2.8 Facilities Maintenance

- Barricade infected wing with manual barrier.
- Increase waste pick up (both clinical and general) Cleanaway.
- Assist as needed with transport of PPE stocktake.
- Supply PPE as per IPC lead/outbreak co-ordinator request
- Any other duties as directed by key personnel.

2.9 Communication Officers

- Obtain daily status through outbreak team meeting every morning.
- Refer all NOK with special requests to Deputy Chair.
- Order stock as required.
- Upload website updates, staff updates and print resident updates

2.10 Lifestyle Team/ Chaplain

- Allocate a designated member of the Diversional Therapy team to the infected wing.
- Facilitate skype, zoom, phone and WhatsApp calls.
- Assist residents with online orders.
- Refer to chaplain as needed.
- Produce and distribute activity booklet.
- Distribute resident updates.
- Distribute deliveries (newspaper, mail etc.)
- Provide emotional support one on one.
- Update on residents' emotional status

2.11 Admin Assistant

- Ensure condition of entry is adhered to (conditions of entry – vaccination evidence, mask wearing, signing in and completing health questionnaire, negative Rapid test).

- Addressing queries at main entrance.

2.12 Registered Nurse

- Daily contact with family members of confirmed positive cases and advise of any changes in addition to daily contact.

2.13 OMT

- Direct and oversee the management team of the Outbreak.
- Liaise with GP's, Department of Health, PHU, Stakeholders
- Regularly communicate with residents' representatives and updating them on the outbreak response including each residents' circumstances and preferences.
- Oversee the implementation of Infection Prevention and control measures as per OMP.
- Manage staff including Rostering and Isolation measures for staff.
- Engage surge workforce where critical staff are available to be sourced through over avenues if required.
- Monitor residents' welfare and wellbeing regularly communicate if residents and their represent.
- Facilitate testing/ pathology request orders and timely specimen collection.
- Liaise with GP's and Allied Health to ensure approach to acute and chronic disease is addressed and deconditioning, grief, cognitive decline and psychiatric sequelae of isolation and loss is addressed.
- Enable access and respond to Aged Care advocates and provide residents and their representatives communication, collateral and materials provided by the advocacy services.

4. Service Provider Details

Service Providers	Name	Phone Numbers and Email Addresses
VACS Team	[redacted]	
Speech Pathologist		
Dietician		
Nurse Practitioners		
PHU		
DOH Details		
Podiatrist		

5. Hospital Contact Details

Hospitals	Address	Telephone	Fax
Blue Mountains Hospital	Cnr Gt Western Hway & Woodlands Rd, Katoomba 2780	4784 6500	4784 6980
Hawkesbury Hospital	2 Day St, Windsor NSW 2756	4560 5555	4560 5563
Nepean Hospital	Derby Street, Kingswood 2747	4734 2000	
Nepean Private Hospital	1-9 Barber Ave, Kingswood 2747	4732 7333	4721 8895
Springwood Hospital	7 Huntley Grange Road, Springwood 2777	4751 0300	4751 0388
St John of God Hospital	177 Grose Vale Road, North Richmond 2754	4570 6100	4571 1552

OMT Meetings

Required Meetings

- Local OMT – Daily, 3 x a week (Monday, Wednesday, Friday).

Optional Meetings

- Cleaning (GSO, Laundry, Catering)
- 9@9
- 10@10
- Virtual Monitoring Meeting, if needed. (Zoom)

6. Line Listing

A line is a table that contains key information about each case in an outbreak, with each row representing a case and each column representing a variable such as demographic, clinical and epidemiologic information.

- Commence and continue Line Listing (on Z Drive) and confirmed cases of residents and staff.
- Maintain accurate Line Listing (PHU Template)
- PHU must be provided an updated copy daily or as instructed.
- Inform PHU of any deaths within 24hrs during an Outbreak.
- The Line Listing indicated the following:
    - Resident Room and Wing Location
    - Date/time Symptoms commenced.
    - Current location, Surveillance Testing & Results
- Any resident hospitalised during Outbreak.
- If any deaths occur related to the outbreak the department must be notified as soon as possible.

7. Infection Prevention & Control (IPC) Precautions

- Routine IPC measures to be in place at all times. Include: -
- Hand hygiene. Soap and H2O or alcohol base hand rub.
- Cough Etiquette and Respiratory Hygiene for staff, residents, and visitors.
- Staff to stay home if not well. If flu like symptoms attend to RAT and viral PCR prior to returning to work – also ensure symptom free before returning.

- Health Promotion and Signage and alerts around Facility – In newsletters, discuss in residents/relative meetings on website and at entries to the Facility.
- Staff maintain physical distancing in nurses' station, lunchrooms.

8. Infection Prevention Control

Standard Precautions: -

Standard precautions are IPC practices used routinely in residential aged care and healthcare. They will be used with a suspected or proven ARI Outbreak and apply to all staff and all residents.

- Hand Hygiene – 5 Moments of Hand Hygiene. Before and after each episode of resident contact and after contact with potentially contaminated surfaces or objects.
- Gloves: - Not a substitute for hand hygiene before putting on gloves and after removing gloves.
- Use of PPE: If exposure to body fluids or heavily contaminated surfaces is anticipated (Gown, Mask, Protective eye wear/Shields and Gloves.
- Cough etiquette and Respiratory Hygiene
- Cough into a tissue (and discard the tissue immediately) or into the end of the elbow, perform hand hygiene.
- Regular cleaning and disinfection of the environment.
- Provision of alcohol-based hand sanitiser at the entrance. The facility and other strategic locations.
- Ensure tissues and bins are available throughout the facility.
- Ensure staff are bare below the elbows.
- Staff wear clean uniform daily.
- Maintain physical distancing where able.

5 Moments of Hand Hygiene - https://cdn.who.int/media/docs/default-source/integrated-health-services-(ihs)/infection-prevention-and-control/your-5-moments-for-hand-hygiene-poster.pdf?sfvrsn=83e2fb0e_21

9. Key Principles

- Continuation of service delivery in line with our mission, vision, and values.
- Deliver all necessary clinical, medical, lifestyle, therapy, and support services to our residents to prevent loss of life or suffering. This will be our main objective in the event of any outbreak. This includes, but is not limited to, the provision of aged care nursing, acute nursing, palliative care nursing, specialist infectious disease and geriatric medical support and GP services.
- Prevent the spread of infection within the facility and beyond. This will include the implementation of appropriate protective measures for staff, residents, and visitors to include PPE use, preventative environmental control measures, decontamination measures, as well as physical access and movements control into and around the facility.
- A monthly audit is completed based and guided by the infection control checklist (Please refer to the attached) provided by the Aged Care Quality and Safety Commission. The said audit is completed by Buckland's IPC lead.
- Engage, liaise, and inform stakeholders of the situation at the facility as appropriate to reduce uncertainty and concern for staff, residents, and their families, to ensure situational awareness for the appropriate authorities and, as necessary, the media.
- Facilitate and enable the wishes of the families and residents, wherever possible within the constraints of the infection control measures, including contact visits, palliative care visits and the facilitation of the consulting processes regarding the return to family for care of uninfected residents if desired.
- Sustain logistically the outbreak response through appropriate inventory management and robust supply network coordination for protective and cleaning consumables, as a priority, as well as normal hospitality services consumables.
- Sustain the wellbeing of staff and residents through the employee assistance program, including religious and pastoral care provision.
- Protect the residents, staff, and the business by ensuring compliance with all regulatory and quality of care policies appropriate to Buckland.
- Protect the staff and Buckland throughout the outbreak response by ensuring clinical and legal oversight of all on facility decisions.
- Adhering to these principles will enable us to control the infection of those infected and affected by the Outbreak.

10. Transmission based precautions

These IPC practices used in addition to standard precautions, to reduce transmission due to the specific route of transmission of a pathogen.

Respiratory Infections, including COVID19 are most commonly spread by contact and droplets. Airborne spread may occur during aerosol generating procedures.

Contact and Droplet Precautions

These precautions apply to:

- All healthcare workers staff during the clinical consultation and physical examination of residents with suspected or confirmed COVID-19, or who are in quarantine.
- All Staff when in contact with ill residents:

Key elements are:

- Standard precautions
- Use of PPE – Mask, Protective eyewear, and gloves when in contact with and ill resident.

Staff including (Surge Staff) working in suspected or confirmed case of ARI, COVID19 will receive daily reminders regarding donning and doffing by the IPC lead, management team and RNs.

- Enhanced cleaning and disinfection of ill residents' environment.

- Isolation of ill residents.
- Limit number of people entering the ill resident's environments.
- Nebulisers to be avoided. Spacer and Puffers to be used instead.

Airborne Precautions

- Apply to residents known or suspected to be infected with microorganism transmitted by Airbourne droplet nuclei.
- These agents may be inhaled by individuals who have not had face to face contact with or have been in the same room as the infectious individual.

Airbourne droplet Nuclei can also be generated through aerosol generating procedures such as nebulisers.

The use of particulate filter respirators such as P2 or N95 masks, prevents inhalation of small particles that may contain infectious agents transmitted through the Airbourne route.

The wearing of correctly fitted surgical masks by coughing residents may also assist to prevent disposal of respiratory secretions in the air.

The Key elements of applying airborne precautions are:

- Use of appropriate PPE, particularly correctly fitted masks (P2, N95)
- Minimise resident movement.

(Please refer to the below infection Prevention and Control Expert Group – Cleaning and disinfection of health and residential care facilities for further information).

https://www.health.gov.au/sites/default/files/2022-12/coronavirus-covid-19-environmental-cleaning-and-disinfection-principles-for-health-and-residential-care-facilities.pdf

Increase PPE requirements where there is significant community transmission – Liaise with PH and NSW Health update and advise to Residential Aged Care Facilities (RACFS) – NSW. Respiratory surveillance report.

11. Maintain stock of Antiviral treatments

1. *Influenza – (Tamiflu Oseltamivir) – We check supply in annually in March and replenish supply for Tamiflu in prepare of an outbreak. Additional stock can be ordered through the PHU in an event of an outbreak.*
2. *COVID-19 - (Molnupriavir Lagevrio) – The administration of antiviral treatment will commence as soon as possible after symptoms onset or diagnosed. This will reduce the risk of severe disease and can prevent hospitalisation and death. (Anti-Virals are restocked via Priceline Pharmacy).*

- Stock supply of antivirals are kept in the nurse's station.
- Stock supply is checked weekly by Care Manager – special note to be used by date.

Priceline pharmacy Springwood – (4751 1101) can be contacted at any time for urgent supply.

- Admission pack holds the consent for Antiviral use for each resident in the event of need. This is to be completed and uploaded into Leecare for each resident and uploaded in the document section). (A copy is also kept on the Z Drive).

For eligibility for antivirals

- Residents will be reassessed for antiviral medication to support timely testing and access.

Pre- Assessment action Plan for respiratory infection in Aged Care Facility residents.
(Found in the admission Pack)

For the best protection against severe COVID-19 and Influenza we strongly encourage residents are up to date with all vaccinations. (Refer to ATAGI). All adults over the age of 75 and older receive an additional 2023 COVID-19 vaccine dose if 6 months has passed since their last dose.

12. Stock Control of PPE:

- Maintain Stock Control Register (IPC Lead) on Z Drive – to be attended. Weekly on a Monday.
  Including:
  Shields
  Goggles
  Hand Sanitizer
  Actichlor
  Garbage Bags
  Masks – Surgical and N95
  Isolation Gowns

Donning and Doffing Sequence

Sequence of Donning PPE

1. **Perform hand hygiene**
2. **Put on gown/apron**
3. **Put on mask**
4. **Put on eye protection**
5. **Perform hand hygiene**
6. **Put on gloves**

Sequence of Doffing PPE

1.	**Remove gloves**	**OR**	**Remove gown and gloves in one step**
2.	**Perform hand hygiene**		
3.	**Remove gown**		**Perform hand hygiene**
4.	**Perform hand hygiene**		**Remove eye protection**
5.	**Remove eye protection**		**Remove mask**
6.	**Remove mask**		**Perform hand hygiene**
7.	**Perform hand hygiene**		

Isolation room/Zone Checklist

Consider the following when setting up an isolation/quarantine room/zone as per site map.

- Dedicated PPE outside of zone, consider how to store this for easy access (using bigger tables) such as dining table when not in use.
- Use spotters checklist to ensure appropriate donning and doffing and safe practices.
- Signage appropriate for the room/zone
- Equipment to be kept to a minimum including soft furnishings
- External entry for deliveries
- Isolated Medication trolley/resident equipment
- Cleaning products in place to accommodate shared equipment
- Adequate handwashing facilities
- Set up staff break up areas.
- Dedicated equipment to avoid sharing.

13. Buckland Spotters Checklist

Donning, Doffing: Spotters Checklist

Instructions

The role of spotter may include:

- Monitoring and documenting in the log all staff and visitor entry and exit from an infected patient's room.
- Checking of donning and doffing of personal protective equipment (PPE)
- Ensuring transmission-based precautions (TBP) are adhered too.
- Alerting staff to breaches in infection control procedure and providing assistance.

	PPE Checklist	✓
	Bare Below the elbows	
1. Mask	**Masks warn correctly,** covering nose and mouth and fit check achieved	
2. Goggles/Shield	**Goggles/Shield,** worn correctly covering eyes	

Ordering of Donning	Donning Checklist	✓
	Bare below elbows	
3. Hand Hygiene	**Hand** Hygiene attended	
4. Gown	**Don** gown and ensure it is tied and covers the staff members back if able	
5. Hand Hygiene	**Hand** Hygiene attended	
6. Gloves	**Don** gloves	
	Enter room	
	Attend to patient needs	

Ordering of Doffing	Doffing Checklist	✓
	Inside the resident's room (if available)	
1. Gloves	**Doff** gloves	
2. Hand Hygiene	**Hand** Hygiene attended	
3. Gown	**Doff** Gown	
4. Hand Hygiene	**Hand** Hygiene attended	
5. Exit Room	**Exit Room**	
6. Hand Hygiene	**Hand Hygiene**	

On exiting Residents Room	
Clean any equipment removed from patients' room	
Breach Examples	
• Missed Hand Hygiene • Not wearing necessary PPE, incorrect order of donning and doffing • WOW's taken into rooms or doorway of rooms, not cleaning equipment e.g., stethoscope, BGL machine	

14. Hospital Transfers

- Where possible, staff will refer any resident who identifies as a deteriorating resident to their GP, RACS Teams prior to ambulance transfer. In the event of emergency, ensure the 000 is notified that the facility is in an Outbreak and the status of the resident being transferred.
    - Ensure Leecare transfer documents are provided in transferred to hospital with letter advising status i.e., ARI, COVID-19, etc.
- Discuss all transfers i.e., NOK, GP, and VACS Team.
- Any resident that is suspected or confirmed COVID-19, must wear a mask on transfer through the facility.

Admissions

Admissions of a new residents to an affected wing during an outbreak should be made in consultation with the new residents and their representative. New residents and their families must be informed about the current outbreak and the controlled measures in places. Families wish to make alternative arrangements until the outbreak is declared over or continue with risk identified.

Re-admission

Residents who are hospitalised for the infection can ne re-admitted.

- All readmissions and transfers must be medically assessed for symptoms. Negative covid swab should also be requested where possible can continue transmission is high risk.
- Resident is to be monitored for signs and symptoms of infection as per the template including RAT test for 3 days. Post hospitalizations.
- Resident may need to be isolated on admission/readmission where risk exists taking to account residents choice.

Deceased residents

- when handling the bodies of deceased persons, or when undertaking a post-mortem examination, standard precautions are required at all times.
- Depending on the known or suspected infection status of the body, transmission- based precautions are also required and should be maintained until the body has been completely enclosed and ready for transport.
- Avoid unnecessary manipulation of the body, is there is a risk of continued transmission.
- Discuss with family re the safe handling and moving of resident's belongings to minimise infection transmission to the community.

Specimen Collection

Collecting specimen is the process of acquiring tissue of fluids for laboratory analysis. Some of the samples collected may include polymerase chain reaction (PCR) panels, Rapid Antigen tests (RAT) and stool samples etc.

https://www.health.gov.au/sites/default/files/documents/2020/06/phln-guidance-covid-19-swab-collection-upper-respiratory-specimen.pdf

15. Vaccinations

Review latest requirements regarding vaccination for

- Residents
- Staff
- Visitors

Promote COVID-19 and Influenza Vaccination

- Staff Include
- Residents Include

Monitor and record vaccinations status of

- Residents
- Staff
- Visitors

Unvaccinated residents

- Minimise exposure, monitor closely,
- Maintain list of unvaccinated residents
- Routine RATs if compliant and consent
- Risk Assessment for refusal of vaccination – Dignity of risk
- All residents who have not received vaccination will be identified in residents vital information and utilise in the handover process.

16. ATAGI

LATEST ADVICE/RECOMMENDATIONS FOR COVID BOOSTER IMMUNISATION DOSE

ATAGI 2023 COVID-19 Booster Advice – first and additional dose*

	2023 COVID-19 booster dose (February 2023 guidance)		Additional 2023 COVID-19 booster dose (September 2023 guidance)	
Age	**At risk#**	**No risk factors**	**At risk#**	**No risk factors**
<5 years	Not recommended	Not recommended	Not recommended	Not recommended
5-17 years	Consider	Not recommended	Not recommended	Not recommended

18-64 years	Recommended	Consider	Consider **if severe immunocompromise**^	Not recommended
65-74 years	Recommended	Recommended	Consider	Consider
≥ 75 years	Recommended	Recommended	Recommended	Recommended

- *mRNA bivalent vaccine preferred; for ages in which a bivalent vaccine is not approved, use a vaccine approved for that age group. Timing: 2023 vaccine doses should be given from 6 months after a person's last dose.
- #Includes those with a medical condition that increases the risk of severe COVID-19 illness (refer to ATAGI clinical guidance) or those with disability with significant or complex health needs or multiple comorbidities which increase the risk of poor outcomes from COVID-19.
- ^ For details, refer to the ATAGI recommendations on the use of a third primary dose of COVID-19 vaccine in individuals who are severely immunocompromised.

ATAGI **recommends** that all adults aged ≥ 75 years **should receive** an additional 2023 COVID-19 vaccine dose if 6 months have passed since their last dose.

People with a past SARS-CoV-2 infection

All people are recommended to defer COVID-19 vaccination for 6 months after a confirmed SARS-CoV-2 infection. ATAGI notes that testing rates have decreased since their peak in December 2021, and there are likely to have been many people with undetected SARS-CoV-2 infection in late 2022 and early 2023. There are no safety concerns for individuals receiving a COVID-19 vaccine who may have had undetected SARS-CoV-2 infection within the past 6 months.

https://www.health.gov.au/our-work/covid-19-vaccines/advice-for-providers/clinical-guidance/clinical-recommendations.

Residential aged and disability care.

Aged care and disability residents can receive a booster dose, from 6 months after a previous dose or 6 months after a confirmed COVID-19 infection.

17. Workforce Management

The number of health care workers available to provide care may be reduced by up to 1/3 because of isolation requirements, personal illness, concerns about transmission in the workplace and family/caregiving responsibilities.

Strategies

Continue with wellness screening of all staff with staff members self-monitoring for signs and symptoms of Acute Respiratory Illness and self-exclude from work if unwell.

Requests to be made with CEO to source additional staff and to implement staffing contingency or surge workforce as required (including staff contact list, external Nursing Agencies, Contract Cleaning etc).

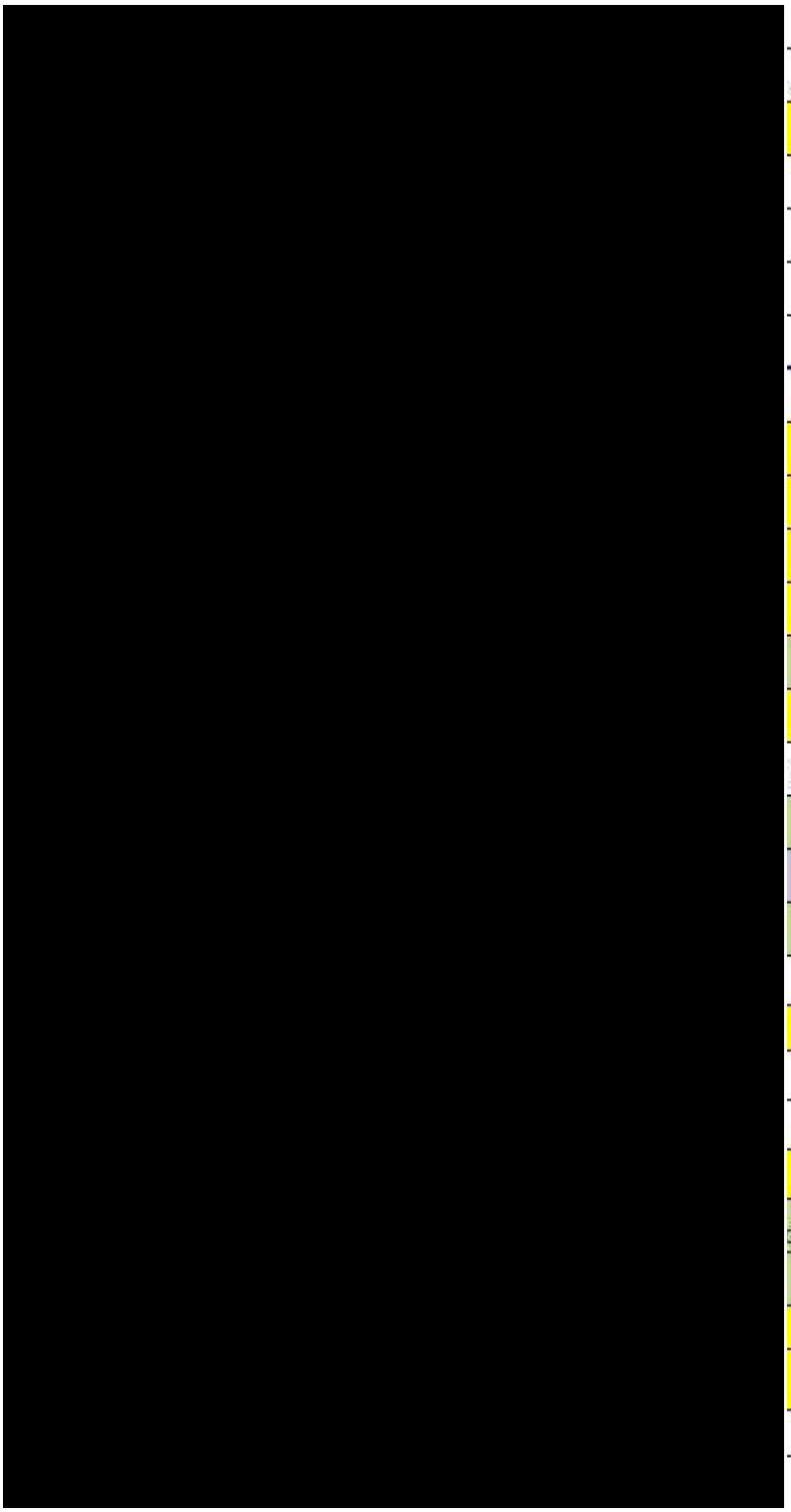
- Sanctuary Recruitment (02 8459 8101)
- Redstone Recruitment (02 9138 1002)
- DOH (Surge)

- Blue Mountains Food Service (02) 4759 2811

Assign designated staff caring for residents with ARI – Roster to be maintained. Where possible, staff members must not move between their allocated section/wings of the facility. (Care, Hospitality, Lifestyle, Allied Health).

(Refer to the below Staff Contact List located in each wing, this list will include all staff and roles, please refer to same in event of contingency e.g. staff are able to do dual roles)

GSO & Maintenance Staff	Updated 06/10/2023		
Staff Name	Home	Mobile	Postion
[redacted]			Kitchen/Laundry
			Cleaning
			BRV Maintenance
			Laundry + Cleaning
			Kitchen
			Kitchen
			Maintanence Officer - BRV
			GSO-Kitchen + G Shift
			Maintenance Officer-BRV
			Laundry
			Cleaning
			Kitchen
			GSO Cleaning & Kitchen
			Maintenance Officer-NH
			Kitchen
			Kitchen
			Kitchen (G Shift)
			BRV Maintenance
			Cleaning & Kicthen & GSO Support
			Cleaning & Kitchen & Laundry
			Laundry
			GSO Support
			Kitchen (G Shift)
			Kitchen
			NH Maintenance Officer/RTW
			Maintanence Officer



GSO Cleaning
Maintanence Officer - BRV
Cleaning
GSO- Kitchen
HSC
MAINTENANCE
Maintanence Officer /Gardener
Kitchen
Cleaning
G4 Kitchen
GSO Support
Cleaning
Kitchen A5 Shift
Cleaning
Maintanence Officer - BRV
Kitchen (G Shift)
Kitchen / Laundry
Kitchen (G Shift)
Kitchen
Cleaning
Cleaning/Laundry
GSO Kitchen
GSO Cleaning
GSO Support/Kitchen/ G Shif
Kitchen (G Shift)
Kitchen &Cleaning
GSO Cleaning
Gardening/Maintenace
Cleaning

Increase staff where possible in the event of staff in contingency requirements to do 12-hour shifts. Liaise with care manager and roster manager.

In the event of requiring OMT contingency, ie OMT or furlough will liaise with local aged care facility and local PHN.

Considerations for choosing dedicated Staff.

- Ensure staff have recently completed 1 training.
- Ensure staff have current Influenza & Covid Vaccination.

Advocate for employees to remain part of the roster arrangements for each shift to allow.

Education/Training:

Staff are to remain up to date with infection control education/training and competencies.

1. Infection Control – All Staff
2. Hand Hygiene – All Staff
3. Outbreak Management – All Staff
4. Initiating the OMP – RN's/ Manager
5. Donning and Doffing - – All Staff
6. Cleaners
7. Laundry
8. Kitchen
9. Mask Wearing and Fit Check Training

Training/ Education includes.

- Face to face
- Spot Checks
- Competency based Assessment.
- Toolbox talks
- AUSmed education platform
- Part of performance appraisal
- Induction

(On Z Drive Education Folder)

Compliance with the above is monitored by the Human Resource Department Annually

Outbreak Management Kits

- These are located at each wing and x1 in the clinical lead's office. (Northwing, Southwing, Liz Roberts Wing, Donald Coburn Wing, Clinical Lead Office).
- Kits are checked weekly on a Monday (with the PPE Stocktake) OMP, ARI (COVID-19), Notices, Signage, Sanitizer, PCR-Swabs, 1 Box RAT tests and Gastro Handbook Outbreak.

19. Knowing the Symptoms

• ARI is defined in this document encompass a range of infections caused by respiratory viruses, including COVID19, influenza, and respiratory syncytial virus (RSV).

• ARI transmission is primarily via droplet and aerosol spread when infected individuals cough, sneeze, talk or shout.

• Many ARIs can be spread before symptoms appear in an infected person, meaning facilities must have systems for the clinical assessment of residents, and response systems at the first sign of symptoms to contain any potential further spread.

• Symptoms of ARIs are often similar regardless of the virus causing illness and therefore testing residents with symptoms is essential to diagnose an index case.

• Outbreaks in RACFs can be caused by the spread of more than one respiratory virus. A resident may be infected with more than one respiratory virus at once. This may require use of more than one management pathway as outlined below.

• ARI definition: Recent onset of new or worsening acute respiratory symptoms: cough, breathing difficulty, sore throat, or runny nose/nasal congestion with or without other symptoms (see box below).

Other symptoms:

• Headache, muscle aches (myalgia), fatigue, nausea or vomiting and diarrhoea. Loss of smell, taste and appetite can also occur with COVID-19 but may be less common with new variants of the disease.

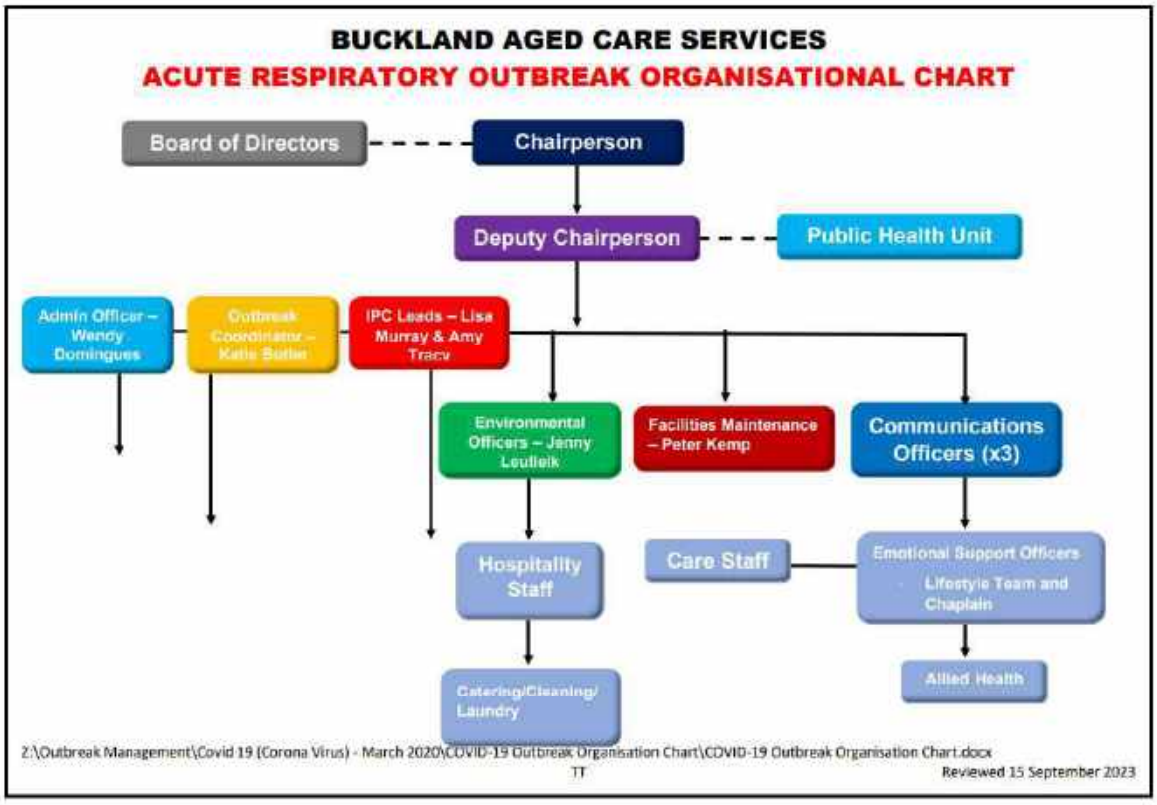
• Fever (≥37.5°C) can occur, however is less common in elderly individuals

• In the elderly, other symptoms to consider are new onset or increase in confusion, change in baseline behaviour, falling, or exacerbation of underlying chronic illness (e.g., increasing shortness of breath in someone with congestive heart failure).

Residents with non-respiratory symptoms should be assessed for appropriateness of testing for respiratory pathogens, especially if there are already ARI cases in the facility.

• Respiratory viral infections can vary from no symptoms to severe disease and death. **Antiviral treatments** are available for COVID-19 and influenza and therefore early recognition, testing and diagnosis are important for individual patient management as well as for preventing spread to others.

• The RACF should ensure staff, family and residents are aware of these symptoms and the need to report them. Note that residents may experience mild symptoms, particularly in a vaccinated population. Residents may have atypical symptoms including behaviour change and may not develop a fever. Ideally, staff should monitor residents to detect subtle changes in condition or behaviour.



21. Risk Assessment

We have undertaken thorough and comprehensive risk assessments in consultation with NSW Health, the workforce, peak bodies, and other industry stakeholders to identify possible risks and hazards associated with COVID-19 in our service environment.

We are committed to inform residents, family members and stakeholders on changing risks at Buckland and control measures being implemented to minimise those risks.

Buckland Risk Assessment

Refer to NSW Health ARI Guidelines and CDNA Guidelines when developing your risk assessment.

Staff PPE in place at outbreak commencement: Ongoing outbreak situation

Summary of Resident Cases as of

Resident Name	D.O.B:	Positive Test Date	Symptoms? onset	Location in facility

Summary of Staff Cases as of -

**Infectious period: 72 hours before the staff member started having symptoms or 72 hours before they tested positive (whichever came first)*

Staff Name	Positive Test Date	Symptoms? onset	Dates on site during infectious period	Where onsite?

Risk Assessment (Wing) (Refer to Appendix 2 ARI Guidelines)

High Risk Resident Contacts Identified

For examples of high-risk contact, please see risk assessment matrix.

Resident Name	Location/ bed number in facility	Swab regime
		• PCR/RAT D0 <date> - Isolation start date. • RAT D2 <date> • RAT D4 <date> • PCR/RAT D6 <date> • *If symptoms develop, COVID RAT and Respiratory virus PCR.* • *REPEAT SWAB REGIME IF REQUIRED (Outbreak continuing)* *Isolation removed D8 if outbreak in high-risk area has ended.*

Low Risk Resident Contacts Identified

For examples of moderate risk contact, please see risk assessment matrix.

Resident Name	Location/ bed number in facility	Swab regime
		• Isolation Yes /No? If isolating, • PCR/RAT D0 <date> • RAT D2<date> • RAT D4 <date> • PCR/RAT D6 <date> • Isolation end date (if isolating and negative D8) <date> - Pending swab result If not isolating,

		• PCR/RAT D0 <date> • RAT D2 <date> • RAT D4 <date> • PCR/RAT D6 <date> • *If symptoms develop, COVID RAT and Respiratory virus PCR*

Staff Contacts Identified

Staff Name	Location in facility if continuing to work/ Furloughed	Contact status (High risk)	Risk mitigation strategy

Risk Assessment (Wing) (Refer to Appendix 2 ARI Guidelines)

High Risk Resident Contacts Identified

Resident Name	Location/ bed number in facility	Swab regime
		• PCR/RAT D0 <date> - Isolation start date. • RAT D2 <date> • RAT D4 <date> • PCR/RAT D6 <date> • *If symptoms develop, COVID RAT and Respiratory virus PCR.* • *REPEAT SWAB REGIME IF REQUIRED (Outbreak continuing)* *Isolation removed D8 if outbreak in high-risk area has ended.*

Low Risk Resident Contacts Identified

For examples of moderate risk contact, please see risk assessment matrix.

Resident Name	Location/ bed number in facility	Swab regime
		• Isolation Yes /No? If isolating, • PCR/RAT D0 <date> • RAT D2<date> • RAT D4 <date> • PCR/RAT D6 <date> • Isolation end date (if isolating and negative D8) <date> - Pending swab result

		If not isolating, • PCR/RAT D0 <date> • RAT D2 <date> • RAT D4 <date> • PCR/RAT D6 <date> • *If symptoms develop, COVID RAT and Respiratory virus PCR*

Staff Contacts Identified

Staff Name	Location in facility if continuing to work/ Furloughed	Contact status (High risk)	Risk mitigation strategy

Appendix 2 – Residential aged care facility COVID-19 risk assessment and management for single or known exposures

	Low risk	High risk
Requirements for staff	**Definition** Where staff have had transient, limited contact that: - Does not meet the definition of high-risk contact. **Management** - Continue to work with the following: ➢ Monitor for symptoms, test (RAT initially, if negative proceed to PCR if available), and isolate immediately if symptomatic. ➢ Daily RATs (until day 7).	**Definition** Where a worker has been exposed to COVID-19 at work and exposure is defined as high-risk. Considerations for high-risk exposure include: - staff who were not wearing airborne precautions (P2/N95 respirators, eye protection) where aerosol generating behaviours or procedures have been involved; - have had at least 15 minutes face to face contact where both mask and eyewear were not worn by exposed person and the case was without a mask; or - greater than 2 hours within the same room with a case with inadequate PPE. • If a worker has been exposed to COVID-19 in the community follow the advice for people exposed to COVID-19 factsheet. **Management** Review affected staff to assess risk of exposure. If staff furloughing is not an option and staff must continue to work the following risk mitigation strategies should be in place: ➢ Monitor for symptoms, test (RAT initially, if negative proceed to PCR if available), and isolate immediately if symptomatic. ➢ Daily RATs (until day 7). ➢ Avoid staff redeployment to unaffected areas to minimise risk of potential spread. ➢ Do not enter shared space or meal rooms. ➢ Work in P2/N95 masks for the first 7 days following exposure.
Requirements for residents	Where a resident has had transient, limited contact that: - Does not meet the high-risk contact definition; or - Based on facility and/or PHU risk assessment is not assessed as a high-risk contact. **Management** - Close monitoring for symptoms. If symptoms develop, isolate immediately and test. - Regular RAT testing in the first 7 days if deemed appropriate by facility and/or PHU. - Other risk mitigation strategies deemed appropriate.	Where a resident has been exposed to a COVID-19 case: - in a shared defined area (e.g., prolonged contact during activity, co-located in a wing of a facility); and/or - who have had household-like exposure with a case during their infectious period; or - outbreak-related contact (e.g., cases in the same ward / wing / shared area with unknown exposure). **Management** - Isolate for 7 days. - Test (PCR or RAT) day 2 and day 6. OR - Consider allowing residents to leave their room after risk assessment, wearing a mask and with: ➢ Baseline and day 6 PCR, or ➢ RAT at least every second day from day 0-7. - If symptoms develop, isolate, and do a RAT and, if negative, do a PCR test. - Release from isolation: ➢ After day 7 with a day 6 negative result and asymptomatic.
Requirements for visitors	• Follow Information for people exposed to COVID-19 factsheet.	• Follow Information for people exposed to COVID-19 factsheet.

This risk matrix does not replace the CEC application of PPE guide. Infection Prevention and Control Manual COVID-19 and other acute Respiratory Infections (Version V4.1) (health.gov.au)

Other considerations relevant to an outbreak situation

New and returning residents to Buckland from hospital or the emergency department • The presence of an outbreak should not prevent new and returning residents from being admitted/re-admitted to Buckland when appropriate infection prevention and control measures are in place. Decisions should be based on the advice of the local Bucklands OMT and in consultation with the PHU, residents, and their representatives.

Resident choice around isolation

Consumer dignity and choice is a foundational standard in the National Quality Standards.
Residents should be given the choice to self-isolate while the outbreak is active, or to mix with people with similar exposure. Their preferences should be recorded in their care plan and regularly reviewed. Residents should be made aware that if they choose not to isolate during an outbreak that this increases their risk of contracting or transmitting the infection. Continued implementation of appropriate IPAC measures should continue. Where practical, and the facility can manage this risk by considering the following.
• Residents with the same ARI being permitted to engage in social activities together if they are well enough to do so and if they can be kept separated from residents who are unaffected.
• Exposed residents may choose to leave their rooms to eat in shared dining rooms and participate in social activities with other residents from the affected area. Exposed residents should be supported to not socialise with positive cases or unexposed residents.
• Unexposed residents can leave their rooms to participate in shared activities and dining with other unexposed residents (i.e., with dedicated staff, dining room, social room).
• Where possible, visits to affected residents should occur in an area with good ventilation. The Aged Care Act 1997, the Charter of Aged Care Rights and the Aged Care Quality Standards provide further information for this requirement.

If a resident wishes to leave the service for emergency leave and staff with family and friends during an outbreak this must be discussed within the local outbreak management meeting. A risk assessment would be completed to assist in providing PHU with determining the risk and benefits for each case.

Ventilation

A portable air cleaner that contains a high-efficiency particulate air (HEPA) filter may be used in addition to any other ventilation provided to manage risks from respiratory viruses and to prevent the build-up of other particulates. HEPA filters are useful to increase clean air exchange rates in a room and to provide additional air treatment where there are areas of known air stagnation. Optimising existing mechanical or natural ventilation, wherever possible, should remain the priority over air cleaning. HEPA filters can also be used when needing to close windows and doors or shut off outdoor air supply to air conditioning or other heating, ventilation and air conditioning (HVAC) systems due to external hazards such as bushfire smoke or adverse weather conditions. For infectious disease risks, it is important that portable air cleaners are used in combination with other public health measures including vaccination, social distancing, limiting occupancy levels, face masks where recommended, good respiratory and hand hygiene, and disinfection of surfaces and objects.

Units that achieve filtration via mechanical means, such as HEPA air cleaners compliant with AS 4260-1997 High efficiency particulate air (HEPA) filters or described as H13, H14 or medical grade (external link). Avoid products that advertise 'HEPA-like' or HEPA-style' filters that do not adhere to filter grading systems, or do not provide crucial information such as mechanical filtering efficiency or coverage.

Air purifiers are hired through AirXpress Hire – contact number 0451 663 033

Aerosol Generating Procedures

Wandering Residents

Consider how long Buckland will manage the movement of residents and staff around the service to minimise the risk of transmission – this is particularly important for resident with cognitive impairment wandering behaviour or dementia.

The following strategies can assist with minimising transmission when residents are actively wandering:

- Offer surgical mask frequently when respiratory infection is suspected or during a respiratory outbreak.
- Increase cleaning rounds such as high-tough surfaces.
- Offer frequent hand hygiene opportunities.
- Change the environment such as removing/moving chairs to assist with social distancing.
- Review roster where able to allocate designated staff member to supervise and assist wandering residents.

22. For Continuity of Care

Emergency induction per agency/surge workforce.

Local Outbreak Management Folders that will inform the agency workforce on the following.

- Isolation Wing Plans – Leecare resident list with photo.
- Site Maps
- OMP
- Staff vaccination List
- Resident Vaccination List
- Copy of recent up to date line list

(This will manage and maintained by the Care Manager/Clinical lead)

23. Clinical Care Considerations

Note: This list is not exhaustive and case by case consideration is required in consultation of the resident/representative and consideration of enduring guardianship.

Clinical Consideration/interventions

- Review advance Care Planning. Advanced care directives – documents are in place for all residents and are up to date and current. (This list is available on Lee Care Reports)
- Clinical review must be completed daily at a minimum for residents with a confirmed transmissible infection.
- Unwell residents must be medically reviewed by their GP,
- Telehealth to be made available where this is GP preference.

(Refer to Lee Care Reports)

The Unwell/Deteriorating resident

- To be medically RIV & GP, VACs, NP.
- Utilise telehealth as per preference.
- During and Post infection and prior to removing resident from isolation GP review/Clinical review is encouraged up to 8-10 days post infection as well as whilst symptomatic.

Clinical Care:

Nutrition/Hydration:

Positive Cases

- Commence Food and Fluid charting and encouraging > 1,000ml in 24hr period (Unless otherwise directed by a medical practitioner).
- Consider lighter meal options when a resident is refusing normal meal items (taking into consideration assessed dietary consistency). Liaise with HSC (hospitality Manager) where needed. Liaise with NP, VACS for Fluid Replacement on site.
    - Paper based charts can be utilized for residents in isolation, then uploading in Leecare Documents for isolation period.
- To Commence (each shift) vital sign monitoring of 4/24 Vital Sign Monitoring and record in Leecare.
    - Ensure all ranges have been set.
    - Out of range values will set in red colour (this will be identified in the alerts – (new weights and vitals outside reportable range)

Negative Residents and Monitoring

- Attend to Vital Sign Monitoring and record in Leecare each shift.
    - Ensure all ranges have been set.

- Out of range values will set in red colour (this will be identified in the alerts – (new weights and vitals outside reportable range).

RN/EN/EEN to attend to vital observations.

for temps out of range: Administer paracetamol as charted.
38> or consult the GP to have it charted.

- RN to follow usual process to access the nurse-initiated medication (NM) if there is no paracetamol charted.

Blood Glucose Levels

Food and Fluid intake may have an impact on residents with diabetes.

- BGL Monitoring
- Consider use of dietary supplements
- RIV diabetic management plan
- Liaise with GP, NP regarding reportable ranges.

Respirations

A respiratory rate of 23BPM, or a resident appears to be in a respiratory distress, contact GP for further advice.

O2 may be helpful to relieve. Respiratory symptoms SP02 < 94%RA

- Contact GP to arrange charting of the oxygen, and must clearly state the amount of oxygen, and must clearly state the amount of O2 to be administered and how often.
- Ensure O2 is readily accessible in each wing and monitored daily.

24. Pain Management

Utilise Pain Monitoring charting on Leecare Charts.

- Administer analgesia as per residents Medication Chart.
- RIV effectiveness of administered pain relief – escalate if not effective.

Monitor Closely per complications such as:

- Pneumonia (secondary bacterial infection)
- Respiratory Failure
- Septicaemia
- Multi organ dysfunction/Failure

If any of the above, contact GP for advice/ Ambulance NSW (dependent upon ACD & Res/enduring guardian wishes).

- For a productive cough, request a chart to expectorant as appropriate.
- Antibiotics may be charted by GP, VACS, NP for secondary infections.
- Sore throat – Irritating cough. Consider if applicable for lemon/honey hot drinks (ensuring consistency is correct) lozenges etc.
- Nurse resident in a semi fowlers position, seated in an upright position bed/chair.
- Refer to allied health physio/OT chest physio as needed.
- Maintain close communication with resident's NOK/person responsible of affected residents to provide status updates at least daily.

Raise Infection Form on Leecare as a new Respiratory Infection – Upon confirmation of ARI/COVID19

- Complete the organism isolated section e.g., if known pathology.
- Complete antiviral/antibiotic treatment section specifying Name, Length of time ordered.
- Complete care interventions sections:

Template to use, when completing a Positive residents ARI report –

1. Isolation precautions

Dates: -

2. PPE Usage – Specify what PPE e.g., N95 mask, shield, isolation gown, protective eye wear.

3. Frequency of observations required

4. Escalation of Deterioration

5. Any specific individual needs the resident has e.g.

6. Commence Food and Fluid Intake (The entirety of the illness until asymptomatic, back to baseline) – Specify if on Leecare or paper based.

7. Attend to vital observations: - BP, P, T, R, O2 Sats. BGL

8. R/V Infection control from each shift with updates and save to progress notes (gives a running timeline a documented evident of resident review and possible early detection of a deterioration).

9. Date and time pathology PCR/RAT was attended and date/time of receiving results.

10. Maintain progress notes each shift or frequency if any clinical concerns.

11. Call Daily to NOK for update where a resident in an outbreak of ARI (Specific area/wing) is asymptomatic.

- Vital signs (entered Leecare and act on any alerted-out range)
- Continue to monitor for signs/symptoms of ARI (As per signs & Symptoms page on OMP)
- Any change in residents' baseline & exacerbations of underling chronic illness.

25. Cleaning and Environment Hygiene

(Refer to the below Ecolab COVID19 info and Action Plan)

Regular scheduled cleaning of all resident care areas is essential during an outbreak.

- Frequently touched surfaces, need to be cleaned more often.
- During a suspected or confirmed ARI Outbreak, an increase in frequency of cleaning with a neutral detergent followed by a disinfection is required. At Buckland we use a 2 in 1 Step Clean (using a combined detergent and disinfectant) is required: Actichlor – Ecolab. (Detailed information on environment cleaning and disinfection is available in factsheet – Commonwealth Department of Health – COVID19 (Dec22)

Frequently touched surfaces should be cleaned at least x 2 daily these include:

- High touch point areas utilise clinell wipes, atichlor to wipe over Bed rails, Bed side tables, light switches, remote controllers, commode, shower chairs, doorknobs/handles, sinks, surfaces, and all equipment close to the resident (Call Bells).
- Floors cleaned with neutral detergent solution.
- Walking Frames and sticks.

- Clinell Wipes are to be placed in high touch point areas such as near lifts, in all wings, PPE stands, strategically located through out the facility.

Cleaners are to:

- Wear appropriate PPE including an impermeable gown, disposable nitril gloves and a N95 mask, plus eye protection/Face Shield while cleaning.
- Avoid touching their face.
- Trained in the correct PPE to be worn when performing their duties, and the correct donning and doffing of PPE and correct hand hygiene.
- Adhere to the cleaning product manufacturers recommended dilution instructions and contact time.
- Use TGA listed disinfectant with Virucidal claims, a chlorine-based product. (Achtichlor).
- Cleaning is to be completed in a methodical way to prevent cross contamination of surfaces clean from high to love, and from clean – dirty and wipe in a "S" shape pattern. Use of damp dusting technique prevents dust particles dispersion when dusting surfaces.
    - Always clean surfaces before any disinfection occurs.
      Safety datasheet is easily located an in each cleaner's room where the disinfectant solution will be found.
- Cleaners will follow the clean first dirty last process. All residents that have been deemed positive to an ARI will have their room environment cleaned last.

Contracted Cleaners: (If required to be deployed)

- Should be trained by their employer in the appropriate use of cleaning and disinfection procedures and products to be used/and are used on site and PPE usage.
- Orientation of contract cleaners will be attended to prior to commencing onsite by the hospitality manager (HSC) Facility Manager/CEO.
- Do not mix cleaning products – to avoid chemical reaction from occurring, this could be harmful to the person cleaning. *always Following this procedure.*
- All SDS available and all bottles have the correct labelling and be stored according to manufacturer instructions.

Cleaning Equipment – Shared Items. (Use Clinell Wipes)

Ordering of Stock Process

(Refer to the below Main Store Stocktake book)

Cleaning			
Responsibility	**Product**	**Supplier**	**Contact Details**
Admin/Admissions	Clinell Wipes N95 Masks	EBOS	[redacted]
Admin/Admissions	Acticlor Hand Sanitisers Rapid Spray	Ecolab	
Admin/Admissions	Garbage Bags	Veridia	

PPE			
Responsibility	**Product**	**Supplier**	**Contact Details**
Admin/Admission	Paper Towels Bin Liners	Veridia	[redacted]
Admin/Admission	N95 Masks	EBOS	
Admin/Admissions	Gloves Paper Towels Toilet Rolls	Chempack & Restock	
IPC Lead/CEO	RAT tests	My Aged Care Portal	
IPC Lead/CEO	Gowns	My Aged Care Portal	
IPC Lead/CEO	Shield Googles	My Aged Care Portal	

Waste Management

Correct segregation is necessary to ensure that materials that are reusable or recyclable are not discarded. Correct waste segregation and containment of all waste is required in order to comply with provision of waste regulation.

Clinical Waste

Clinical waste includes any waste resulting from medical, nursing, dental, pharmaceutical, skin penetration or other related clinical activity, being waste that has the potential to cause injury, infection or offence.

Used aprons, gowns, and gloves in both clinical and non-clinical aged care settings are classified as general waste. Any bulk fluids should be emptied into domestic sewerage systems.

Clinical waste should be handled in a manner consistent with standard precautions

Sharps are to be disposed of in sharps containers and returned to suitable collection point.

The following requirements must also be adhered to:

- The are must be signposted with biohazard symbol.
- Waste is not to be decanted under any circumstances.
- The area must be secure and not visible to the public with access restricted to employees only.
- The site should not affect nearby residents from odour or other.
- The storage area must be weatherproof (have a roof and side walls)
- Have adequate containment measures to contain spills.
- A spills kit must be available to clean up any spills containing disinfectant, bucket, gloves, disposable overalls, safety goggles/shields, plastic waste liners.
- Wherever possible the area allocated should be able to be accessed directly from isolation/quarantine zone.
- A record of any spills, causes and corrective actions should be captured on Hazard Form
- Trolleys used to transport waste bags to collection bins must be cleaned disinfected after use.

General Waste

- Waste bags should never be stored directly on the floor.
- All clinical waste must be stored in a dedicated storage area outside loading dock.

Waste Collection

Infection Control measures are adopted to prevent cross-infection between care recipients and staff changed in infection control and advances in technology have resulted in the increased use of disposable clinical products, which have turn increased waste treatment/disposable volumes.

Implement the following during an outbreak:

- Collection frequency must be increased 32in waste licensed contractors to a minimum every 24 hours to prevent decay of certain wastes which starts to occur after this time. The amount of yellow clinical waste bins available at the care centre also needs to be increase with the contractor.
- Increased collection of general waste should also be organised, and additional plans to be set in place for Sundays and public holidays where additional collection services can not be organised.
- If Buckland is unable to adequately manage the clinical waste generated during an outbreak, then contact your licenced clinical contract for additional pickups.

For additional pickups, contact Daniels on 1300 667 787 and quote account number [redacted]

Waste Collection throughout facility

Waste is collected by the GSO support staff off the floor in each wing frequently through the day.

TBW – GSO support to collect and transport to the waste storage in the loading dock.

LRW - GSO support to collect and transport to the waste storage in the loading dock.

MRW - GSO support to collect and transport to the waste storage in the loading dock.

DCW – Care Staff and cleaner will transport to DCW waste storage area of loading dock.

GSO support will clean outside of the bins with Actihcor prior to returning to the wings.

Waste Handling

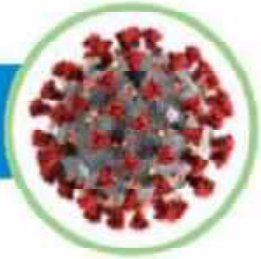
Follow these steps when preparing waste for collection with appropriate 4-point PPE to be used:

- Waste bags must not be overfilled (approximately 2/3 capacity) and excess air should be excluded, without compaction, prior to closure using a bag tie at the point of waste generation.
- All bags should be held away from the body by the closed top of the bag and placed directly into a mobile garage bin or trolley.
- Ensure clinical and general waste bags are tied off with knots facing upwards and ensure all clinical waste bins are kept closed.
- Disinfect the lids, handles, and top of the bins when you open, close and move them.
- After handling clinical waste ensure you wash your hands for at least 20 seconds using soap and water where possible or use alcohol hand rub containing 70 percent alcohol if hand is not visibly soiled and access to a wash basin is not available.

EcoLab Action Below;

FACT SHEET | Food and Beverage Processing

Coronavirus (COVID-19) Action Plan



Public health officials have identified a new coronavirus (COVID-19). Focusing on standard infection prevention practices, training and compliance in Food and Beverage processing will help keep your employees and customers safe. Together, we can help combat the spread of COVID-19.

What are the food safety implications?

There is currently no evidence that COVID-19 is transmitted to humans through food. Standard food safety practices are encouraged, including:

- Avoid direct, unprotected contact with live animals and surfaces that may have been exposed to live animals in regions where excessive illness cases are being reported
- Avoid consuming raw or undercooked meat or meat from sick animals
- Avoid cross-contamination by properly handling raw meat, milk or other animal materials
- Properly clean and sanitize food contact surfaces including hands and utensils

TAKE ACTION — What can I do in my food or beverage processing plant?

Contact your Ecolab service representative to discuss best practices and set up time to refresh staff on proper infection prevention protocols.

Follow good manufacturing and food safety practices from receiving, handling and preparing raw materials, ingredients, packaging, work-in-progress and finished products.

Ensure employee health and hygiene practices are in place and maintained, including proper hand washing.

Clean and sanitize food contact and non-food-contact surfaces as well as carrying out environmental cleaning and sanitation (floors, walls, ceilings and equipment).

Use only sanitizers suitable for their use in a food manufacturing facility, following label instructions.

What are the risks from materials coming from China?

Generally, coronaviruses have poor survivability on surfaces, so the risk of spread from products or packaging is low. Currently, there is no evidence to support transmission of COVID-19 associated with imported goods.

WHERE CAN I GET MORE INFORMATION?

Ecolab: **ecolab.com/coronavirus**
CDC: **cdc.gov/coronavirus/index.html**
WHO: **who.int/health-topics/coronavirus**
EPA: **content.govdelivery.com/accounts/USAEPAOPPT/bulletins/278e716**

ECOLAB

Coronavirus image source: https://phil.cdc.gov

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Cleaners Checklist and Schedule

Buckland Aged Care Services AM/PM Checklist – GSO Q1 - BNH

Day:	Date:	Completed by:
DAILY AM CHECKLIST – GSO Q 1- BNH		
LeeCare communications & rosters – Log onto LeeCare & read all communications. Check roster.	Yes ☐ No ☐	Comments:
Room – has your cleaner's room been found in a neat & tidy manner? *If not please provide details in comments section.	Yes ☐ No ☐	Comments:
Cleaning trolley & PPE – Check cleaning trolley is fully stocked & clean *If not please provide details in comments section. Collect all PPE required throughout the day including your allocated red & blue cleaning gloves.	Yes ☐ No ☐	Comments:
Check cleaning schedules book– Confirm all the previous days tasks have been completed.	Yes ☐ No ☐	Comments:
Fridge Temps, Serveries & Staff Room. Check and record all fridge temps for Serveries 1 – 3 and the Upper Staff Room. If out of range please check, adjust temp and log a Maintenance request if needed.	Yes ☐ No ☐	Comments:
Hallway Cleaning- Sweep all hallway floor area from Rm 65, TBW to Upstairs Staff Room, paying attention to corners and behind doors. Clean remaining floor area using the large scrubbing machine, mop areas scrubbing machine will not reach.	Yes ☐ No ☐	Comments:
Bin run - Empty garbage bins in the following areas: Reception, Care Managers Office, Facility Managers Office, Assistant Care Manager's Office, PA to Facility Managers Office, Nurses Station 1&2.	Yes ☐ No ☐	Comments:
Foyer – *Sweep all floors moving all furniture, paying attention to corners and behind doors. *Wipe down all furniture, picture rails and pictures. *Clean remaining floor area using the large scrubbing machine. *Wash down door and window leading to outdoor soft fall area (internally and externally) removing all cobwebs. *Water all pot plants. *Clean visitors bench at reception and sliding glass window.	Yes ☐ No ☐	Comments:
Visitors Toilets - *Clean toilets *Wash down walls. *Wash down doors internally and externally including handles, frames and hinges. *Clean paper towel dispensers (the paper towel dispensers in the main foyer are NOT to have paper towel as it causes plumbing blockages if flushed). *Clean and replenish handwash dispenser *Clean basins and splash backs, including underneath plumbing, drain hole and base of taps *Mop floors paying attention to corners and behind doors. *Remove any cobwebs. *Replace toilet brushes as required, ensuring any stickers are removed. *Replenish toilet paper.	Yes ☐ No ☐	Comments:
Tea Trolley- check that tea trolley is fully stocked and clean.	Yes ☐ No ☐	Comments:
Morning Tea Service – Provide Morning Tea to residents in Rooms 65 – 108 and Main Lounge Area using Morning/Afternoon Tea book for residents dietary requirements	Yes ☐ No ☐	Comments:
DAILY PM CHECKLIST – GSO Q1 - BNH		

N:\Duty Schedules & Position Descriptions\Duty Schedules & Position Descriptions\GSO Cleaning Schedules\GSO Cleaning Schedules - Current\Q1\AM PM Checklist - GSO Q1 - BNH Copy.docx

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Reviewed January 2021 JL Due for review March 2024

Afternoon Tea Service- Provide Afternoon Tea to Residents in Rooms 65 – 108 and Main Lounge Area using the Morning Tea Book for Residents dietary requirements.	Yes ☐ No ☐	Comments:
Tea Trolley- fully strip, clean & re-stock ready for next shift.	Yes ☐ No ☐	Comments:
Final check/tidy– Do a final check/tidy of all rooms/areas of responsibility.	Yes ☐ No ☐	Comments:
Cleaning equipment & trolley – Fully empty strip, clean & restock trolley ready for the next shift. Clean all equipment used throughout the day with hot soapy water, then dry. Vacuums are to be emptied & any buckets/containers left upside down to fully dry overnight.	Yes ☐ No ☐	Comments:
Cleaner's room – is to be fully vacuumed, mopped and cleaned (all surfaces). Stock is to be checked to ensure adequate supply	Yes ☐ No ☐	Comments:
Paperwork: cleaning schedules – Complete cleaning schedule and return to Reception prior to finishing for the day.	Yes ☐ No ☐	Comments:
LeeCare communications and rosters – Log onto LeeCare and read all communications). Ensure all maintenance requests are logged in the Corrective Maintenance Folder located in Reception. .Check rosters. **Any issues in relation to equipment must be logged in the Corrective Maintenance Folder at Reception and the HSC notified.*	Yes ☐ No ☐	Comments:

In the event of an outbreak and Agency Staff being bought in the following is to occur:

Buckland Staff in each wing to Orientate and instruct agency staff (set up with cleaning equipement etc.).
Buckland staff to clean & disinfect Infectious rooms /areas, our residents know you and you know what is expected.
Agency staff to be allocated to clean all other (non infectious) rooms/areas.
Actichlor to be used for all areas, high touch points and infectious room clean.

MAINTENANCE ISSUES IDENTIFIED (must be entered into the Corrective Maintenance Folder at Reception)
Issue

INFECTION CONTROL, WHS & OTHER ISSUES IDENTIFIED	
Issue identified:	**Corrective action taken:**

Comments:

26. Laundry

- Adhere to AS/NZS 4, 14, 6, 2000 laundry practice.
- Soiled linen should always be treated as infectious.
- Handle soiled laundry with minimum agitation to avoid contamination of the air, surfaces and persons e.g., roll up.
- Ensure linen is washed using hot H2O (>65 degrees) for at least 10 minutes with standard laundry detergent.
- At the point of generation, linen used for a person with confirmed, probable or suspected infection should be placed in a red alginate bag and then into an appropriate laundry receptacle.
- A long-sleeved fluid resistant gown or apron and disposable nitrile/latex powder free gloves should be worn during handling of soiled linen to prevent skin and mucous membrane exposure to blood and body substances.
- Hand hygiene must always be performed following the handing of used linen.
- Ensure shared linen is dried in a dryer on a hot setting.
- In an event of an Outbreak, it is recommended that laundry be attended onsite and not taken home by family members. In this case, ensure laundry is transported in a sealed bag (linen bag).
- Restrict Family Members from entering the laundry.
- Soiled linen trolleys are not to be overfilled when not in use, stored in pan rooms in designated areas/
- Reusable linen bags must be laundered before reuse.
- Washing Machine and dryers are serviced every 2nd month by Electrolux.
- Infectious Wash, items in alginate bags will be put through an infectious wash at 71 degrees Celsius. This is a 65-minute cycle.

Clean Entry – Doors are signed, for linen collection when staff are in clean areas, they are to wear N95 masks, hand wash, sanitizer.

Dirty Entry – Doors are signed, the MRW laundry shoot will drop directly into the dirty area. Staff are to wear full PPE, N95, isolation gowns, googles/shields and gloves. Internal donning station is located inside the laundry at the entrance to the dirty entry. Doffing station located inside the dirty area exit.

Handling, Disposal and transport of used linen

All used linen should be handled with care to avoid dispersal of microorganisms into the environment and to avoid contact with HW clothing (108, 109). Each HO is to have a written policy and/or procedures on the collection, transport, and storage of linen. Furthermore, a HO that processes or launders linen in-house will also have documented policies and/or procedures consistent with AS/NZS 4146:2000 Laundry Practice.

The following principles apply when handling linen used for all patients: i.e. whether or not transmission based precautions are required.

- Handle soiled laundry with minimum agitation to avoid contamination of the air, surfaces and persons (e.g., roll up).

- Used, soiled or wet linen should be placed into appropriate laundry receptacle at the point of generation; water-soluble bags and double bagging are not necessary and are not recommended.

- Clear leak-proof bags are to be used to contain linen that is heavily soiled with blood, other body substances or other fluids (including wet with water).

- Linen bags should be tied securely and not be filled completely as this will increase the risk of rupture in transit and injury to bag handlers.

- Reusable linen bags must be laundered before re-use.

• Hand hygiene must be performed following the handling of used linen.

Used or soiled linen are not to be rinsed or sorted in patient care areas or washed in domestic washing machines. Domestic type washing machines are only to be used to launder a patient's personal items and only one patient's personal items can be washed per cycle.

All patient care items, and facility linen is to be washed using non-domestic (commercial) washing machines. Washing machines are to be housed in suitably designed rooms with a clean and dirty workflow. Clothes dryers should be used for drying.

• Laundry carts or hampers used to collect or transport soiled linen need not be covered.

• Containers (including carts, bags, and plastic bins) for collecting, storing, or transporting soiled linen should be waterproof, leak-proof, nonporous, and in good repair, and should be decontaminated after use.

• The vehicles which transport linen to and from the laundry should be clean. Soiled and clean textiles should not be transported in the same vehicle, unless they are separated by a suitable barrier e.g. containers with suitable closures, moisture impermeable bags that would prevent contamination between the soiled and clean linen. If a compartment has carried soiled laundry, that compartment should be thoroughly cleaned before it is used to carry clean linen.

• Special handling of linen for clients/patients/residents on Additional Precautions is not routinely required. Routine practices for handling and laundering are sufficient, regardless of the source of the linen.

• Linen bags should be held away from the body to avoid potential risks of contamination and injuries due to possible sharps.

• Disposable linen is the first-choice preference for patients with a high consequence infectious disease. Reusable linen should be discarded as clinical waste.

Kitchen

- Crockery and Cutlery is to be washed in a hot dishwasher or if not available, by hand using hot water and detergent rinsed in hot water and dried. Alternately disposable items can be used.
- Trolleys and trays used for delivery of food should be cleaned and disinfected after use.
- Hand Hygiene should be performed after collecting and handing used Crockery/Cutlery.

In the event of contingency, we will utilise Blue Mountains food Services - (02) 4759 2811. CEO will activate this in an event of a contingency requirement.

PPE requirements – Kitchen staff are required to wear a N95 mask, however when entering the facility they are required to wear googles/shields.

A donning and doffing station is located in the loading dock at the main kitchen entry.

Burlodge

Where a Burlodge Trolley is used – Care staff are to wipe over outside of the trolley and handles/doors prior to sending back to the kitchen. Once emptied in the kitchen, kitchen staff are to wipe/disinfect – inside of Burlodge trolleys using TGA approved chemical, prior to restocking and reuse.

Serveries

Tray trolley is to be wiped over immediately post meal tray service, and again prior to use of each meal service.

Tea Trolleys

In the event of a lockdown in DCW, a separate tea trolley will need to be set up for the LRW studios areas, so that there is no crossover between wings.

27. Visitors and Communal Activities

Receiving Visitors is essential for residents' wellbeing and assists with reducing the impact of social isolation. At Buckland, we will reduce the risk of spreading Covid19 or ARI by supporting visits in the safest possible way.

Strategies include:

- Highlighting that visitors should not enter the facility when respiratory symptoms are present.
- Avoiding communal areas
- Where possible, visits should be held outdoors or in well-ventilated areas away from other residents.

(Reference: Industry code for visiting Residential Aged Care Homes during COVID 19)

Entry Restrictions:

- Visitors should not enter the facility if they have:

    - Tested for COVID19: Visitors should not enter Buckland for at least 7 days after their positive test, unless an agreement has been reached with the Facility Manager e, g. (Compassionate Reasons)
    - Visitors are strongly recommended to wear a N95/P2 Mask between day 8 -10
    - Any acute respiratory symptoms or are waiting for COVID19 or other respiratory pathogen test results.
    - If a visit must occur when a visitor meets the above circumstances, the visitor must wear a mask (N95/92) when moving through the facility and minimise movement within the facility.

When respiratory viruses are circulating at a moderate or high level in the community. All visitors should wear a mask indoors (NSW respiratory Surveillance Report). This will be monitored by the Facility Manager and IPC Lead and decisions around community transmission will be communicated to residents and relatives on the Buckland website, Bulletin, and resident/relative meeting. If unable to visit due to high risk, Buckland can arrange other forms of communications, social connection such as telephone calls, What's app, Zoom, Facetime, Skype.

28. Lifestyle and Emotional Support

- Non affected residents – Continue to safely in communication activities, cough etiquette, option of surgical masks, hand sanitiser, pre and post activity, one on one as needed, Partnerships in care.
- Affected resident – One on one, activity book, Chaplain as requested (social and spiritual), promote visitation, Partnerships in care program. Use or alternative communication such as Zoom, WhatsApp etc.
- When provided one and one, lifestyle social, emotional and spiritual support ensure when interacting with infected residents that non affected affected residents are attended first (one on one).

- At Buckland we utilise alternative arrangement for clinical arrangements in an event of an outbreak situation
    1. Telehealth
    2. Phone call GPs
    3. Vacs Team
    4. 1300 sick
    5. Rapid response ambulance
        - Refer to commonwealth health department prevent and prepare for covid19 in residential health care.

29. Partnerships in care

During an exposure and or outbreak, Buckland supports the industry code for visiting residential aged care homes which was developed by aged care peak bodies and consumer advocacy organisations.

In addition to this, Buckland makes decisions and supports the advice to residential aged care facilities by the Ministry of Health and any Public Health Order/s.

Additional restrictions and changes to visitation rules apply in the event of an outbreak. Our visitor management plan considers the needs of residents in the last day of their lives.

We are aiming to facilitate end of life support through family members in the event of an outbreak, including face to face access to your loved ones, however NBMLHD – Public Health Unit will ultimately determine accessibility to the facility. Access to the facility will be based on a comprehensive risk assessment completed by a Registered Nurse or the IPC Lead and family members will be asked to sign a health declaration and adhere to conditions of entry.

Regardless of the circumstances our primary goal will be to enable resident access through virtual communication as well as window visits to minimise the risk for all stakeholders involved.

This program access to provide care and companionship to residents they already support at Buckland. (See program) includes education resources e.g., factsheets and references to online modules.

Partnerships in care available at reception as well as Buckland website and Admission Packs and all new admissions receive the information in Partnerships in Care.

Australian Government
Aged Care Quality and Safety Commission

Engage
Empower
Safeguard

Partnerships in care
Caring together

A fact sheet for family and friends of those in residential aged care

The Aged Care Quality and Safety Commission recognises the importance of social engagement and the continuity of close relationships for the health and wellbeing of aged care residents. We also know there can be negative health impacts when these relationships are restricted during COVID-19 outbreaks or similar circumstances.

Joining a Partnerships in care (PiC) program will help you to continue to provide care and companionship to the person you already support in residential aged care, even during periods of outbreak. This includes increasing your skills in infection prevention and control and formalising your care arrangements with the aged care home.

Partnerships in care take a person-centred approach to promoting existing relationships of care between a resident and their family members or close friends.

Partnerships in care build on recent public health advice relating to access for visitors to aged care residents including the Industry Code for Visiting Residential Aged Care Homes During COVID-19 and the Interim Guidance on Managing Public Health Restrictions on Residential Aged Care Facilities.

There are many different types of visitor arrangements, including specific arrangements during an outbreak. It is the right of the resident to request at least one visitor, even in an outbreak. Visitor access in an outbreak will always be subject to a risk assessment.

Who are partners in care?

A partner in care (also referred to as a partner) is a person identified by the aged care resident, or their representative, who they have a close and continuing relationship with, such as a family member or close friend. A partner regularly visits and provides care and companionship to the aged care resident.

Partners in care may provide support such as:

- helping with dressing
- sharing stories, food or other pastimes
- helping to practise exercise routines
- helping to visit places of special interest.

A partner in care is not a casual visitor, a visitor not providing an aspect of care, or a visitor who the resident does not want to have assisting with their care.

What are the benefits of partnerships in care?

Becoming a partner can help:

- keep families together to support each other through life experiences and times of need
- support the daily routines of people living in aged care homes including during infectious outbreaks
- decrease the psycho-social impacts associated with visitor restrictions, lockdowns and sustained social isolation including loneliness, anxiety, boredom, fear and depression and cognitive decline
- you learn or improve your knowledge and skills around infection control practices and other caring skills.

How to join a Partnerships in care program?

1. Have a look at the information and resources available on the Commission's website. They will give you an opportunity to learn key infection control practices and what to expect in an outbreak.

2. If your family member or close friend lives in an aged care home and identifies you as their partner in care, talk to the aged care home to see if you can join their PiC program.

3. If the aged care home does not have a PiC program, encourage them to read about partnerships in care on the Commission's website. If you'd like support to talk to an aged care home about partnerships in care you can contact the Older Persons Advocacy Network (OPAN) on **1800 700 600** or via their website – www.opan.org.au

What resources are available to help me?

The PiC resources have been developed by the Commission to help you build your skills in preventing the spread of germs. There are risks of infection any time you visit an aged care home, but as a partner you may be visiting during an outbreak or when the person you are caring for is COVID positive. We want to help you prepare, understand and manage the risks for you and others.

The PiC resources include a partner information package and online learning modules. You can access these resources on the Commission's website.

While these resources are tailored for formal partners in care, the content is useful for all visitors to an aged care home.

30. Partnerships in care reference modules

- **Visiting essentials for partners in care – an online learning module exploring infection prevention and control for partners in care.**

This learning experience has been developed by the Aged Care Quality and Safety Commission (the Commission) as part of the suite of resources for partnerships in care. This learning is for partners, or potential partners in care, or for other visitors to aged care homes. It will introduce everyday visiting essentials to follow in a residential aged care setting to help keep you, the person you care for and others safe.

Use link below:

https://www.agedcarequality.gov.au/sites/default/files/minisite/static/d8cb2409-7635-41f9-8e10-034f77bde352/content/index.html#/lessons/zQjZpnWYmcOprVtb1BiNmGzCXp_5O_N5

- **Visiting essentials during an infectious outbreak – an online learning module focusing on keeping safe during an infectious outbreak.**

This learning experience has been developed by the Aged Care Quality and Safety Commission (the Commission) as part of the suite of resources for partnerships in care. This learning is for partners, or potential partners in care, or for other visitors to aged care home. Following from the introductory module, this module focuses on ways to keep you and the person you care for safe during an infectious outbreak.

Use link below:

https://www.agedcarequality.gov.au/sites/default/files/minisite/static/b96ddf93-1d39-41c6-ae3e-42682c5499ba/content/index.html#/lessons/_F_qh0N-lasL7uNVtdmlsHeQtDgPLfSa

- **Partner information package for family and friends of those in residential aged care.**

  Use link below:

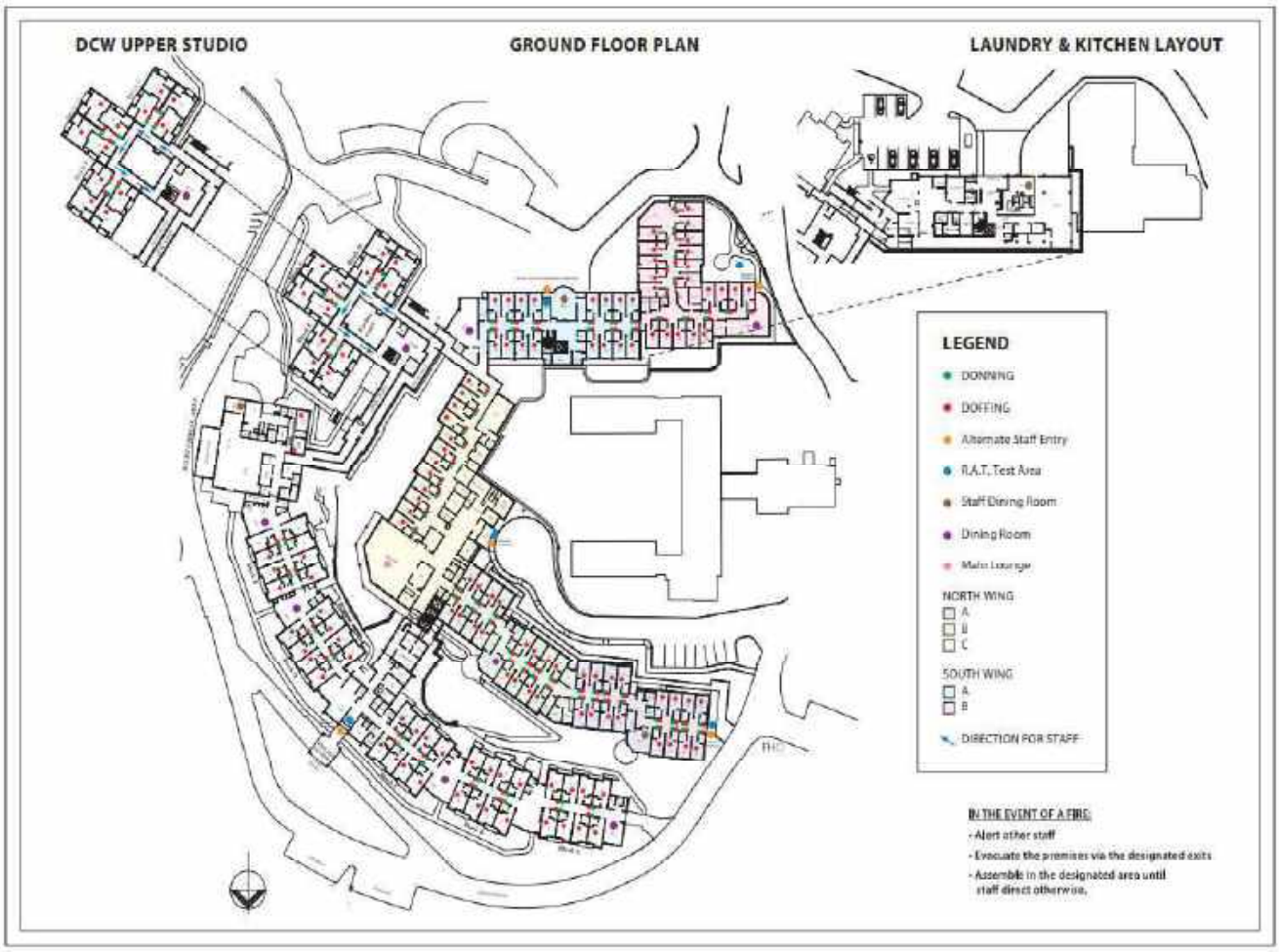
https://www.agedcarequality.gov.au/sites/default/files/media/partnerships-in-care-partner-information-package.pdf

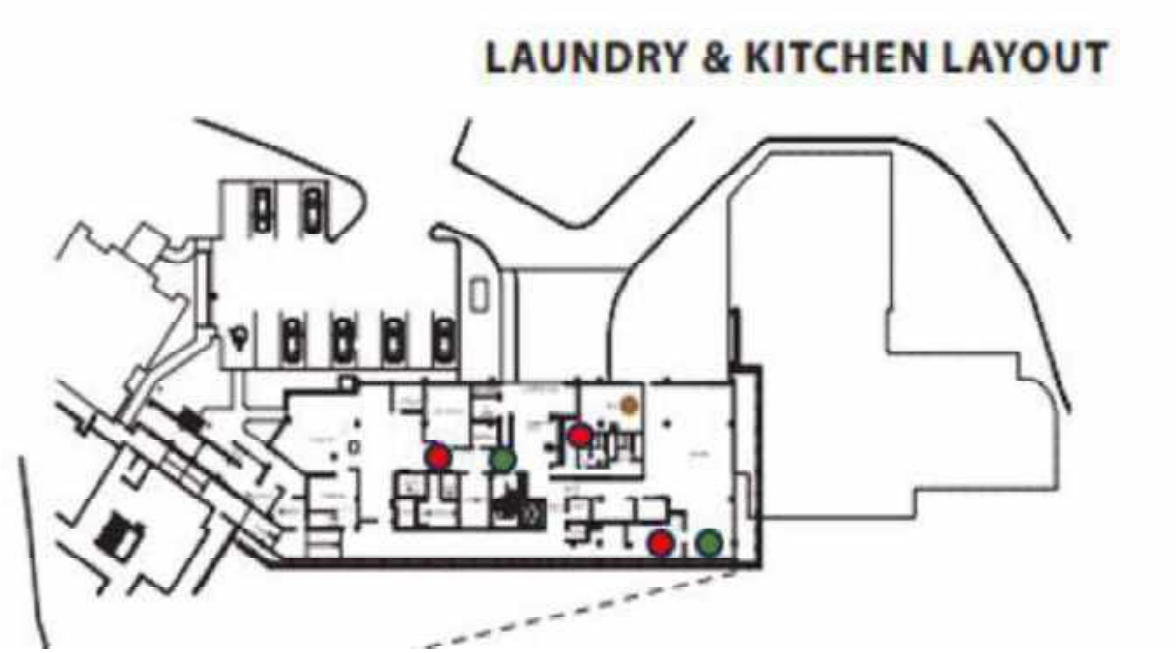
- **Visiting During an Outbreak Reference Guide**

  Use link below:

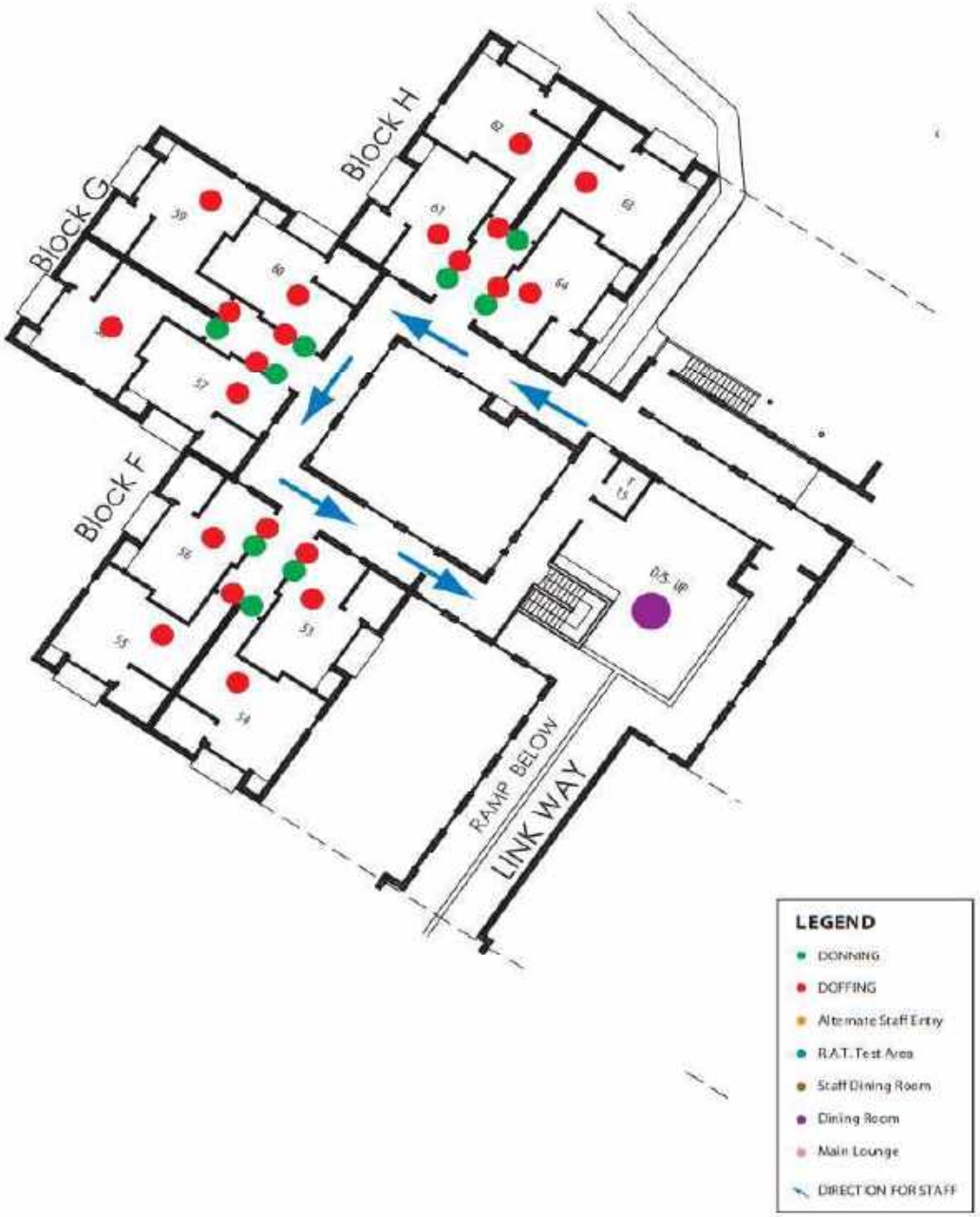
https://www.agedcarequality.gov.au/sites/default/files/media/visiting-an-aged-care-home-during-an-outbreak.pdf

31. Donning and Doffing Check Points

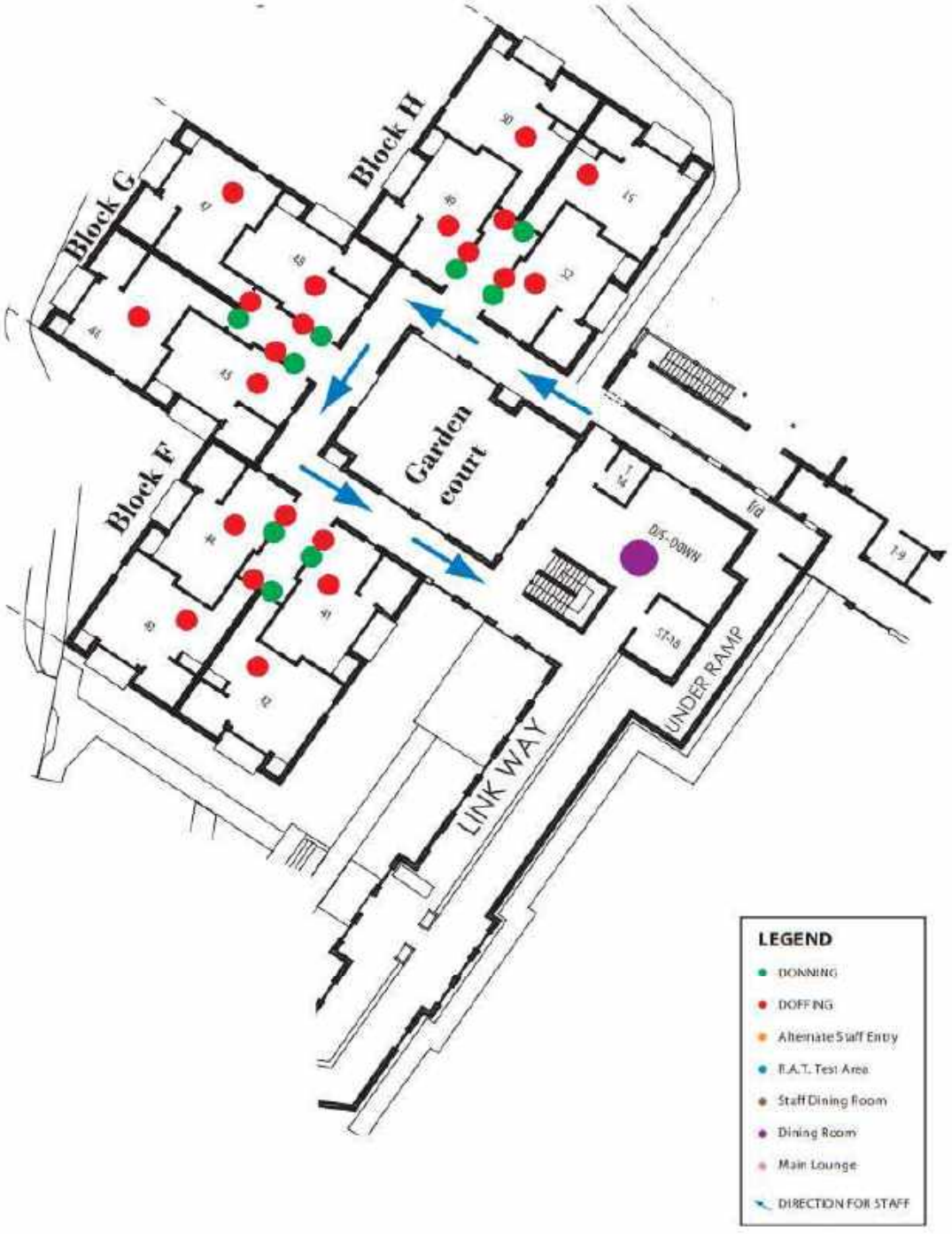




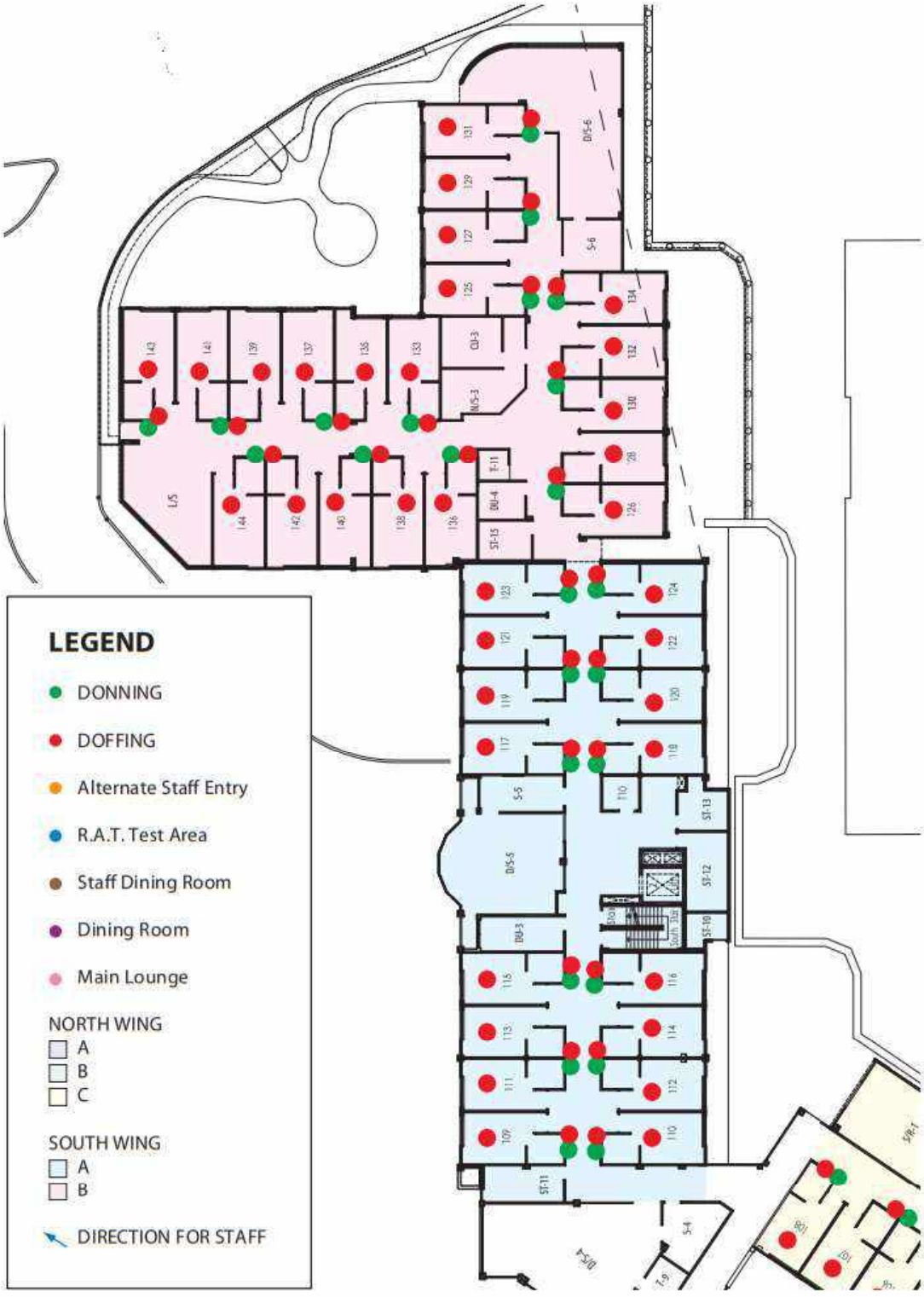
DCW UPPER STUDIO



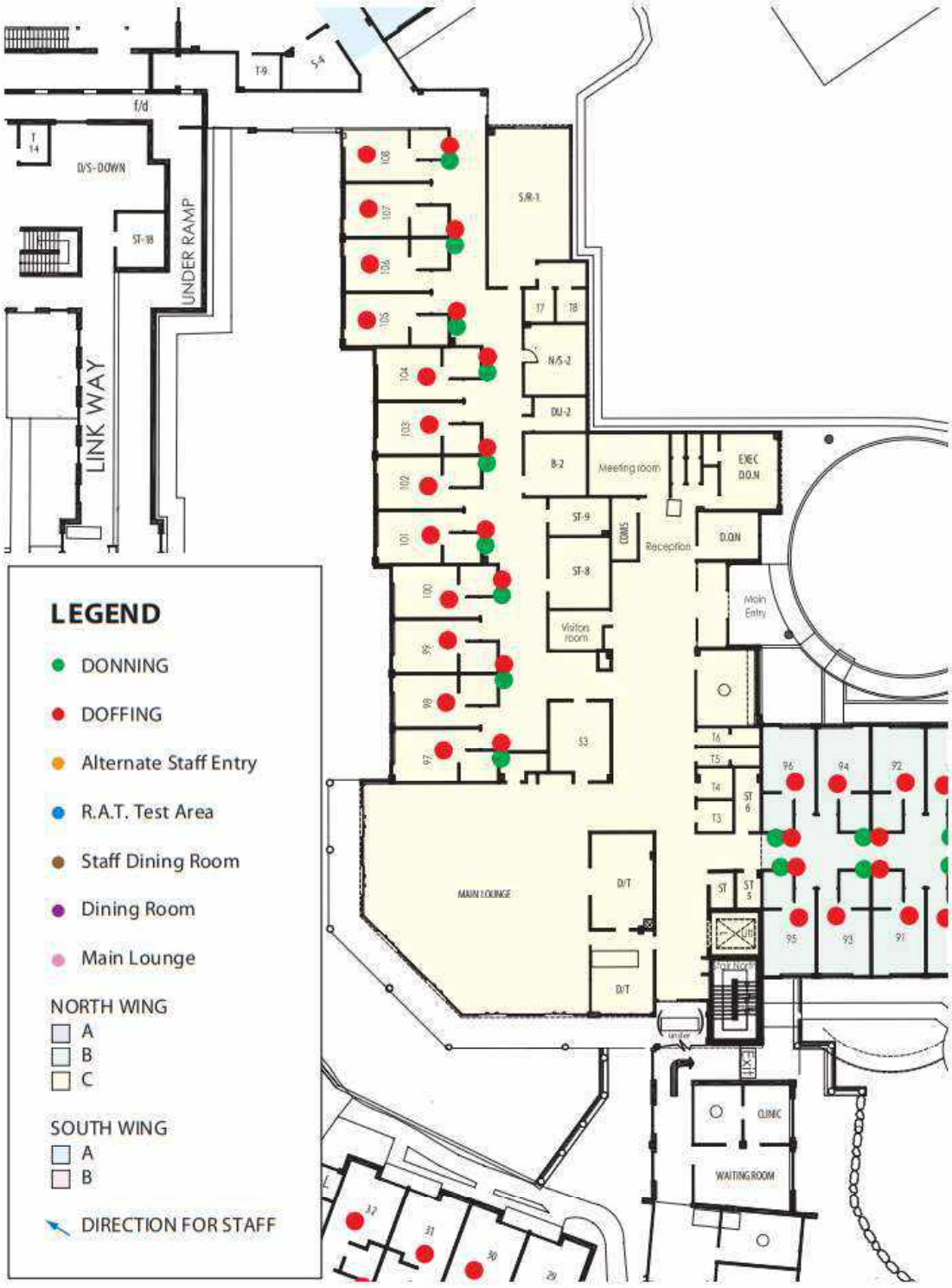
DCW LOWER STUDIO



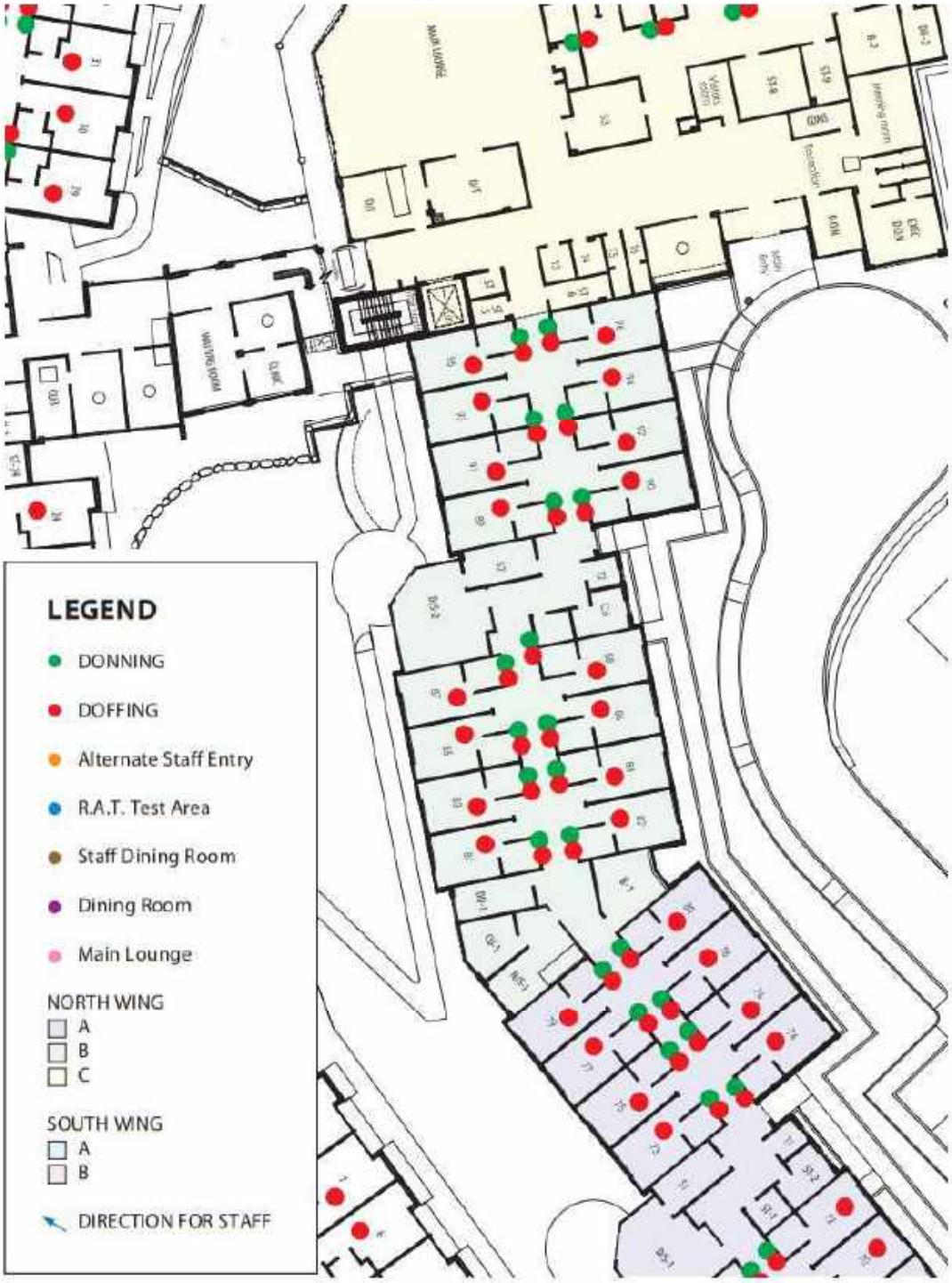
NURSING HOME SOUTH WING A-B



NURSING HOME NORTH WING C

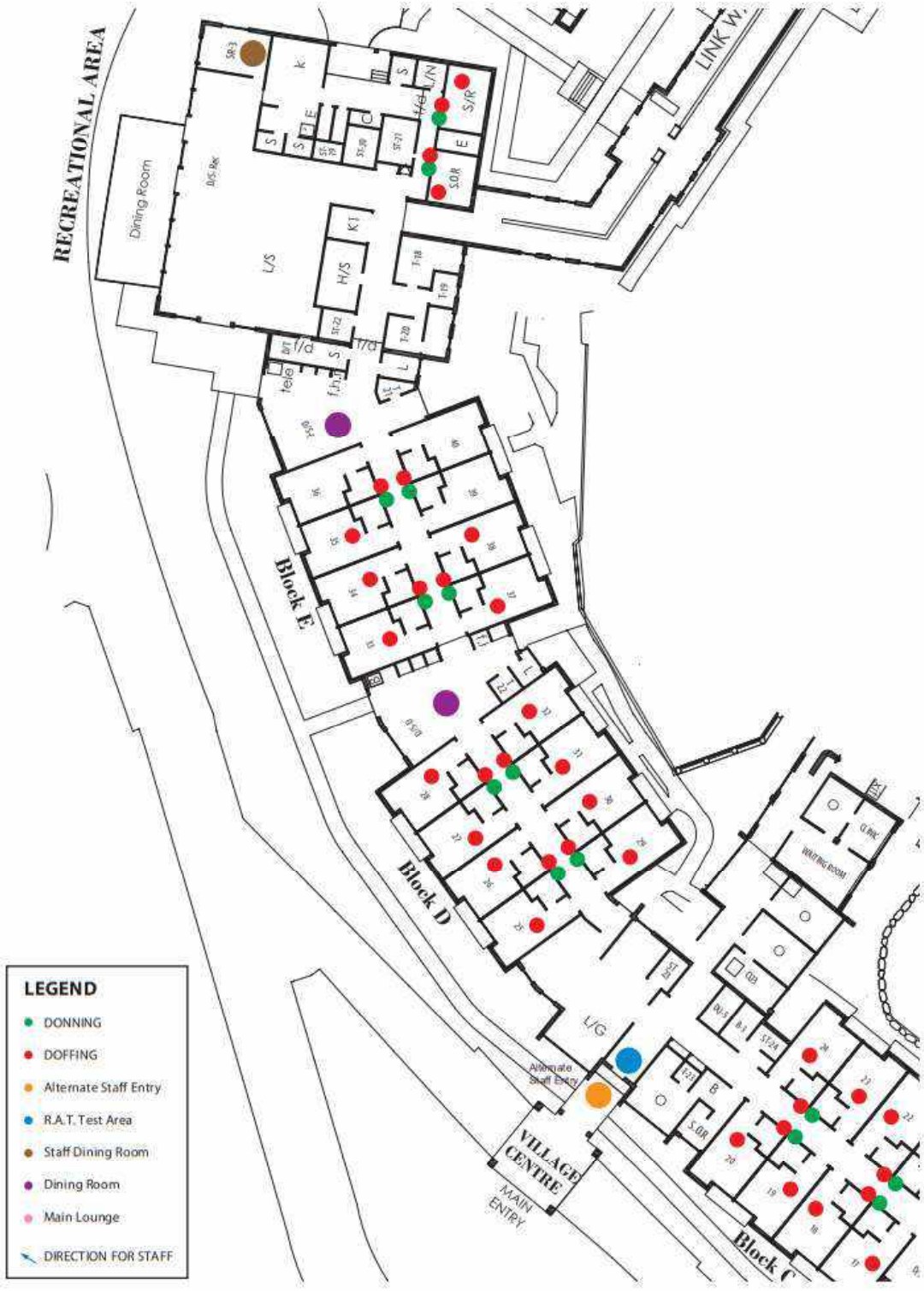


NURSING HOME NORTH WING B

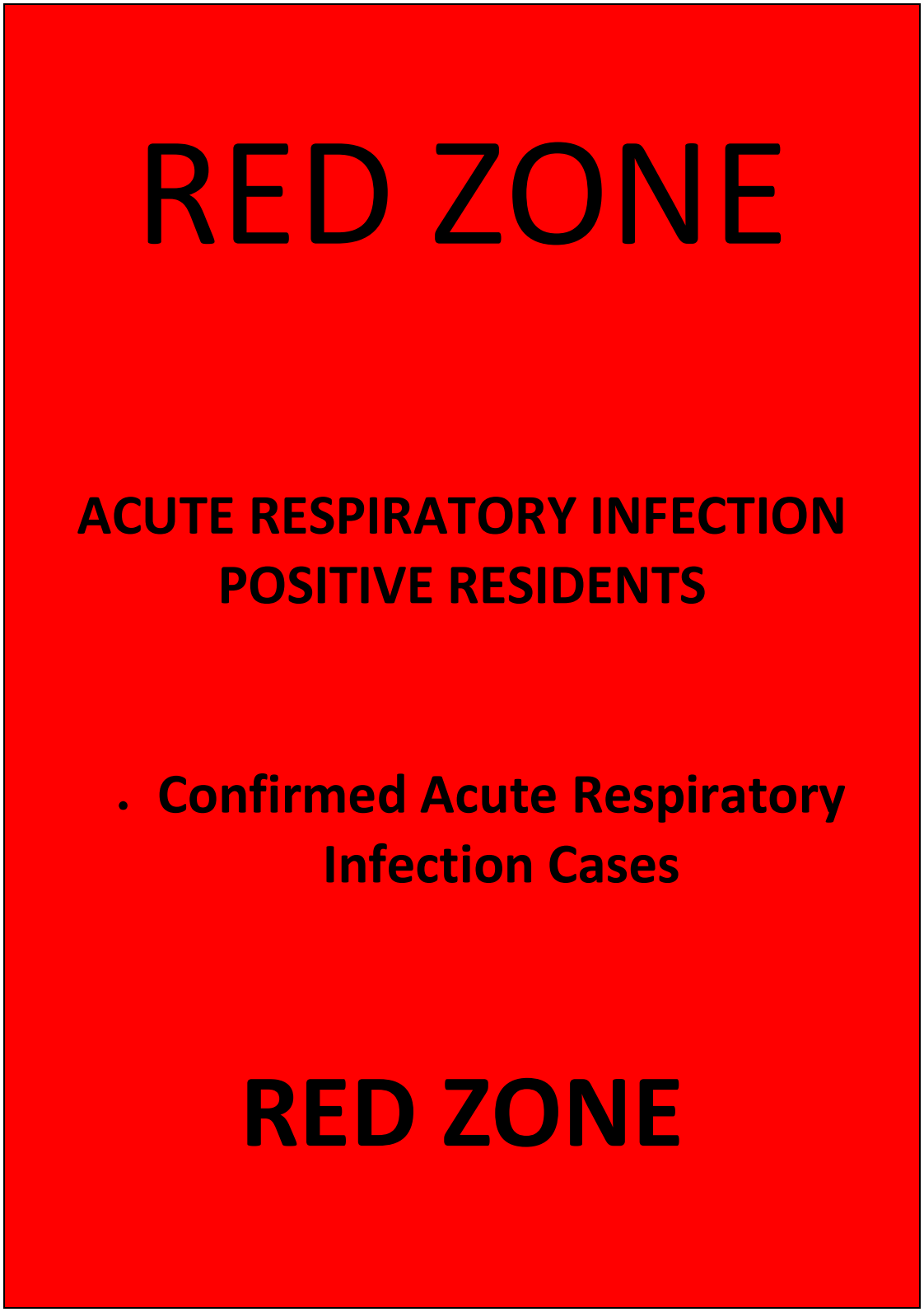


NURSING HOME NORTH WING A

DCW SOUTH


RECREATIONAL AREA
Dining Room
L/S
H/S
LINK W.
Block E
Block D
L/G
VILLAGE CENTRE
MAIN ENTRY
Alternate Staff Entry
LEGEND
DONNING
DOFFING
Alternate Staff Entry
R.A.T. Test Area
Staff Dining Room
Dining Room
Main Lounge
DIRECTION FOR STAFF

32.Signage


RED ZONE
ACUTE RESPIRATORY INFECTION
POSITIVE RESIDENTS
. Confirmed Acute Respiratory
Infection Cases
RED ZONE

AMBER ZONE

Close Contacts or suspected cases of Acute Respiratory Infection

- **Areas for close contact in quarantine/self - isolation or suspected cases.**

AMBER ZONE

GREEN ZONE

AREAS THAT HAVE BEEN CLEARED OF HAVING ACUTE RESPIRATORY INFECTION

- **Areas for cleared residents.**

GREEN ZONE

DOFFING STATION

1. Remove Gloves

2. Sanitise your hands

3. Remove Gown

4. Sanitise your hands.

MASK DONNING STATION

1.Sanitise your hands.

2. Apply mask.

3.Sanitise your hands.

4.Face shield/Goggles

5. Sanitise your hands.

MASK/SHIELD DOFFING STATION

1.Sanitise your hands

2.Remove face shield

3.Sanitise your hands

4.Remove mask

5.Sanitise your hands

DONNING STATION

1. Sanitise your hands.

2. Put on long sleeve gown.

3. Sanitise your hands.

4. Put on gloves.


STOP
VISITOR RESTRICTIONS MAY BE IN PLACE
For all staff
Airborne precautions
in addition to standard precautions
Before entering room/care zone
1
Perform hand hygiene
2
Put on a particulate filter respirator (e.g. P2/N95) and perform a fit check
3
Put on protective eyewear
4
Perform hand hygiene
What else can you do to stop the spread of infections?
• Consider patient placement
• Use a negative pressure room, where available
• Keep door closed at all times
• Minimise patient movement.
At doorway prior to leaving room/care zone
1
Perform hand hygiene
2
Leave the room/care zone
3
Perform hand hygiene (in the anteroom/outside the room/care zone)
4
Remove protective eyewear (in the anteroom/outside the room/care zone)
5
Perform hand hygiene (in the anteroom/outside the room/care zone)
6
Remove and dispose of particulate filter respirator (in an anteroom/outside the room/care zone)
7
Perform hand hygiene
Always use standard precautions
• Perform hand hygiene before and after touching a patient or their surroundings
• Use personal protective equipment (PPE)*
• Use respiratory hygiene and cough etiquette
• Use aseptic technique
• Use and dispose of sharps safely
• Perform routine environmental cleaning and maintain a clean and safe healthcare environment
• Clean and reprocess reusable patient equipment
• Handle and dispose of waste safely
• Handle and dispose of used linen safely
*When used as part of standard precautions, PPE protects against probable exposure to blood and body substances. When used as part of transmission-based precautions, PPE services as a barrier to specific means of transmission of infectious agents.
AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

Standard precautions

Standard precautions must always be used when caring for all patients, regardless of their infection status

Perform hand hygiene

Clean and reprocess reusable patient equipment

Use personal protective equipment (PPE)*

Perform routine environmental cleaning

Use respiratory hygiene and cough etiquette

Handle and store waste safely

Use aseptic technique

Handle and store linen safely

Use and dispose of sharps safely

*When used as part of **standard precautions**, PPE protects against probable exposure to blood and body substances. When used as part of **transmission-based precautions**, PPE services as a barrier to specific means of transmission of infectious agents.

PPE image reproduced with permission of the NSW Clinical Excellence Commission.

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

NSW GOVERNMENT | CLINICAL EXCELLENCE COMMISSION

33. Key Resources

1. CDNA Guidelines – https://www.health.gov.au/sites/default/files/documents/2022/10/coronavirus-covid-19-cdna-national-guidelines-for-public-health-units.pdf

2. below infection Prevention and Control Expert Group-https://www.health.gov.au/sites/default/files/2022-12/coronavirus-covid-19-environmental-cleaning-and-disinfection-principles-for-health-and-residential-care-facilities.pdf

3. ATAGI - https://www.health.gov.au/news/atagi-update-on-the-covid-19-vaccination-program

4. Dining Experience - https://www.agedcarequality.gov.au/sites/default/files/media/ps-getting_the_dining_experience_right_fact_sheet.pdf

5. ARI Guidelines - https://www.health.nsw.gov.au/Infectious/covid-19/Documents/racf-ari-guidance.pdf

6. Industry Code for Visiting Residential Aged Care Homes during COVID-19 https://agedcare.royalcommission.gov.au/system/files/2020-10/CTH.4000.0001.1959.pdf

7. National COVID – 19 Health Management Plan for 2023 https://www.health.gov.au/sites/default/files/2022-12/national-covid-19-health-management-plan-for-2023_0.pdf

8. Advice to residential aged care Facilities https://www.health.nsw.gov.au/Infectious/covid-19/Pages/racf-latest-advice.aspx

9. NSW respiratory surveillance reports - https://www.health.nsw.gov.au/Infectious/covid-19/Pages/weekly-reports.aspx

10. Laundry Standards -https://www.saiglobal.com/PDFTemp/Previews/OSH/as/as4000/4100/4146.pdf

11. Clinical Excellence Commission COVID 19 – Infection Prevention and control https://www.cec.health.nsw.gov.au/keep-patients-safe/infection-prevention-and-control/COVID-19

12. Suppliers List (refer to the below Nursing home Stocktake Main store book) or located in Z Drive, under NH Stores.

13. 5 Moments of Hand Hygiene - https://cdn.who.int/media/docs/default-source/integrated-health-services-(ihs)/infection-prevention-and-control/your-5-moments-for-hand-hygiene-poster.pdf?sfvrsn=83e2fb0e_21

14. collection of nasal swab - https://www.health.gov.au/sites/default/files/documents/2020/06/phln-guidance-covid-19-swab-collection-upper-respiratory-specimen.pdf

BUCKLAND NURSING HOME STOCKTAKE

MAIN STORE – LOWER GROUND (BEHIND ROLLER DOOR)

Date

To be undertaken after all Cleaners Room and Kitchen General Stores have been replenished.

STORE ITEM	CODE	UNIT / PACK	CURRENT	MAXIMUM	ORDER
VERIDIA (918)	**www.caterex.com.au**			**Phone: 1300 228 222**	
Garbage Bag 73L – Black	20518	CTN / 5x50		20 CTNS	
Apron Plastic – Disposable White	20557	CTN / 10x100		5 PKTS	
RAID Odourless Insect Spray	15829	CAN		10 EA	
RAID Residual Surface Spray	15831	CAN		10 EA	
Goggles	10796	MINIMUM / 6		2 EA	
DEB Cutan Alcohol Foam Sanitiser 400mL (12)	19107	CTN / 12		2 CTNS	
DEB Cutan Alcohol Foam Sanitiser 1L Cartridge (6)	19103	CTN / 6		1 CTN	
CHEMPACK	**https://www.chem-pack.com.au/**			**Phone: 02 8536 9500**	
Gloves Clear P/Free – Small	01-3100-04-02	CTN / 10		20 CTNS	
Gloves Clear P/Free – Med	01-3100-04-03	CTN / 10		30 CTNS	
Gloves Clear P/Free – Large	01-3100-04-04	CTN / 10		30 CTNS	
Gloves Clear P/Free – XL	01-3100-04-05	CTN / 10		30 CTNS	
Paper Towel – Ultraslim 23 x 24cm	TAD2400	CTN / 20		30 CTNS	
Tissues	AFT	CTN / 48		10 CTNS	
Toilet Paper Rolls – 700 Sheet	P700	CTN / 48		12 CTNS	
Bin Liners 36L – White	WH36LT	CTN / 1000		10 CTNS	
Garbage Bag 240L – Black	PR240LT	CTN / 100		20 CTNS	
Clinical Waste Bag 80L – Yellow	YIW7010	CTN / 250		10 CTNS	
Gloves Pink S/L Utility – Size 7	GLVSL075PV	DOZ		12 PKTS	
Gloves Pink S/L Utility – Size 8	GLVSL080PV	DOZ		12 PKTS	
Gloves Pink S/L Utility – Size 9	GLVSL090PV	DOZ		12 PKTS	
Gloves Blue S/L Utility – Size 7.5	GLVSL075BV	DOZ		12 PKTS	
Gloves Blue S/L Utility – Size 8	GLVSL080BV	DOZ		12 PKTS	
Gloves Blue S/L Utility – Size 9	GLVSL090BV	DOZ		12 PKTS	

STORE ITEM	CODE	UNIT / PACK	CURRENT	MAXIMUM	ORDER
Toilet Brush and Holder	B12302	EA		10 EA	
Dustpan & Broom – Tall, Green	B-11115G	EA		3 EA	
Dustpan & Broom – Small, Green	B10207G	EA		5 EA	
Scourers – Green	18119	PACK / 10		24 PACKS	
EBOS	**https://www.eboshealthcare.com.au/**			**Phone 1800 269 534**	
Alginate Laundry Bag Red	CCXSSEAM-R	CTN / 200		8 CTNS	
Alginate Laundry Bag Yellow	CCXSSEAM-Y	CTN / 200		2 CTNS	
WINC	**www.winc.com.au**			**Phone: 13 26 44**	
Orange Squirt - 5L	18815413	EA		2 EA	
SETONS (2720081)	**seton_aust@seton.com**			**Phone: 1800 651 173**	
Ear Muffs	A24818	EA		2 EA	
NILFISK (026394)				**Phone: 1800 011 013**	
Vacuum Bags	81620000	PACK / 5		10 PACKS	
BIO Natural Solutions	**www.bnsolutions.con.au**			**Phone: 1300730551**	
Wee Off Stain & Odour Remover 750ml	WO0041	BOX / 12		3 BOXES	
Stocktake Completed by:	**Date:**				
Once stocktake has been completed please give book to Facility Manager					
Approved by:	**Date:**				
Once approved please give book to Administration Support Officer					

Supplier Name	Purchase Order Number	Purchased By Name	Date Submitted	Date Stock Received
VERIDIA				
WINC				
SETONS				
NILFISK				
BIO NATURAL SOLUTIONS				
CHEMPACK				
EBOS				

NOTE: Before ordering gloves and aprons check the storage in Buckland House

Infection Control Checklist

Infection Control Monitoring Checklist

Date of assessment contact: Click to enter a date. to

Entry Time **Exit Time:**

Names of Regulatory Officials: Click to enter text.

Service name: Buckland Aged Care Services

Commission ID: Click to enter text.

Name of person in charge of service: Click to enter text.

Number of consumers currently at the service: Click to enter text.

Room arrangements: Single rooms with ensuite.

SCREENING ON ENTRY ***Question 1 to 2 completed based on observations when entering the service and of all other admission points to the service***		**Yes**	**No**
1	The service has screening procedures:		
	Sign in register for all visitors, agency staff, transportation staff and other contacts who enter the service	☐	☐
	Pre-entry screening questions/measures/expectations of visitors clear	☐	☐
	Alcohol-based hand sanitiser	☐	☐
	Sanitiser wipes available at staff or visitor electronic sign in	☐	☐
	Direction on PPE currently required to enter the service	☐	☐
	Other, RAT testing outside entrance for staff to test self.	☐	☐
2	Are signs located at all entrances to the service instructing visitors and staff not to enter if they have a fever or symptoms of a respiratory or gastrointestinal infection?	☐	☐
If no to any of the above, provide details and areas of improvement: Click to enter text; where there were other entry requirements not listed, ensure they are recorded here.			

OUTBREAK MANAGEMENT PLAN ***Question 3 to 14 completed during review of the Outbreak Management Plan***		**Yes**	**No**
3	Date last reviewed: Enter date Date plan last practiced:		
4	Name of nominated infection prevention and control lead		

	OUTBREAK MANAGEMENT PLAN *Question 3 to 14 completed during review of the Outbreak Management Plan*	Yes	No
5	Does plan include a list of people with allocated roles and contact details including alternative staff contacts? Clear staffing plan for immediate support, information, and guidance for on-site staff unfamiliar with environment, processes, and individual consumers at all times i.e., every shift?	☐	☐
6	Is there a current staff list with contact details, including detailed rosters and a mechanism for managing risk where staff may work across multiple aged care/disability/health care services or multiple sites?	☐	☐
7	Is there a list (spreadsheet) of all consumers including recent photos, room numbers, vaccination status and emergency contact details? Is there process to identify consumers when familiar staff are not present e.g., wristbands?	☐ ☐	☐ ☐
8	Are Medicare numbers for all consumers able to be accessed when needed?	☐	☐
9	Does plan include other key points of contacts such as the PHU; Department of Health and Aged Care; GPs including after-hours GP contacts and other visiting staff; PPE stockists; surge workforce organisations; clinical waste contractor (increase frequency of bin collection)?	☐	☐
10	Does the service have a floor plan readily available to support isolating positive consumers and/or symptomatic consumers if required?'	☐	☐
11	Does the plan outline: The approach for managing all potential outbreaks including COVID-19, Acute Respiratory Illness (ARI) and gastrointestinal infections? The approach for managing a COVID-19 exposure? The process for managing an outbreak of COVID-19, ARI, or gastroenteritis? The process for identifying and defining the risk of specific exposures and the quarantine and isolation requirements? How staff will be assigned to teams to support cohorting/isolating positive consumers? Processes for clinical handover? Guidelines to determine the decision-making process for considering when a COVID-19 positive or ARI confirmed consumer may transfer to hospital? * Details of arrangements for GP or equivalent medical access during an outbreak? The service's Communication protocol and plan? (Consumers, staff, families, external bodies, and professionals) Access details to electronic records by all relevant parties, including contingency plan for loss of electronic records?	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
12	Are there contingency plans if practical to safely move and isolate COVID-19 or ARI positive consumers in a single room/share with another positive consumer with ensuite/separate bathroom or if bathrooms are shared, commodes are used to minimise sharing bathrooms?	☐	☐

OUTBREAK MANAGEMENT PLAN *Question 3 to 14 completed during review of the Outbreak Management Plan*		Yes	No
13	Is there prepared signage to communicate an outbreak and to identify areas that are active COVID-19 or ARI consumers zone/cohorts?	☐	☐
14	Is there a process to identify staff who actually worked on relevant dates (not just a roster), to determine dates, shifts and areas of work, and the consumers they cared for?	☐	☐
If no to any of the above, or the service does not have a current trained IPC lead for the service provide details and areas of improvement: Click to enter text.			

PERSONAL PROTECTIVE EQUIPMENT (PPE) *Responses to question 15 to 31 completed based on PPE observations;*		Yes	No	Not Required*
PPE supply and storage				
15	Does the service have sufficient PPE to manage the initial phase of an outbreak until they can access their further supply (including gloves, long sleeve fluid resistant gowns, eye protection, surgical and P2/N95 masks)?	☐	☐	
16	Has an area been identified for bulk stocks of PPE (pallets) to be safely delivered, received, and stored?	☐	☐	
17	Are PPE stock levels monitored, stored securely and always accessible by a designated person?	☐	☐	
18	Is PPE readily available and in easy reach of staff who require it (including masks, gowns, gloves, face shields/eye protection, hand sanitiser, waste disposal bins and liners)?	☐	☐	
PPE usage				
19	Does the service have a process for overseeing and monitoring that staff are using the required PPE, and using PPE correctly?	☐	☐	
20	Are there separate areas/stations for PPE donning and doffing that are clearly identified?	☐	☐	☐
21	Are posters/instructions on donning/doffing PPE available	☐	☐	
22	Where PPE is required, are staff donning and doffing PPE correctly?	☐	☐	☐
23	Where PPE is required, are staff correctly applying PPE?	☐	☐	☐
24	Where required, is appropriate PPE used by staff with different roles (care/non-care staff)?	☐	☐	☐
25	If required, is everyone (except consumers) in the service wearing the type of mask specified by the relevant State or Territory Health Department?	☐	☐	☐
26	If required, are staff wearing face shields or other protective eyewear in addition to masks?	☐	☐	☐

PERSONAL PROTECTIVE EQUIPMENT (PPE) *Responses to question 15 to 31 completed based on PPE observations;*		Yes	No	Not Required*
27	Are staff undertaking good hand hygiene practices and changing gloves (if applicable) between consumers?	☐	☐	
28	Where PPE is required, were staff observed **not to be touching** their face or mask?	☐	☐	☐
PPE disposal				
29	Are there sufficient and appropriate waste bins available which are emptied frequently enough?	☐	☐	
30	Are staff disposing of PPE correctly?	☐	☐	
31	Is the waste service sufficient to ensure adequate waste removal from site (large volume in outbreak)?	☐	☐	I
If no to any of the above, provide details and areas of improvement: Click to enter text.				

INFECTION CONTROL MEASURES *Responses to question 32 to 41 completed based on infection control observations;*		Yes	No	Not Required*
Hand hygiene				
32	Are hand washing and/or alcohol-based hand sanitiser stations readily available for staff, consumers, and visitors in all areas of the service including in kitchen, laundry areas?	☐	☐	
33	Is there hand wash available at all hand basins and in bathrooms?	☐	☐	
34	Are acceptable hand washing frequency and techniques being used by staff, consumers, and visitors?	☐	☐	
Environment/Equipment Cleaning				
35	Adequate supplies are in place for increased frequency of cleaning particularly high touch surfaces, including detergent for cleaning, approved disinfectant, and disinfectant wipes?	☐	☐	
36	Is all shared equipment being cleaned and disinfected between consumers?	☐	☐	
37	Is shared equipment such as telephones and computers, door handles, rails, chair arms and other high touch items being cleaned and disinfected after each use?	☐	☐	
38	Are there appropriate cleaning directions and cleaning supplies for high-risk spaces including areas in isolation, staff meeting spaces, shared and separate bathrooms, kitchen, laundry, and medication administration?	☐	☐	
Other Preventative Strategies				
39	Are all staff and consumers using own drink bottles and/or are there appropriate management plans for communal taps or fountains (as high touch points)?	☐	☐	☐

INFECTION CONTROL MEASURES *Responses to question 32 to 41 completed based on infection control observations;*		Yes	No	Not Required*
40	Are all staff and consumers screened daily for symptoms (fever, acute respiratory symptoms and change in behaviour in consumers)?	☐	☐	☐
41	Are visitors attending the service as per any visitor access/restriction requirements	☐	☐	☐
If no to any of the above, provide details and areas of improvement: Click to enter text.				

WORKFORCE *Responses to questions 42 to 47 completed based on interview with the person in charge during the entry meeting and observations of the workforce;*		Yes	No
42	Is there a process for orientation, induction and training in PPE and infection control, including for agency staff and/or surge workforce for each shift?	☐	☐
43	Is a process in place to ensure staff competency following PPE and infection control training that is consistent with public health directions and best practice guidance? This includes how the service satisfies itself that all staff are able to adhere to hand hygiene and PPE requirements at all times and across all shifts, such as donning and doffing PPE. This includes ensuring staff competency for any anticipated increase in the use of PPE, for example, through PPE drills. Provide details.	☐	☐
44	A process is in place to determine and record staff and consumer COVID vaccination and Influenza vaccination status (whether voluntarily or as required under a law of a State or Territory)? Include monitoring when next doses due and enabling access.	☐	☐
45	There is a surge contingency staffing plan if a significant number of staff become sick or require quarantining (may include access details to the temporary surge workforce through the Department of Health and Aged Care)?	☐	☐
46	Clear handover arrangements occur for consumers' individual risks, care needs, social needs, and monitoring requirements?	☐	☐
47	The service has determined how it can resource cleaning staff and supplies, including induction and training at surge periods? New product	☐	☐
If no or unchecked to any of the above, provide details and areas of improvement: Click to enter text.			

COMMUNICATIONS AND SIGNAGE *Responses to question 48 to 50 completed based on observations of communications and signage; 'yes' and 'no',*		Yes	No
48	Service has notice boards, signs, and other sources of information throughout the premises for staff, consumers and visitors on infection prevention and control including:		

COMMUNICATIONS AND SIGNAGE *Responses to question 48 to 50 completed based on observations of communications and signage; 'yes' and 'no',*		Yes	No
	Hand hygiene	☒	☐
	Cough etiquette	☐	☐
	Physical distancing/staying 1.5m away from other people *based on each State/Territory health directions* (Staff/Visitors)	☐	☐
	Advice to stay at home even with the mildest of symptoms or possible exposure/close contact to COVID-19 positive person or person with other infectious disease symptoms	☐	☐
	Density signage is displayed based on each State/Territory health directions	☐	☐
49	Information materials and signs are language appropriate for the consumers, staff, and visitors of the service?	☐	☐
50	The service has signage and processes in place to monitor staff physical distancing, e.g., during handover, breaks, entry, and exit, and including remaining in separated and defined work zones based on each State/Territory health directions.	☐	☐
If no or unchecked to any of the above, provide details and areas of improvement: Click to enter text.			

CONSUMERS *Responses to question 51 to 64 completed based on observations; 'yes' and 'no'*		Yes	No
51	Has the service spoken to all consumers and/or consumer representatives and documented consent or the decision to refuse antiviral treatment for the consumer?	☐	☐
52	Is the information on consumer consent or decision to refuse antivirals accessible to staff, including out of hours?	☐	☐
53	Is there a process to re-discuss antiviral use and consent with consumers who test COVID-19 positive and/or consumer representatives who make the decision to refuse antiviral treatment?	☐	☐
54	Has the service spoken to consumer medical officers to plan for review of consumer health status and prescribing of antivirals for consumers who test positive to COVID-19 including out of hours?	☐	☐
55	Has the service contacted their pharmacy/pharmacies to ensure availability of antiviral medication including out of hours?	☐	☐
56	Has the service provided education and training to staff on the use and administration of antivirals for consumers including where there may be swallowing difficulties	☐	☐
57	Are consumers able to move freely outside of their rooms	☐	☐
58	Is the service aware of the Industry Code for Visiting in Aged Care Homes?	☒	☒

CONSUMERS *Responses to question 51 to 64 completed based on observations; 'yes' and 'no'*		Yes	No
59	Are consumers and visitors observed to be participating in visits in line with the service's policies and procedures and the principles of person-centred care (as outlined in the Partnerships in Care Fact sheet?	☐	☐
60	Does the service have a documented risk-based approach to facilitate essential visitors to all consumers including during an outbreak?	☐	☐
61	Does the service have a documented process to ensure non-essential visitors can have contact with consumers if they become COVID-19 positive or have another viral illness?	☐	☐
62	Does the service ensure access to volunteers continues during an outbreak?	☐	☐
63	Does the service ensure access for visitors to unaffected parts of the service during an outbreak?	☐	☐
64	Does the service ensure that consumer risks are managed during an outbreak including nutrition, psychosocial and physical activity?	☐	☐
If no to any of the above or are unchecked, provide details and areas of improvement: Click to enter text.			
General consumer observations: Click to add your observations of consumers within the service.			

BUCKLAND DOCTORS CONTACT DETAILS

DOCTOR	SURGERY	SURGERY ADDRESS	AH ON CALL	AH DOCTOR SPECIFIC	AH PRIV
[redacted]					

IN THE FAIR WORK COMMISSION

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

Re Application by: Virginia Ellis, Mark Castieau, Sanu Ghimire, Paul Jones and Health Services Union; Australian Nursing and Midwifery Federation; Health Services Union

WITNESS STATEMENT OF LOUANNE RIBOLDI
DATED 31 OCTOBER 2023

I, Louanne Riboldi of Level 12, 2 Park St, Sydney, NSW 2000 state as follows:

Background

1. I am employed as the Chief of Operations (**COO**) at Royal Freemans' Benevolent Institution (**RFBI**). I have held this position for around 7 years, after being appointed to the role in 2016. I am a member of the RFBI Senior Management Team.

2. I joined RFBI in 1997 as part of the administration team. In 2000, I became a Self-Care Manager. Since then, I taken on multiple roles including General Manager and Regional General Manager, a position I held for 5 years before becoming COO.

3. I have over 20 years' experience working in the aged care sector.

4. I hold a Bachelor of Health from the University of Newcastle.

5. In my role as COO:

   (a) I have broad knowledge and understanding of the administration, financial and operational functions and practices (including recruitment and staffing) within each residential aged care village, retirement village, and in relation to the home and community services provided by RFBI.

   (b) I am responsible for the following:

      (i) overseeing the ongoing operations throughout the residential aged care villages and retirement villages, including personal care services, clinical care, hotel services (including cleaning, laundry, catering/kitchen), administration and maintenance;

      (ii) overseeing the ongoing operations relevant to the delivery of home and community services;

      (iii) ensuring RFBI are meeting the Aged Care Quality Standards (**ACQS**) and that its operations are consistent and compliance with legal obligations and guidance published by the Aged Care Quality

Lodged by: Joint Employers
Telephone: 0482 181 223
Address for Service: Level 7, 8 Chifley Square, Sydney, NSW 2000
Email: Nigel.Ward@ablawyers.com.au; Alana.Rafter@ablawyers.com.au

Commission, Clinical Excellence Commission and the Department of Health and Aged Care;

(iv) overseeing the development and delivery of training and education for all staff throughout RFBI, including ensuring all RFBI staff understand and are compliant with the ACQS;

(v) ensuring the strategic goals of RFBI are communicated and pursued consistently throughout each of residential aged care villages, retirement villages, and in the home and community sectors, with the aim to ensure every resident and client received the very best care and services;

(vi) working closely with the general managers; and

(vii) keeping the senior management team informed about the status of operations throughout RFBI.

6. My daily duties include:

(a) mentoring and support Regional General Managers;

(b) oversight and analysis of key performance indicators (**KPIs**);

(c) supporting regional team to meet KPIs;

(d) managing serious complaints;

(e) oversight of Serious Incident Response Scheme (**SIRS**);

(f) oversight of clinical trends and indicators;

(g) management of senior personnel;

(h) review of policy and procedure;

(i) village visits;

7. I report to Frank Price, Chief Executive Officer.

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

RFBI

9. RFBI is an aged care organisation that provides care services. The operations of RFBI include:

   (a) 22 residential aged care villages in the following locations:

      (i) Sydney and South Coast: Basin View, Berry, Concord and Lakemba;

      (ii) Hunter, Central and Mid North Coast: Cessnock, Hawkins, Kurri Kurri, Lake Haven and Benhome;

      (iii) Southern Highlands and Canberra: Goulburn and Holt;

      (iv) Central West and Riverina: Bathurst, Dubbo, Leeton and West Wyalong;

      (v) New England: Armidale, Glenn Innes, Moonbi and Tamworth;

      (vi) Mid North Coast: Bellingen, Coffs Harbour and Raleigh Urunga;

   (b) 20 retirement villages in the following locations:

      (i) Sydney and South Coast: Basin View, Berry and Roselands;

      (ii) Hunter, Central and Mid North Coast: Cessnock, Hawkins and Lake Haven;

      (iii) Southern Highlands and Canberra: Pearce, Goulburn, Moss Vale and Holt;

      (iv) Central West and Riverina: Bathurst, Dubbo and Leeton;

      (v) New England: Armidale, Glenn Innes, Moonbi and Tamworth;

      (vi) Mid North Coast: Bellingen and Coffs Harbour;

   (c) a range of home and community services throughout:

      (i) ACT and Southern Tablelands;

      (ii) Central Coast;

      (iii) Mid North Coast;

      (iv) Newcastle and Hunter Region;

      (v) New England;

      (vi) South Western Sydney.

Staff

10. Across its operations, RFBI currently employs over 1900 employees.

11. RFBI employ the following:

    (a) nursing employees:

        (i) nurse practitioners (**NP**);

        (ii) registered nurses (**RN**);

        (iii) enrolled nurses (**EN**);

    (b) care workers;

    (c) chefs/cooks;

    (d) hotel services employees (which includes laundry employees and cleaners);

    (e) catering employees;

    (f) maintenance employees (which includes maintenance and gardening employees); and

    (g) administration employees.

12. Whilst RFBI prefers to engage permanent employees where possible, if the care needs of our residents require additional staff, RFBI engages agency workers. We have also sourced staff via migration pathways, most recently via the Pacific Australia Labour Mobility (**PALM**) scheme.

Training

Onboarding and Induction

13. The onboarding process for all new staff is as follows:

    (a) Each new staff member is required to attend and complete a 2-day in-person induction at the village. During that induction, the following occurs:

        (i) the sessions are primarily led by the educator (who is generally a RN or Certificate IV employee);

        (ii) the General Manager of the village will introduce themselves to the new staff;

        (iii) the Fire Warden will take them through the facility and conduct the practical fire training; and

(iv) a qualified staff member of the village will go through the relevant manual handling training for care staff to walk them through the equipment used at the site the care worker is employed.

A COPY OF THE RFBI INDUCTION DAY 1 CHECKLIST IS ANNEXED AND MARKED "LR-1".

(b) Each employee is required to read and acknowledge receipt of the following RFBI policies that are accessible on RFBI's intranet and in Policy Connect:

(i) Social Media Policy;

(ii) Harassment, Bullying and Discrimination Policy – Located in PolicyConnect Human Resources Module;

(iii) RFBI Values and Ethics Policy – Found in PolicyConnect, Code of Conduct for Aged Care (The Code) Module;

(iv) Staff Grievance Resolution Policy – Located in PolicyConnect Human Resources Module;

(v) Staff Confidentiality Policy – Located in PolicyConnect Human Resources Module;

(vi) Staff Uniform Policy – Located in PolicyConnect Human Resources Module;

(vii) Procedures for Identifying, responding to and Reporting Elder Abuse and Neglect – Found in PolicyConnect, Resident Care Module, Executive Summary, Consumer Safety and Behaviour Module;

(viii) Work Health and Safety Policy;

(ix) Privacy Policy – Located in PolicyConnect Privacy and Dignity Module; and

(x) Workplace Surveillance Policy Located in PolicyConnect Resident care Module.

A COPY OF THE RFBI NEW EMPLOYEE ACKNOWLEDGEMENT OF RFBI POLICIES AND PROCEDURES IS ANNEXED AND MARKED "LR-2".

(c) Each new staff member is provided 1-week to complete the following mandatory training modules (together with an indication of the typical duration time to complete each module):

(i) Infection prevention and control (**IPC**) (30 minutes);

(ii) Elder abuse (60 minutes);

(iii) SIRS (20 minutes);

(iv) Antimicrobial stewardship (30 minutes);

(v) Minimising restrictive practises (30 minutes);

(vi) About me – ACQS 1-8) (80 minutes);

(vii) Fruit Personality Workshop (a unique module provided by RFBI, designed to help staff members understand and work with different personality types that they may encounter in other staff members).

(d) Within their first month of employment, each staff member must complete the following online modules:

(i) Work health and safety (**WHS**) (45 minutes);

(ii) All about RFBI;

(iii) Feedback, Complaints and Open Disclosure (25 minutes);

(iv) Customer service (30 minutes);

(v) How to use time and attendance system (30 minutes);

(vi) Privacy and confidentiality (30 minutes);

(vii) Dignity and respect (30 minutes);

(viii) Bullying and harassment (30 minutes);

(ix) Cultural diversity and safety (30 minutes);

(x) manual handling (i.e. safe lifting and safe transfer) (30 minutes); and

(xi) Food services.

A COPY OF THE 2023 RFBI NEW STARTERS EDUCATION PLANNER IS ANNEXED AND MARKED "LR-3".

(e) If the new staff member is a care worker, they are required to complete additional modules within the first month:

(i) restrictive practices;

(ii) sensory loss; and

(iii) manual handing (with respect to safe movement and handling of residents and including the use of specific lifting equipment).

14. In their first week, which is focused upon completion of the online modules, new staff members are given the option to complete their training remotely or at the village. The RFBI educator is made available for the entirety of that first onboarding week and can assist new staff members that complete the training modules onsite.

15. The modules range up to 1 hour in length and include a short assessment at the end to confirm understanding.

16. During the induction, the new staff members will receive an induction pack.

Buddy-shifts

17. After the new staff members have completed onboarding and induction, they will be allocated buddy-shifts. A *"buddy-shift"* is where a new staff member is paired with an existing member of staff that works with the relevant team that the new staff member will ultimately be working in.

18. During a buddy-shift, the new staff member will shadow and accompany the existing staff member, who will also help the new staff member get familiar with the RFBI process and practices relevant to their role (reinforcing the training and education received during induction).

19. There is no hard and fast rule for duration of buddy-shift allocation, the key determiner is whether the new staff member understands the necessary competencies and that both employee and employee feel confidence the employee can exercise them on their own. For some employees, 1-2 buddy-shifts may be sufficient, for others 10 buddy-shifts may be required. Neither is bad.

Competency Book

20. Each year all RFBI staff are provided a list of competencies they have to undertake and period of time to complete. The educator will be the one to determine whether or not they have achieved them. The educator may also arrange for additional training to help an employee achieve the necessary level of competency required of a role.

Mandatory Training

21. All RFBI staff have mandatory training to complete every year. That training is assigned online.

22. The mandatory training modules are the same modules that are initially completed as part of the onboarding process.

23. Each village will also do a training needs analysis and apply face-to-face education as needed.

Other Training

24. RFBI also require all staff to complete a training module that addresses dementia, which is assigned to all staff.

25. The training module is delivered online and takes around 45 minutes to complete.

26. This decision was made due to the prevalence of residents with different stages of dementia throughout the villages. In some cases, sadly, residents may display signs of aggression.

27. Although the administration, hotel services, catering and maintenance employees may have different degrees of interaction with resident (by comparison to a carer or nursing employee), they will necessarily see them most days (if not everyday) because they work in their home.

28. The training covers the following topics:

(a) state general information about dementia;

(b) list the causes and symptoms of dementia;

(c) outline the stages of dementia;

(d) understand people's actions, reactions and responses in relation to unmet needs;

(e) identify common triggers and contributing factors for people's actions, reactions and responses;

(f) list strategies to improve people's wellbeing and reduce or prevent their actions, reactions and responses to unmet needs;

(g) discuss communication strategies to aid the person's wellbeing;

(h) consider the needs of culturally and linguistically diverse older people; and

(i) identify carer and family issues and strategies to support them.

29. By providing this information, RFBI ensures that all staff are informed about the features of their work environment. It also reinforces the importance of walking away and contacting an RN if they ever spot potential risks to their safety or possible the safety of the resident.

RFBI Expectations and Established Procedures for hotel services, catering, administration and maintenance employees

30. The procedures and practices to be followed by hotel services, catering, administration and maintenance employees are consistent throughout the villages operated by RFBI. This enables RFBI to ensure the quality of services it delivers to residents everyday throughout NSW and the ACT.

31. Each employee receives training and instruction in relation to the following:

(a) interaction with residents;

(b) responding to incidents (for example, falls);

(c) responding to preferences; and

(d) interaction with families.

32. For this section of my statement, I will adopt the shorthand of *"indirect care workers"* to refer to hotel services, catering, administration and maintenance employees.

Interaction with Residents

33. All indirect care workers will have varying degrees of interaction with residents throughout their workday. The following training modules communicate expectations about interaction with residents:

    (a) About me (which is the ACQS standards 1-8);

    (b) Code of conduct;

    (c) Customer service; and

    (d) Dignity and respect.

34. That training and information provided by RFBI sets out an expectation (and encourages) all employees to engage in friendly and respectful conversation with residents. It may be a small interaction, but it can make a real difference to the quality of a resident's day.

35. If a cleaner was to enter a resident's room without regard for the presence of the resident, that would not be consistent with the expectations of RFBI.

36. As part of that training, indirect care workers are instructed to direct any concerns they may have about a resident they observe or interact with to the RN or senior care staff on duty. Of course they are not expected or required to make clinical assessments, take progress notes or intervene in clinical matters. However, some may be in a position to notice a mood change because they attend a resident's room most days. If they spot something out of the ordinary from their perspective, they are to let the care staff know.

37. Similarly, catering staff that are helping to serve food may also notice a resident is not eating or having difficulties managing to feed themselves. They are instructed to pass those concerns on to the care staff.

Responding to Incidents

38. If an indirect care worker observes or discovers a resident has had a fall, as set out in both the SIRS and WHS training, they are trained to immediately go and get the RN.

39. Indirect care workers are not encouraged to intervene unless it is a life-threatening situation. For example, if a resident is found bleeding profusely the expectation is they would call for help (RN or ambulance) and start applying first aid. All RFBI employees are required to complete First Aid Training, which means they are competent to provide basic first aid.

40. Even with first aid training certification, the standard protocol is that indirect care workers go get the person with the clinical expertise (i.e. the RN).

Responding to Preferences

41. At RFBI, the indirect care workers do not have access to a resident's care plan. Instead they have access to particular information about a resident that is relevant to their scope of duties. The relevant processes that apply are highlighted during buddy-shifts.

Catering staff

42. The catering staff have access to resident information about a resident's dietary requirements, likes and dislikes, together with any allergies via the Simple Food Safety Management & Consumer Meal Ordering Software (**the Simple system**).

43. The purpose of this access is to enable the catering staff to respond to requests made by a resident. For example, if *Resident A* asks, *"can I have potato chips"*, the catering employee can review the information stored on the Simple system to check if there are any factors that might impact that request, such as a note that the resident is on a strict *"pureed diet only"*. In that case, they catering employee would have to say no to the request but could help the resident select an alternative option.

44. In that example, we would not expect the catering employee to approach a carer and double-check whether *Resident A* can have potato chips. They have the information needed to answer that question and it falls within the scope of their role.

45. A different approach is required if they receive a request that is outside the parameters of the Simple system. In those circumstances, the expectation is that the catering employee will escalate the inquiry to the RN. For example, staying with the example of *Resident A*, if the situation escalated to Resident A deciding if he cannot have the potato chips he will not eat, that is a situation a catering employee would refer to the RN.

Cleaning, Laundry and Maintenance staff

46. For cleaning, laundry and maintenance staff, they do not use the Simple system. Rather, information relevant to resident preferences is stored in the wardrobes to retain the resident's privacy.

47. Another practice which helps maintain discretion and privacy is the use of symbols to communicate certain matters to staff. For example, a butterfly symbol on the resident's door means they are living with dementia.

48. These RFBI practices are addressed during induction training and reinforced during the buddy-shifts.

Interaction with Families

49. At RFBI, care workers, nursing employees and indirect care workers wear the same uniform. This means the position of an employee walking through the village may not be immediately apparent. Even so, family members have the right to approach any RFBI employee with feedback, an inquiry or a complaint.

50. The key training indirect care workers receive to prepare them to deal with those interactions with families is delivered through the customer service and feedback and complaints handling online modules.

51. If the matter falls outside of the indirect care workers' scope of competency, they are trained to politely and respectfully listen to the family member, acknowledge they have heard what has been said and, if they cannot provide the answer, find the appropriate person at the village.

52. If a family member makes a request that falls within the capabilities of the indirect care worker, for example, a request is made to provide additional towels or to fix a picture frame that has fallen off the wall – if they can attend to it, the expectation is the indirect care worker will do so.

53. A strict protocol applies if the family is communicating a complaint to an indirect care worker. For example:

(a) a family member communicates to a cleaner that enters the room *"why hasn't mum had a shower yet?"*, being a matter relating to personal care, the process is that the cleaner will promptly find the senior carer to discuss the matter with the family member;

(b) a family member communicates to a maintenance employee, *"I don't think dad has had his medication today"*, being a clinical matter, the process is that the maintenance employee would promptly find the RN.

54. The complaints process that is followed is then document by either the senior carer or the RN.

Infection Prevention and Control

Pre-covid

55. Prior to the pandemic in 2020, RFBI had a standard protocol for managing outbreaks of infectious diseases within the villages (**the outbreak management plan**). The

outbreak management plan addressed different types of infection (e.g. *"airborne"* and *"gastro"*).

56. RFBI employs a NP who is responsible for ensuring our plan, protocols and programs in relation to outbreak management and IPC are up-to-date with the latest advice from the Clinical Excellence Commission (**CEC**). RFBI's outbreak management plan is regularly updated throughout the year.

57. Prior to the pandemic, RFBI had an infection control committee at each village that was responsible for overseeing the delivery and maintenance of infection control measures at the villages.

58. The ACQSC conduct audits of the villages on a regular basis, visiting each facility at least once a year and sometimes every six months. They conduct an IPC audit at least every six months at every village operated by RFBI. The average length of a visit is 3-hours, during which they will request to see the outbreak management plan.

59. RFBI is required to provide training and information to all staff about managing outbreaks. That requirement existed before the pandemic.

60. Examples of outbreak management protocols include:

    (a) restrictions on the movement of staff into the outbreak zone;

    (b) increased frequency of surface cleaning; and

    (c) PPE requirements.

The pandemic

61. In 2020, when the pandemic was declared RFBI implemented a strict protocol for managing the risk of a COVID-19 outbreak.

62. RFBI adhered to the requirements and advice of the relevant health and government bodies with respect to COVID-19. This included having a standalone COVID-19 Management Plan. During the peak of the pandemic, aged care providers were not allowed to simply update our exiting outbreak protocol – a separate management plan had to be created and maintained.

63. The COVID-19 Management Plan was frequently updated to be consistent with the latest advice.

64. Additionally, RFBI appointed an IPC lead at each village. This was a mandatory requirement introduced in or around December 2020. Each IPC lead was required to undertake and complete specific training to be qualified as an IPC (i.e. it was not sufficient to hold a nursing qualification).

65. Across 2020-2021, RFBI had a few outbreaks that required adherence to the outbreak management plan.

66. During the pandemic, specific donning and doffing training was introduced for all staff. A refresher of that training had to be completed every three months by all staff.

Impact of the pandemic as at 2023

67. As at 2023, RFBI has returned to having a standard protocol for managing outbreaks in the villages. The protocol for managing a COVID-19 outbreak falls under the management of an *"airborne"* outbreak.

A COPY OF A CURRENT RFBI OUTBREAK PLAN (UPDATED ON THE 4 SEPTEMBER 2023) IS ANNEXED AND MARKED "LR-4".

68. The ACQSC have confirmed that an integrated plan is compliant. This approach is also consistent with advice communicated by the CEC and the NSW Ministry of Health.

69. RFBI also follows the guidance published by the NSW Ministry of Health, which concerns the management of acute respiratory infections (including COVID-19, influenza, and respiratory syncytial virus).

70. The RFBI outbreak management plan continues to be regularly updated. For example, the protocol was updated twice within the past month.

71. All staff continue to receive training with respect to IPC and outbreak management in the villages, which has been updated. For example, it is now mandatory for all staff to complete a *"donning and doffing"* module for PPE each year. Previously only care workers completed specific training about donning and doffing. This addition forms part of the annual refresher training that all staff are required to complete.

72. RFBI continues to employ IPC leads in each of the villages.

Staffing Shortage

73. RFBI is experiencing staff shortages across all areas, but particularly in the role of RN. This does not, however, correlate to poor care outcomes for residents.

74. Factors that inform how many staff are required at a village include the following:

    (a) the care needs of the resident – this may include dementia, palliative care needs as they arise; and

    (b) the size and layout of a village.

75. To ensure that the care outcomes of our residents is not compromised, RFBI takes steps to supplement its permanent workforce. This includes:

(a) engaging agency workers;

(b) exploring different migration pathways to create an alternative source of labour; and

(c) internal scholarships to existing staff members who wish to get nursing qualifications.

Agency workers

76. Due to the staff shortages, these additional steps are necessary to ensure that the quality of care for our residents is not compromised and we do not have to consistently rely on our permanent employees to work additional hours. From time to time, our workers will work additional shifts to ensure care outcomes are not compromised.

77. RFBI have labour agreements with preferred agencies, including some long-term contracts with the same agency workers. Agency staff are contracted if there is a risk to the wellbeing of a resident if a shift is not filled.

78. Whilst engaging agency workers is a last resort, we use preferred agencies because we prefer to engage the same agency staff where possible, so they have familiarity with the residents.

79. Local managers will also contact agencies via the phone to fill short-term staff vacancies (for example, sick leave).

Migration pathways

80. An example of a migration pathway we have established includes a labour agreement entered with Fiji. By this program, Fijian qualified RNs a provided an employment pathway at RFBI. They are provided financial support to travel and live in Australia, whilst the work for RFBI as a care worker and undertake the required education and examination to have their international nursing qualification recognised in Australia.

81. Currently, we have recruited around 120-130 employees via that labour agreement.

82. RFBI is continuing to take steps to expand its use of migration pathways, including via the PALM scheme.

83. An RFBI facility will make the decision to run below capacity if necessary to ensure the care needs of residents are not compromised.

Care minutes

84. RFBI is also required to comply with mandatory targets set by the Federal Government:

(a) 24/7 RN coverage; and

(b) care minutes.

85. For RFBI facilities that are unable to meet the 24/7 RN coverage via their permanent workforce, we adopt the following strategies:

(a) engage agency staff as a last resort;

(b) ensure an EN is rostered with access to an on-call RN, if possible;

(c) put an additional staff member on the roster to assist with workload;

(d) always have an RN on-call;

(e) have an escalation process in place.

86. Whilst the EN is not a RN, they have a level of clinical care within their scope of practice. The access to an on-call RN is an important escalation process to ensure if an extra level of care is required it is available.

87. The introduction of care minutes is an initiative to support the delivery of quality care, however, it does not tell the whole story of what is happening in a facility. For example, that fact a facility may not achieve its 24/7 RN coverage does not mean that residents in that facility are not receiving quality care from the care workers or nursing employees at the facility. Additionally, they do not reflect any of the contribution made by the hotel services employees, etc to the resident's experience.

[redacted]

Louanne Riboldi

31 October 2023

Royal Freemasons' Benevolent Institution

Day 1 Induction Checklist

This checklist is to support leaders to induct new employees. It includes activities to complete with your new starter on their first day.

Please fill in any extra information below that is specific to the new starter's position. Once the checklist is completed add it to the employee's file.

Activity	Person responsible	Notes/actions required	Tick when complete
Welcome and introduce your new starter			
Meet your new starter at the agreed location Introduce them to colleagues throughout the day: • Meet Department Manager and Key Personnel • Start with their new team members then introduce them to people from other teams within the work environment • Consider whom you might need to email or message to introduce your new starter if they're not there in person	Hiring Manager		

Provide a Village tour to familiarise the new starter with the work environment, Include as applicable:
• Work station /desk
• Bathrooms
• Kitchen facilities
• Fire and Safety Tour
  ○ RACE
  ○ PASS
  ○ Evacuation Procedure
  ○ Break Glass Alarm
  ○ Danger Tag
  ○ Heat and smoke detector
  ○ Emergency Evacuation Area
  ○ Smoke Door
  ○ Floor plan regarding fire requirements
• Telephone System/ Fax/ Photocopier
• Call Bell System
• Communication Procedure
	Fire Officer		

Work Health and Safety			
RFBI Employees As a worker (including executives, employers, managers, supervisors and employees) you must: ○ take reasonable care for your health and safety ○ take reasonable care for the health and safety of co-workers and ensure that your actions do not put your co-workers at risk ○ use and maintain machinery and equipment properly ○ ensure that your work area is free of hazards	Quality Officer		

○ cooperate with RFBI in anything that you are required to do to ensure a safe workplace including: ○ notifying your supervisor of actual and potential hazards ○ notifying your supervisor of incidents and injuries ○ carrying out work in a safe manner ○ wearing or using prescribed safety equipment ○ following health and safety instructions, policies and procedures ○ cooperating with any investigation into an incident or accident ○ taking notice of signs ○ adhering to speed limits ○ participating in safety training. As a worker, **You Must NOT**: ○ intentionally or recklessly interfere with or misuse anything provided in the interests of health, safety and welfare ○ move or deface signs ○ tamper with warning alarms ○ remove machine guards ○ 'Skylark' or play jokes that may put the health and safety of others at risk ○ behave in a way that results in risk to yourself or others ○ intentionally hinder or obstruct the giving or receiving of any form of aid when a person is injured at work. **Education/ Administration Staff member to show the Hazard form and Staff Accident Incident Report and explain.**			
Go through fundamental information – the why, when, where and how of the position			
Cover essential administration such as: • Access to any systems or equipment they will need – this may be different for each area and could include: ○ Payroll system (e.g. Workforce Dimensions) ○ Learning Management System (CompliLearn) ○ Policy Management System – PolicyConnect and SharePoint ○ UKG Log In • Provide them with security passes/ keys • Pens/ notebooks • Key contacts • Roster requirements • Health and safety information	Hiring Manager		

Talk through information about our organisation, your team and their role so they become familiar with RFBI and understand their role. Use your 'Welcome Pack' which includes things like: • Who we are • Organisation charts • Team priorities • RFBI's strategy **Fruit Personality Training** ○ About this program and its benefit ○ Provide the below link to complete the fruit quiz (Mandatory) Take Lynne Schinella's Fruit Quiz ○ Record the completed task for future audit			
Training and Support			
Discuss any training needs you've identified and check this with your new employee. This includes: • Role-related training • Mandatory training (Fire training/ Hand Hygiene/ PPE etc.) • IPC- Discuss Outbreak Management storage areas, Outbreak Box, and Spill Kit along with all the other essential factors regarding the outbreak management • The New Starter's Day 1 training is to be completed in the village • The New Starter Induction (Part 2) will have a due date of 30 days • Access to CompliLearn, the procedure to mandatory orientation training • How will the buddy shift look and who their buddy is	Educator		
End of day 1 check-in			
Check-in with your new starter to see: • How they are feeling at the end of their first day? • If they have any questions about their role, the team or our organisation? Mention what their focus will be in the coming days.	Hiring Manager		

Employees Name:	
Position:	
Village:	
Employees Signature:	**Date**:
Managers Signature:	**Date**:

Food Handler and Staff Food Hygiene should be completed by Catering Staff, Care Staff and RNs. The form must be completed and placed in their training files. Send a copy of all the Catering staff to their Hospitality Managers.

Royal Freemasons' Benevolent Institution

Food Handler Declaration Form

Employees Name:

I agree to report to my manager, on the following occasions and understand that I may be required to submit samples for examination:

1. If I develop an illness involving:
   - Vomiting
   - Diarrhoea
   - Skin Rash
   - Septic Skin Lesion (boils, infected cuts, etc) however small
   - Discharge from ear, eye, nose or any site

2 Before commencing work following an illness involving any of the above conditions and I must submit a Medical Certificate of Fitness to Work from a Doctor.

3. On return from a trip abroad, during which an attack of vomiting and /or diarrhoea lasted more than two days.

4. I have/have not had typhoid, paratyphoid or enteric fever (for recorded purposes only). (Delete as appropriate).

I have read (or had explained to me) and understand the above rules on personal hygiene and have received a copy of this statement.

Employees Signature:	**Date**:
Witness Name: **Witness Signature**:	**Date**:

Royal Freemasons' Benevolent Institution

Staff Food Hygiene Information

RFBI is committed to ensuring that its foods are safe.

To support the development & implementation of our food safety system based on HACCP principles and as a follow up to the initial food safety training we carried out, the proprietors are providing one to one training for all staff.

If there is anything explained to you that you do not understand, please ask. Our system in food safety will only work if we have the commitment from our staff.

- No jewelry to be worn during preparation, exempt single band rings & sleepers.
- Ensure that your head covering fully covers your hair, when handling food.
- Ensure that your clothing and footwear are clean daily.
- Wash your hands regularly,
  - after handling waste;
  - after a break & before you start work;
  - after coughing, sneezing, touching your hair;
  - after eating & drinking;
  - after going to the toilet.
- Only wear gloves when handling finished product.
- Cover all cuts, burns and the like with waterproof blue band-aids.
- Fingernails to be kept clean and short.
- Report any symptoms of food poisoning. You legally have to do this.
- Clean as you go. Don't leave spillages for someone else to clean. Clean all food contact equipment after **EVERY** use.
- Make sure that the food contact equipment you are about to use is clean.
- Keep raw materials and finished products separate to avoid cross-contamination.
- The danger zone is 5°C – 60°C.
- Dispose of any cleaning cloth that is old, dirty and cannot clean effectively.
- Ensure all bags of rubbish are tied correctly before placing them into the bin.
- Do not leave items in the sink.
- Ensure that the water in the sink for cleaning is hot with the detergent.
- Do not leave mops and buckets in the facility after use.
- Keep the toilets clean at all times.
- Ensure that all food containers are clean.
- Report any worn or broken food contact equipment.
- Report any structural defects to machines or the fabric of the building.
- Report any signs of pest infestations

Employees Name:	**Date**:
Employees Signature:	

Royal Freemasons' Benevolent Institution

New Employee Acknowledgement of RFBI Policies and Procedures

Welcome to Royal Freemasons' Benevolent Institution (RFBI), as part of your onboarding to the RFBI way, you are required to read, understand and acknowledge the following polices, these policies can be found on RFBI's Intranet or in PolicyConnect.

Corporate Policies:

2.13 -Social Media Policy

Human Resources Polices:

Harassment, Bullying and Discrimination Policy – Located in PolicyConnect Human Resources Module

RFBI Values and Ethics Policy – Found in PolicyConnect, Code of Conduct for Aged Care (The Code) Module

Staff Grievance Resolution Policy – Located in PolicyConnect Human Resources Module

Staff Confidentiality Policy – Located in PolicyConnect Human Resources Module

Staff Uniform Policy – Located in PolicyConnect Human Resources Module

Operational Policies:

Procedures for Identifying, responding to and Reporting Elder Abuse and Neglect – Found in PolicyConnect, Resident Care Module, Executive Summary, Consumer Safety and Behaviour Module

4.15 -Work Health and Safety Policy

Privacy Policy – Located in PolicyConnect Privacy and Dignity Module

Workplace Surveillance Policy Located in PolicyConnect Resident care Module

All RFBI polices are provided to you through the RFBI Intranet and PolicyConnect. As polices change from time to time we advise you that printed documents are uncontrolled and you should only view them online to guarantee the latest version.

If you have any questions in relation to any of the policies, please speak with your manager.

I have read and understood the above policies and by signing this formal hereby agree to abide by all RFBI's Policies and Procedures and understand these policies form part of my employment with RFBI.

Name: _____ Signature: _____ Date: _____

Witness: _____ Signature: _____ Date: _____

Royal Freemasons' Benevolent Institution

2023	New Starters Education Planner

Residential Village Day 1 Induction 2023

Course	Duration
Mandatory Serious Incident Response Scheme (SIRS)	20 mins
Mandatory Elder Abuse	60 mins
Mandatory Minimising Restrictive Practices	30 mins
Mandatory Aged Care Standards 1 – 8	80 mins
Mandatory Antimicrobial Stewardship	30 mins
Mandatory Infection Prevention and Control - Clinical and non-clinical staff	30 mins
CompliLearn Quick Start Guide	8 mins

Residential Village Induction 2023 (Part 2)

Course	Duration
Mandatory Feedback, Complaints and Open Disclosure	25 mins
Mandatory Bullying and Harassment	30 mins
Mandatory Privacy and Confidentiality	30 mins
Mandatory Cultural Diversity and Safety	30 mins
Mandatory Dignity and Respect	30 mins
Mandatory Manual Handling	30 mins
RFBI Employee Time and Attendance	30 mins
Welcome to RFBI	20 mins
Work Health and Safety	45 mins
Customer Service in Care	30 mins

LR-4

Royal Freemasons' Benevolent Institution

GUIDELINE AND OUTBREAK MANAGEMENT PLAN FOR RFBI

Updated on the 4th September 2023 for the use of all RFBI Residential Aged Care Facilities (RACF) (excluding ACT).

About this Guideline and Management Plan

This Guideline and Management Plan is updated on a regular basis to captures the knowledge of experienced professionals and provides guidance on best practice based upon the available evidence at the time of completion. Readers should not rely solely on the information contained within this guideline. Guideline information is not intended to be a substitute for advice from other relevant sources including, but not limited to, advice from NSW Health and health professional. Clinical judgement and discretion may be required in the interpretation and application of these Guidelines. This Guideline and Outbreak Management Plan will enable the RFBI RACF's to rapidly identify and respond to a COVID-19 outbreak within each Village.

Throughout this document the Organisation at all times ensures that consideration is given to the cultural and diverse background of each and every consumer. The Organisation at all times ensures that a culture of inclusion and respect for each individual consumer and supports consumers to exercise choice and independence respects the consumers' privacy

Standard 1. Consumer dignity and choice | Aged Care Quality and Safety Commission

The purpose of the Guideline and Outbreak Management Plan for RFBI can be used to help facilities with planning, preparation, detection and management of cases and outbreaks of COVID-19. This guideline can assist the following groups in providing best practice information on preventing and managing COVID-19 outbreaks within the RFBI Villages:

- Administrators of the RFBI Villages
- Staff of the Villages
- Health and aged care workers of each Village
- Public health unit (PHU)/communicable diseases unit.

NSW Health COVID-19 – Public Health Unit (PHU)

Ph: 1300 066 055| Email: agedcareCOVIDcases@health.gov.au

This Guideline and Management Plan is stored and maintained in the RFBI intranet there are other useful documents on the COVID-19 tab all which are updated on a regular basis for the Organisation such as but not limited

- COVID-19 Outbreak Management signs
- Environmental Cleaning and Disinfection Principles for COVID
- List of contents in COVID-19 outbreak box
- COVID-19 Outbreak Box Monthly Checklist

UPDATED INFORMATION FOR ALL STAFF EFFECTIVE FROM THE 5TH SEPTEMBER 2023

Please be advised that from Monday 5 September 2023, RFBI will no longer require staff and visitors to wear surgical masks while in our Villages unless in outbreak or mask wearing is once again made mandatory by the Department of Health.

The NSW Department of Health removed mask wearing as a requirement some months ago however RFBI chose to maintain mask wearing to keep our residents and staff safe during the winter months. Since this time, we have been closely monitoring the situation in each of our locations and now feel it is appropriate for the mandatory wearing of masks to be removed. We will continue to monitor the situation in each of our locations and will re-instate mask wearing if appropriate or are directed by the Department of Health.

As a precautionary measure we will be introducing periodic Rapid Antigen Testing (RAT) for staff and visitors throughout September. Whether the need to continue periodic RAT beyond September will be determined towards the end of the month, taking into consideration community transmission and the advice of NSW/ACT Health.

Across our organisation, staff have done a great job minimising the risk of the spread of COVID-19 and other infectious diseases which are circulating in the community. Staff have effectively managed the situation when we have had cases of COVID-19 within the Villages. I thank each of you for your ongoing vigilance and dedication: your actions have helped keep our residents and staff safe.

Periodic RAT - All staff will be required to have a RAT at least once every 48 hours prior to commencing work and we will be asking visitors to RAT test prior to entering the village each time they visit. Staff will be given RATs to test at home prior to coming to work. I thank you in advance for your cooperation and for keeping our residents as safe as possible.

RAT testing station(s) will be set up at the front of the Village for visitors to take a test before commencing work/entering the village.

Table of Contents

27. Room Set Up
28. Isolation Room / Zone Checklist
29. Raise Awareness / Signage
30. Workforce Management including RFBI Workforce Management Strategies
31. Consumer care and safety
32. Contingency Workforce Guidance

    32.1 Emergency Induction for Agency/Surge Workforce including access to Clinical Manager
33. Cleaning and Environmental Hygiene including terminal clean
34. Laundry Service
35. Catering and Food Service Utensils
36. Waste Management

Note: The following RACFs have general waste being collected by their local council; Armidale, Basin View, Bathurst, Berry, Goulburn, Hawkins, Lake Haven, Leeton & West Wyalong

Where increase collection of general waste collection is required the RACF Maintenance Department will coordinate

37. Staff stations / desk areas
38. Handling of consumer paper health records
39. Stock control
40. Visitors to the Village
41. Partnerships in care during a COVID-19 Outbreak
42. Admission and Transfers

    41.1 Admissions

    41.2 Re-admission of consumers confirmed to have COVID-19

    41.3Re-admission of consumers/people without COVID-19
43. Declaring the Outbreak Over
44. Review and Debrief
45. Key Resources
46. Link to Documents reference in OMT

Appendix 1: Transfer Notification for Hospital

Transfer Letter to the Accepting Medical Officer at the Hospital

1. Immediate Outbreak Response

If a staff member or consumer in your service becomes positive with COVID-19 you are required to immediately notify the Australian Government Department of Health and Aged Care.

All residential aged care providers are required to report all cases of COVID-19 through the COVID-19 Support Portal via the My Aged Care provider portal.

Some state or territories may also require you to notify them of cases of COVID-19. To find out more about these requirements please refer to your local state and territory health unit.

2. Preparedness

All Villages must have appropriate preparedness plans in place to ensure a prompt response to an outbreak. Ensuring that the "Preparedness" is the direct responsibility of the IPC lead and the IPC Champions of each Village. This includes the following (but not limited):

- Vaccination including the latest jurisdictional requirements regarding vaccination for consumer, staff and visitors
- Promote COVID-19 and influenza vaccination among consumer and monitor and record vaccination status of consumer, staff and visitors for COVID-19 and influenza.
- The following steps need to be taken to access the vaccination status of the consumers via Clinical Manager - Vaccination Status - Staff are able to view status via Medical History assessment form and also the Covid-19 Vaccination form information is viewable via assessment, care plan under Medical history and also can be generated in reporting>spreadsheets. Please refer to attached processes for detailed information.

Course: Training documentation, Topic: Version 10.1 - 10.5 (icarehealth.com.au)

- Establish clinical management, treatment, and referral pathways for consumer
- Maintain stocks of anti-viral treatments or methods to access rapidly

- Ensure adequate supplies of personal protective equipment (PPE), hand hygiene, waste and cleaning supplies and equipment.
- Consider the clinical suitability of consumer for COVID-19 treatments and prophylaxis and obtain an indication of treatment preference or consent from consumer and/or their representatives
- Encourage Medical Officers to pre-assess consumer for antiviral treatment including the most appropriate drug and any dose adjustment required because of renal impairment. Where possible, this assessment should be undertaken pre-emptively during routine appointments.
- Discuss with the consumer(s), where possible and the person responsible about the use and their wishes regarding anti-viral treatment in the event that their loved one is at risk or contract COVID-19.
- Consider where and how consumer can be feasibly cohorted according to risk
- Engage consumer and their representatives in key decisions prior to an outbreak
- Regularly review the outbreak management and surge capacity plans to ensure they align with current advice, public health directions and guidelines
- Establish laboratory testing arrangements, pathology request processes, and timely method of receiving results
- Ensure staff are trained in the collection of appropriate specimens for testing
- Develop a systematic method for detecting and recording consumer in the facility who develop respiratory symptoms, such as fever or cough
- Support enhanced infection prevention and control (IPC) training for staff including appropriate use of PPE and recognition of ARI symptoms
- Ensure staff are trained in responding to an outbreak
- Establish workforce surge capacity and contingency planning for staff absenteeism

Please note: If there is no designated IPC Lead or IPC Champions within the Village the responsibility is then with the General Manager and Care Manager.

3. Isolate and implement infection prevention and control (IPC) measures

- Isolate and implement infection prevention and control (IPC) measures
- Isolate symptomatic consumer immediately in their own room if possible
- Allocate staff to symptomatic consumer and ensure no cross over of staff from separate wings, cohorts, and zones.
- Implement initial IPC measures including transmission-based precautions – contact, droplet, and airborne precautions (N95/P2 respirator mask, eye protection, gown and gloves to be worn by staff caring for symptomatic consumer/s).
- Set up dedicated donning/doffing area with signage, PPE and hand hygiene.
- Where possible and where able, isolating consumer should wear surgical mask particularly when staff members or visitors are in their room.
- Review vaccination status (COVID-19 and influenza) of consumer and staff and prioritise vaccination of those not up to date
- Environmental cleaning and disinfection
- Allocate trained staff for cleaning of affected areas – ensure they are skilled to perform routine, additional, and terminal cleaning

3a - Test

Test symptomatic person(s) as soon as possible

Testing for COVID-19 is critical for establishing a diagnosis, early treatment and planning and control of any potential outbreak. Facilities should communicate and consult with a Medical Officer (MO) or Nurse Practitioner (NP) regarding clinical review and respiratory virus testing (PCR) of all consumer with COVID-19 symptoms. Respiratory virus PCR should include Influenza A, B and other respiratory pathogens.

- SARS-CoV-2 rapid antigen testing (RAT) may be used for symptomatic people when PCR is less available or turn-around time for PCR is long. Initial symptomatic consumer should be tested by both RAT and PCR
- Symptomatic staff should be directed to their Medical Officer

- Villages should clearly identify the name of the Village (or outbreak code if relevant) on the order form and ensure the requesting Medical Officer's details are complete.
- Ensure all symptomatic consumer remain isolated until initial testing is complete, and pathogen is known
- If no pathogen is detected on respiratory virus testing for three or more symptomatic consumer, precautions should be maintained while consumer are symptomatic and the PHU contacted for further advice.

3b - Risk Assess

Following receipt of test results, assess risk to facility from symptomatic consumer(s):

Isolate respiratory pathogen positive consumer in their own room with designated bathroom if possible and test all other symptomatic consumer. Continue to isolate consumer while awaiting test result.

- Trigger the outbreak management plan with the first consumer who has tested positive. for COVID-19 or influenza while awaiting additional test results of another consumer. The outbreak management plan is activated before the definition of an outbreak is met to prepare for a potential outbreak.
- Review IPC measures implemented, then identify and address any gaps.
- Assess and manage risk from symptomatic staff:
- Furlough symptomatic staff and direct to their Medical Officer

3c - Case Management

Immediately escalate to the Management Team and IPC Lead if a consumer, visitor, or staff member tests positive for COVID-19 and they have been at the Village during their infectious period.

Inform consumer and/or substitute health care decision-maker / relative of positive results or exposure.

· Treatment

- On diagnosis, Villages must promptly contact the consumer's Medical Officer/Nurse Practitioner regarding clinical assessment, care, and treatment
- Consumer' MO/NP will continue to provide their routine primary care as needed either onsite and/or virtually
- Cases should be managed according to the diagnosis
- The case should isolate in their own room or, if more than one consumer case is positive (with the same organism), the consumer could be cohorted together for ease of management.
- The case should continue to receive ongoing daily care onsite (e.g., mobilisation, allied health services, time sensitive pathology tests, routine catheter changes and wound reviews etc).
- Essential off-site appointments also should continue (e.g., dialysis), with negotiation with the service provider if the consumer has COVID-19 or has been exposed to COVID-19.
- IPC measures
- Cohort and zone
- Identify the areas of the Village that are at risk
- Cases with different respiratory pathogens should be cohorted separately, e.g., influenza cases should be cohorted away from COVID-19 cases.
- Apply the risk assessment outcomes and test results to confirm areas in the Village
- Are staff only e.g., nurses' station, medication room, kitchen, reception area (E.g., Blue zone)
- Are likely to be completely unaffected and can be staffed with non-exposed staff and managed separately (E.g., Green zone) have been affected due to exposures (E.g., Amber zone)
- Set up donning/doffing areas as per outbreak management plan
- Allocate staff to a zone for the duration of the outbreak
- Cohort staff to work in only one part of the Village (where staffing permits)
- Staff members who are a positive case must be furlough from the Village

3d - Case Management (diagram)

Case and Contact Management Diagram for COVID-19

		COVID -19 (RAT or PCR)	
CASE	Consumer	Case Isolation	7 days from positive test date. Case can cohort with COVID-19 positive consumers
		Releasee from isolation	After 7 days if substantial resolution of acute respiratory symptoms and no fever for 24 hours - No testing is required
		Antiviral Treatment	COVID-19 antivirals and other disease modifying therapies as indicated (via clinical review)
	Staff	Return to Work	After 7 days of no symptoms for 24 hours, no testing required. If symptoms continue, return when substantial resolution of acute respiratory symptoms and no fever for 24 hours
	Visitors	Visitors to Village	They can visit the Village from Day 8 if they have no symptoms
		Contact Testing	All Consumers in the affected zones (likely wing)

CONTACTS	Consumer	Contact Isolation	Limit movement until test results pending and risk assessment completed - See Appendix 1 below
		Contact post exposure prophylaxis	Nil
	Staff	Return to Village	- See Appendix 1 below
	Visitor	Return to Village	Can attend from Day 8 if no symptoms

3e - Contact Management

- Following an exposure each Village should undertake exposure assessment to determine if any staff or consumer have been exposed to the case and develop an agreed management plan based on the degree of assessed risk. In assessing contacts of a positive case, the Village should identify all staff and consumer in the affected zone who have been potentially exposed. Covid-19 Status / Infection Status - there is a tag (banner) which is able to be made visible to notify staff as consumers are diagnosed Covid-19 positive or suspected of Covid-19. At this stage for infections staff would need to refer to the medical history assessment form for information (infection tag is currently on the Telstra Health roadmap for creation into clinical manager) Please refer to attachment for Covid- 19 tag/banner. Staff can refer to following training document for step by step procedure
  Course: Training documentation, Topic: Version 10.1 - 10.5 (icarehealth.com.au)
- To support assessment and management of staff and consumer contacts of a positive COVID-19 case (for known exposures or single case with a known source), refer to COVID-19 exposure and outbreak management (see below)

- Ensure consumer contacts are monitored for symptoms and limit movement within the facility.
- If the source of infection of COVID-19 is unknown, all consumer in the identified zone should be tested to find cases, irrespective of whether they have symptoms. refer to COVID-19 exposure and outbreak management (see below)
- Consider use of influenza antivirals during influenza outbreaks as post exposure prophylaxis for consumer in the affected zone in consultation with the public health unit and treating general practitioner.
- For single cases with no clear source of infection, or multiple cases among consumer, consult the local PHU as assessment and management of contacts may differ.
- It is important that RCF use a risk-based approach to contact assessment and management. The risk of transmission should be managed whilst balancing the risk related to social isolation and deconditioning through application of the least restrictive controls appropriate.

3f - Notifying and Reporting

- Notify positive cases of COVID-19 in compliance with Commonwealth, State and Territory requirements.
- Discuss as required with the local PHU when one consumer has tested positive for COVID-19
- Notify positive COVID-19 cases in each Village to the Commonwealth via the My Aged Care provider portal.
- Notify the local PHU of an OUTBREAK when 2 or more consumer test positive to either COVID-19 or 2 or more consumer test positive for influenza within a 72-hour period.
- Cases of COVID-19 or influenza in staff members are not a trigger for an outbreak response
- Where PCR test results are delayed RAT can be conducted in parallel to assist with early identification of a COVID-19 outbreak.
- Notify other care providers, facilities, and hospitals where consumer have had a high-risk exposure and have subsequently been transferred or require immediate transfer for care.
- Record and report details of each consumer and staff case:

- Confirm with the local PHU on preferred data format and template. Facilities must complete required information for all affected consumer and staff, this will include vaccination status, symptoms, symptom onset, test results and other identifying information.

3g - Activating Outbreak Management Plan

- The Village should activate their Outbreak Management Plan (OMP) with the first consumer who has tested positive for COVID-19 or influenza while awaiting additional test results of another consumer.
- Once an outbreak has been declared, the Village should convene an internal outbreak management team (OMT) meeting and confirm with the Village staff members who will be designated:
    - Outbreak Management Lead
    - Infection Prevention and Control lead
- The OMT should meet and communicate regularly, with decisions documented
- The Village should remain in regular contact with the PHU
- The PHU will determine whether an inter-agency OMT meeting is required in a COVID-19 outbreak
- Regular or scheduled visits from the Medical Officer and other Allied Health Professionals are to continue regardless of the outbreak

During the outbreak

- IPC measures
    - Use the facility plan to establish cohort areas. Ensure all areas:
        - are clearly designated with clear signage in place.
        - have an adequate number of sites for hand sanitiser, ideally at each bed space.

- have hand hygiene, PPE station and waste disposal at each entry and exit (if appropriate), ensuring that each station is replenished at several intervals throughout each shift
- are decluttered as much as possible to make cleaning and decontamination easier
- have limited entry/access to each cohort
- have separate (and spacious if possible) break areas for staff
- For detailed information on risk assessment for appropriate PPE use and IPC for RCF, see the Infection Control Expert Group guidelines for IPC in residential care facilities and refer to local public health advice.
- Villages should undertake a local risk assessment to inform the appropriate level of PPE for staff providing direct care or working within the consumer zone.
- The assessment should consider controls already in place and also the consumer' pre-existing likelihood of COVID-19, consumers factors that enable transmission, nature of the care episode and physical location.
- Increase the frequency of cleaning and disinfection.
- Frequently touched surfaces and those closest to consumer should be cleaned more often. These surfaces include: (but not limited)
- equipment
- door handles
- trays
- tables
- handrails
- chair arms
- light switches
- patient care equipment (e.g., commodes, lifter slings, etc)
- Activate strategies established for increases in clinical and general waste storage and removal and linen supply.
- Consumers movement during an outbreak

- Essential off-site appointments also should continue (e.g., dialysis), with negotiation with the service provider if the consumer has been exposed to COVID-19 or influenza.
- Any transfers (other than on the basis of clinical need) should be planned and coordinated with hospital services and in consultation with the consumer, their family or alternative decision-makers and public health units. The receiving hospital must be informed about the outbreak at the RCF/wing, regardless of whether the consumer being transferred is a case or not.
- If practical, consumer of similar exposure can also be cohorted together.
- Consumer in unaffected zones are able to attend external appointments.
- Consider relocating consumer who are on a palliative care pathway and require additional supports (e.g., compassionate care / visiting, symptom control) to an area where they are less at risk of further exposure (or if cases, plan for how consumer could be supported with visits).
- Staff considerations
- During a confirmed influenza outbreak, staff who have not received the influenza vaccination are at higher risk of acquiring influenza, therefore they are recommended to work only if asymptomatic, wearing a mask, and taking appropriate antiviral prophylaxis (see Table 6), in keeping with the RCF influenza outbreak management policy. Any antiviral use by staff should be documented.
- Contingencies should be in place for unvaccinated staff who decline to use antivirals.
- Staff who are higher risk contacts should not move between their section and other areas of the facility, in line with basic IPC principles.

Other considerations relevant to an outbreak

- New and returning consumer to each Village from the community, hospital, or emergency department.

- The presence of an outbreak should not prevent new and returning consumer from being admitted/re-admitted to the facility with appropriate IPC measures in place. Decisions should be based on the advice of the local OMT and in consultation with the PHU, consumer and their representatives.
- Consumer and families entering the RCF during outbreak should be informed of the current situation, as well as any associated restrictions (e.g., visitor limitations).
- Consumer choice regarding isolation
- Consumer should be given the choice to self-isolate while the outbreak is in progress or to mix with people with similar exposure. Their preferences should be recorded in their care plans and regularly reviewed. Consumer should be made aware that if they choose to not isolate during an outbreak this may increase their risk of transmission of the infection.
- Ensure that all Consumers Advance Care Plans (or equivalent) are reviewed, updated and current
- Lifestyle Officers need to continue in their usual employment and discuss each day and their input with the General Manager, Care Manager and IPC lead at the commencement of each shift (discuss consumer needs, location of Lifestyle Officer and risks).
- For Aged Care, consumer dignity and choice are foundational standard 1 in The Aged Care Quality Standards.
- Where it is practical, and the facility can manage this:
- Consumer with the same condition should be allowed to engage in social activities together if they are well enough to do so and if they can be kept separated from consumer who are exposed or unaffected.
- Consumer exposed to the same pathogen may choose to leave their rooms to eat in shared dining rooms and participate in social activities with other consumer from the exposed area[1]. Exposed consumer should not socialise with positive cases or consumer from unaffected areas. Unexposed consumer can leave their rooms to participate in shared activities and dining with other unexposed consumer (e.g., with dedicated staff, dining room, social room).

- Where possible, visits to affected consumer should occur in an area with good ventilation. The Aged Care Act 1997, the Charter of Aged Care Rights and the Aged Care Quality Standards include specific responsibilities that provide a legislative basis to this requirement for RACFs.

3h - Communication

- A communication plan should have established systems to manage communications and engagement with families of consumer and community that support the RCF.
- Ensure all affected consumer are aware of their diagnosis, exposure status, testing and isolation requirements. Individual communications strategies need to be considered for consumer who may have difficulty following instructions due to cognitive impairment or language barrier.
- Ensure consumer' family and carers are aware of the exposure/outbreak at the RCF and status of individual consumer, including their diagnosis and management.
- Ensure staff are aware of the exposure/outbreak at the RCF and remain on high alert monitoring themselves and consumer for ARI symptoms
- Ensure visitors are aware of the exposure/outbreak at the RACF and that essential visitors and volunteers are permitted to continue to visit affected consumer, including those considered to be high risk and in designated zones. Essential visitors include carers and usual 'partners-in-care', named visitors, people who provide personal care; those visiting a consumer who is at/approaching end of life. Visitors must comply with RACF entry requirement, including any screening, PPE and vaccination as outlined in jurisdictional advice The RACF may arrange virtual visits (e.g. via tablet) or contactless visits for unvaccinated visitors (e.g. window visits).

3i – COVID-19 Exposure and Outbreak Management

Suggested actions based on classification of high-risk COVID-19 exposure:

High-risk exposure	Suggested actions based on classification of high-risk exposure
Staff Where a worker has been exposed to COVID-19 case in a workplace setting where the risk of exposure is defined as high. Considerations for high-risk exposure include: - staff who were not wearing airborne precautions PPE (N95/P2 masks, eye protection,) where aerosol generating behaviours or procedures have been involved - have had at least 15 minutes face to face contact where both mask and eyewear were not worn by exposed person and the case was without a mask, - greater than 2 hours within the same room with a case during their infectious period, where masks have been removed for this period.	Review affected staff to assess exposure and risk. · Staff who if absent will have a high impact on services, will be able to continue attending work with specific requirements in place: - Continue to work with negative Day 1 PCR/RAT - RAT test every working day, until Day 7 result clear (prior to commencement of workday) - Monitor for symptoms, test (RAT and if negative PCR), and isolate immediately if symptoms develop. Additional mitigation steps: - Work in a P2/N95 respirator for the first 7 days following exposure - No shared break areas - Limit work to a single site/area - Consider redeployment to lower patient risk area if possible.
Consumers If a consumer has been exposed to a COVID-19 case: - in a shared defined area (e.g., prolonged contact during activity, co-located in a wing of a facility) and/or - who have had household-like exposure with a case during their infectious period, or - outbreak-related contact (e.g., cases in the same ward / wing /zone with unknown exposure). Note: the risk of transmission should be managed whilst balancing the risk related to social isolation and deconditioning through	Quarantine for 7 days - Test (PCR/RAT) Day 2 and Day 6 OR Consider allowing consumer to leave room after risk assessment, with - Baseline and Day 6 PCR, or - RAT at least every second day from Day 0-7 Release from quarantine: - After Day 7 on Day 6 negative result - If symptoms develop, RAT and, if negative, PCR.

application of the least restrictive controls appropriate.	

Suggested approaches to management of an outbreak of COVID-19 in residential care facilities

Outbreak Situation	Testing, isolation, IPC and closure
Simple Cases arising from single / known exposure and/or limited to a few cases in one area of the facility and/or limited secondary transmission.	Cases isolate for 7 days as per Table 1 (Case and Contact Management) and CDNA Series of National Guidelines (SoNG) on COVID-19. - Baseline and Day 6 (D6) PCR for defined at-risk consumer, quarantine in room for 7 days OR allow at-risk consumer to leave room as long as they remain with consumer of similar risk but with RAT testing every second day. - If no cases detected from D6 PCR in at-risk consumer's release from quarantine after 7 days and outbreak may be declared over.
Complex Poorly understood exposure, or multiple cases affecting multiple areas, or ongoing transmission, or difficultly isolating consumer (e.g. dementia unit).	Cases isolate for 7 days (Case and Contact Management) and CNDA Series of National Guidelines (SoNG) on COVID-19. - At-risk consumer in affected areas should remain in quarantine. Develop a regular schedule of testing in the affected zone for negative at-risk consumer every 72 hours by RAT (or PCR) and continue until 7 days after the last case. - Declare outbreak over 7 days after the last positive consumer case detected or 7 days after the last positive infectious consumer case was effectively isolated (whichever is longer). - Continue to monitor consumer for symptoms in affected zone for a further 7 days after the

	outbreak declared over. - Staff maintain higher standard of PPE for a further 7 days (P2/N95) after the outbreak declared over.

3j – Treatment and Prophylaxis

Oral Antiviral	Treatment indications	Dosing guidance	Comments
Molnupiravir (trade name Lagevrio®, MSD)	Diagnosis of COVID-19 in resident of residential care facility, ≥70yrs or ≥50yrs with one additional risk factor, and to be given as soon as possible after a diagnosis of COVID-19, and within 5 days of symptom onset	800 mg (four 200 mg capsules) orally every 12 hours for 5 days, with or without food. No dose adjustment is recommended for elderly people including those with renal or hepatic impairment.	Dispensed following consultation and direction from an authorised prescriber.
Paxlovid® (nirmatrelvir + ritonavir)	Diagnosis of COVID-19 in resident of residential care facility, ≥70 yrs or ≥50yrs with one additional risk factor, and to be commenced as soon as possible after a diagnosis of COVID-19 and within 5 days of developing symptoms	The two active substances of the medicine, nirmatrelvir and ritonavir, which are given as separate tablets, must be taken together twice a day for 5 days	Extensive drug interactions. A PBS listing for Paxlovid means it can be prescribed by an authorised prescriber following consultation.

4. Signs and Symptoms of Coronavirus (COVID-19)

The signs and symptoms can range from mild illness such as a cold and fever to pneumonia with some consumers, staff members or volunteers recovering quickly, whereas others may get very sick quickly. Consumers, staff members and volunteers with COVID-19may experience signs and symptoms of the following but not limited:

- Fever (elderly consumers do not always have a fever) 37.5 degrees or higher
- Cough
- Sore Scratchy Throat
- Runny nose
- Flu-like symptoms such as coughing, sore throat or fatigue
- Shortness of breath and difficulties in breathing
- Sputum production
- Loss of taste
- Loss of smell
- Diarrhoea
- Fatigue
- Muscle and Joint Pain
- Headache
- Nausea or vomiting
- Loss of appetite
- Haemoptysis (coughing up blood)
- Nasal congestion
- Conjunctival congestion
- Increased confusion or behavioural change
- Worsening chronic conditions of the lungs
- Vague changes: 'not their usual self', looks unwell and pale
- Decline in functional state

Staff should be aware of these symptoms and note that the majority of cases experience mild symptoms. If staff develop any symptoms, they must isolate and get tested for COVID-19 to prevent transmitting the virus to other staff members or consumers.

5. Mode of Transmission

SARS-CoV-2 is primarily transmitted by exposure to infectious respiratory droplets and particles. Exposure occurs primarily through three routes.

- Inhalation of respiratory droplets and aerosolised particles
- Deposits of respiratory droplets and particles on mucous membranes (mouth, nose, eyes).
- Touching of mucous membranes with hands directly contaminated with virus-containing respiratory fluids or indirectly by touching surfaces contaminated with virus-containing respiratory fluids.

Acute respiratory infections (ARI's) including COVID-19 are transmitted between individuals when the virus is released from the respiratory tract of an infected person and is transferred through the environment, leading to infection of the respiratory tract of an exposed and susceptible person. There are several different routes (or modes) through which transmission could occur, the chance of which is modified by viral, host and environmental factors. ARIs differ in how readily they spread (transmissibility) and the mechanism (mode) of transmission. Respiratory infections can be transmitted via four major modes of transmission: (large) droplets and (fine) aerosols, direct (physical) contact, indirect contact (fomite). The primary mechanism of transmission of SARS-CoV-2 is via infected respiratory particles. SARS-CoV-2 replicates in the respiratory tract and the highest viral load is just prior to symptom onset or in the first 5 days of symptoms. Transmission also occurs with asymptomatic infection. The primary mechanism of transmission of SARS-CoV-2 is via infected respiratory droplets. SARS-CoV-2 replicates in the respiratory tract and the highest viral load is just prior to symptom onset or in the first 5 days of symptoms. Transmission also occurs with asymptomatic infection. Infection occurs either by direct or indirect contact with respiratory droplets. Most transmission occurs through close contact:

- People who are physically near (within 1.5 metres) a person with COVID-19, or have direct contact with that person, are at greater risk of infection compared to individuals who remain >1.5 metres from cases. Transmission studies show household members are at the highest risk

- Infections occur mainly through exposure to respiratory droplets when in close contact with someone who has COVID-19. Respiratory droplets of various sizes are produced by breathing, talking, coughing, sneezing and behaviours such as yelling, singing and shouting

- Respiratory droplets cause infection when they are inhaled or deposited on mucous membranes, such as those that line the inside of the nose and mouth.

- Pathogens mainly transmitted by close contact can sometimes also be spread via airborne transmission through aerosols. Circumstances where airborne transmission of SARS-CoV-2 appears to have occurred include:

- Enclosed spaces within which an infectious person either exposed susceptible people at the same time or to which susceptible people were exposed shortly after the infectious person had left the space

- Increased exposure to respiratory particles, often generated with expiratory exertion (e.g., shouting, singing, exercising) that increase the concentration of suspended respiratory droplets in the air space

- Inadequate ventilation or air handling that didn't adequately remove suspended small respiratory droplets and particles from the air.

Other consideration when assessing for airborne transmission risk:

- COVID-19 can be spread by exposure to the virus in small droplets and particles that can linger in the air for minutes to hours

- As respiratory droplets travel further from the person with COVID-19, the concentration of droplets decreases. Larger droplets fall out of the air due to gravity. Smaller droplets and particles spread apart in the air

- With passing time, the amount of infectious virus in respiratory droplets also decreases

- There is evidence that under certain conditions, people have been infected with SARS-CoV-2 despite being more than 1.5 metres away from someone with COVID-19. This has usually occurred

within enclosed spaces with inadequate ventilation. Sometimes the infected person was breathing heavily, for example while singing or exercising

- Under these circumstances, scientists believe that the amount of infectious smaller droplets and particles produced by people with COVID-19 became concentrated enough to spread the virus to other people. The majority of spread however is via close contact rather than via airborne transmission.

6. Incubation and Infectious Period

The incubation period is the duration between exposure to the virus and the onset of symptoms. The WHO currently estimates that the incubation period for COVID-19 ranges from 1 to 14 days, with a median incubation period of 5 to 6 days and only 3 days for some of the most recent variants such as Omicron. Around 1% of COVID-19 cases will develop symptoms more than 14 days after exposure. Epidemiological data to date suggests that most of the transmission occurs from symptomatic cases. COVID-19 appears to be infectious from 1-3 days prior to symptom onset with most onward transmission occurring early after infection. Taking a precautionary approach, cases are currently considered infectious from 48 hours prior to the onset of symptoms until they meet criteria for release from isolation. More conservative periods (e.g., 72 hours prior to onset of symptoms) may be considered in high-risk settings at the discretion of the Public Health Unit. Influenza incubation period is about 2 days, but ranges from one to four days (WHO) and for RSV is usually 3–6 days (ranging from 2 to 8 days).

7. Clinical Presentation and outcome of those at higher risk

COVID-19 usually presents with symptoms similar to other acute respiratory infections (ARI). Less commonly, SARS-CoV-2 can cause more severe disease including pneumonia, acute respiratory distress syndrome (ARDS), complications affecting other organ systems, and long-term sequelae (e.g. post COVID-19 condition). Increasing age is the most important risk factor for severe disease, with risk significantly increasing around 60-70 years of age.

- Unvaccinated or partially vaccinated people are at greater risk of severe disease
- Those that are no suitable to be vaccinated against COVID-19

- The number, severity and nature of comorbidities
- Immunosuppression
- Disability and frailty
- Aboriginal and Torres Strait Islander status

8. Recording and reporting a positive Rapid Antigen Testing (RAT)

If you test positive to COVID-19 using a rapid antigen test, NSW Health recommends that you register your result with Service NSW. Although this is no longer mandatory, it helps you to access medical support from NSW Health, including antiviral medications (if eligible).

9. Physical distancing and use of shared space

Where possible, physical distancing is to be practiced within all RFBI facilities, between staff and consumers to limit the transmission of COVID-19. This includes but not limited:

- Loungeroom and waiting room chairs and other seating separated by greater than 1.5 metres (where possible)
- Where practical, staff and consumers to remain greater than 1.5 metres apart except for clinical examinations and procedures, acknowledging that in some environments this may not be possible
- Villages should consider setting up several outdoor areas for meal breaks for all staff (small table and chair) ensuring that each table setting has a hand sanitiser and wipes available for the employee to wipe the table and chair down prior to their break and also after the conclusion of their break.

Additional precautions are required for staff in a shared space

Shared working space can include vehicles, small rooms, tea rooms, staff meeting rooms, conference rooms, break out rooms, employee stations or any room which workers may use to

congregate. As vehicles are enclosed and are confined spaces, there is an increased risk of cross transmission.

The additional precautions are:

- Where possible workers to maintain physical distancing requirements in any shared areas
- Ensure signage is displayed to advise on the number of people allowed in a room at any given time, this should include all rooms within the Village, with no exception.
- Considerations should be given to safer ways to eat and drink when designated meal rooms or eating areas are not available (e.g., not removing or pulling down mask in clinical areas to have drink)
- When entering the tearoom or other shared space a mask is worn except when eating and drinking
- In an enclosed space (vehicle or small room), the situation arises where you must remove your mask (e.g., eating or drinking) make sure to do it in a safe manner, one person at a time when removing your mask. If possible, allow external ventilation e.g., change car airflow to external exhaust not recirculate.
- Use a surgical mask when sharing space with other people if physical distancing cannot be maintained (such as in a vehicle or confined tearoom space)
- Ensure safe mask use, dispose correctly and perform hand hygiene after disposal
- Use virtual meetings or gatherings where possible
- Worker's car-pooling to and from work should be risk assessed
- Workers are to perform hand hygiene when entering and exiting shared spaces
- Ensure hand hygiene products are available at the entrance and exit
- Avoid crowding and attempt to schedule breaks in advance with flexibility
- If the room capacity is limited, consider choosing an alternative space, or if time permits wait for others to leave the area
- Where possible consider having a responsible person to perform unannounced checks of activity in these areas
- Ensure availability of neutral detergent wipes or solution for cleaning surfaces such as high touch points and equipment (e.g., taps, kettles, fridge handles and microwaves)

- Ensure shared areas are kept clean and tidy after use
- Remove items that cannot be cleaned or wiped down (including magazines and clutter)
- Laminate signs or notices posted in shared workspaces and wipe down with neutral detergent regularly
- Do not share stationary such as pens, post-it notes and writing pads
- Wipe down shared items such as computer keyboards, mouse, phone handsets, desk, keypad with neutral detergent before and after use
- Take all personal stationery and belongings when leaving a workspace and remove all personal belongings from tearooms
- Personal belongings should be stored in dedicated areas and not in shared workspaces
- Ensure ongoing enhanced cleaning of shared work environments as per the local cleaning schedule
- Designated person to ensure the cleaning has been undertaken and should maintain documentation

10. Recommendations for isolation of COVID-19 Cases

Although isolation is not mandatory, isolation of COVID-19 cases is recommended as an effective way to reduce the spread of infection. Cases should be educated about their potential to infect others for up to 10 days after onset of symptoms and provided with advice on additional strategies to help protect the community when they leave their room.

11. Respiratory hygiene and cough etiquette

The following measures to contain respiratory secretions are recommended for everyone. STAFFs are to provide education to consumers:

- Covering the mouth and nose with a tissue when coughing or sneezing
- If a tissue is not available, cough or sneeze into the elbow
- Use the nearest bin to dispose of the tissue after use

- Perform hand hygiene e.g., hand washing with soap and water for 20 seconds or use alcohol-based hand rub after coughing or sneezing or if contaminated objects, materials, or equipment are touched

The following should be available in waiting areas for consumers and visitors:

- Relevant signage and education resources/posters
- Tissues and no-touch receptacles for used tissue disposal
- Conveniently located dispensers of ABHR; where sinks are available ensure that supplies for hand washing (i.e., soap, disposable towels) are always available.

12. Advice for those with acute respiratory symptoms and / or suspected and /or suspected or confirmed COVID-19

Consumers with any acute respiratory infection symptoms must be encouraged and supported to wear a surgical face mask providing it is tolerated and not detrimental to their medical or care needs. This is to minimise the dispersal of respiratory secretions and reduce both direct transmission risk and environmental contamination.

- A surgical mask should only be worn by consumers if their clinical care is not compromised for example, when receiving oxygen therapy via an oxygen mask
- The surgical mask can be worn until it is damp, moist, damaged or uncomfortable for the wearer, provide education on appropriate use, storage and cleaning if reusable
- Once the consumer is isolated in a single room, they do not need to routinely wear a mask, although as staff will be entering the room it is encouraged to reduce the risk of transmission.
- If a consumer requests a N95/P2 mask then they need to be allocated a mask
- Consumers should be encouraged to perform hand hygiene before leaving their room and when they re-enter their room at all times

13. Care of consumer who is confirmed or suspected COVID-19

- P2/N95 respirator and eye protection to be worn (extended use based on risk assessment) at all times if within 1.5 metres of the Consumer.
- Gowns or gloves are not required outside of the consumer's room (e.g., in the corridor or nurses' station). The corridors are seen as a "clean area"
- Adhere to hand hygiene practices, cleaning of shared consumer equipment in between consumer care
- Gowns or aprons (risk assessment) and gloves to be applied at the entrance to the room if there is likely to be direct contact with the consumer (e.g., assisting with personal care)
- Gown and gloves are not required if you are placing a food tray on the table or talking to the consumer
- COVID-19 is not transmitted via intact skin and therefore, gloves do not add a layer of protection against COVID-19

14. Recommendations for COVID-19 surveillance testing in NSW healthcare facilities

As an overriding principle, any testing should be done in conjunction with an assessment that includes a symptom check, contact status, whether they are immunocompromised and whether the person has recently recovered (for COVID-19 in the last 5 weeks). Note: In the absence of the recommended test or result being available, consultation, investigation or treatment should proceed using a risk assessment and implementing IPAC and hierarchy of controls including appropriate patient placement and PPE.

Nucleic Acid Tests (NAT or PCR)

Sample types for NAT

Combined deep nasal and throat swabs: These are the traditional sample types consisting of a single flocked swab used to collect a throat sample followed by bilateral deep nasal sample for the highest sensitivity. Combined throat and deep nasal swabs are indicated for

COVID-19 diagnosis in symptomatic individuals. They may be poorly tolerated in the repeated sampling required for routine surveillance testing.

Rhinoswabs: Self-collected nasal mucosa sampling using the Rhino swabs device may be better tolerated but with lower sensitivity than combined nasopharyngeal and throat swabs. Rhino swabs may be used for routine surveillance testing in asymptomatic staff in an attempt to maintain compliance. They should not be used for diagnostic purposes in symptomatic individuals.

Saliva: Saliva testing usually has lower sensitivity compared to other sample types, and so may require daily testing to overcome this. If local validation shows high sensitivity, then saliva testing could be done third daily. Saliva testing was used for surveillance in individuals with professional contact with patients with COVID-19 such as border and quarantine workers.

Test platforms used for NAT

Standard NAT: Typical run times are between 2 and 6 hours, with expected turnaround times of 12 to 48 hours depending on prioritisation and transport. Sample pooling has been validated on NSW Health Pathology platforms and is used to conserve reagents and increase testing capacity when the number of positives is low. Pooled testing is NATA accredited. Pooling is not suitable when the number of positives exceeds approximately 3% because of the need for a second round of PCR testing to identify the positive in a pool (leading to delays in diagnosis and increased reagent utilisation). The reduced testing capacity when prevalence and testing volumes are high results in extended turnaround times.

Rapid NAT: Rapid NAT platforms provide shorter run times (GeneXpert 45 minutes, Roche Liat 20 minutes) but are of relatively limited availability due to constraints on consumables and throughput.

15. Complications

Most people with COVID-19 have mild disease and will recover. Some people can develop complications that are life-threatening and may lead to death. If severe disease occurs, deterioration can be rapid and distressing. Older age is a risk factor for severe disease. Some chronic conditions also place people at higher risk of serious illness from COVID-19. COVID-19 vaccination and boosters provide good protection against severe illness and death, including with the Omicron variant. RFBI have Lifesize available for all 22 Villages where a Nurses Practitioner can be accessed 24 hours a day to assess, plan and treat a consumer who is deteriorating.

16. Screening

The RFBI Villages has a screening process in place prior to entering the RACF for all staff, visitors, volunteers and contractors also including all consumers being admitted and re-admitted. Each Village must consider current advice (Public Health Unit, Department of Health or equivalent) in relation to screening of visitors and staff prior to entry into the facility and use of PPE.

- All consumers, staff, contractors and visitors may be expected to attend a RAT prior to entry of the Village. (This will depend on the restrictions at the time of entry and upon assessment of the community). The Regional General Manager, General Manager, Care Manager and IPC Lead will ensure that the most appropriate screening process is in place (if any). If a RAT is required the General Manager will notify the staff prior to arrival or on arrival.
- Screening for symptoms of COVID-19 which also includes the loss of taste and smell
- Screening for epidemiological risk factors which also includes being in a geographical area of risk in the last 14 days (RACF continue to ensure that the pre-screening tool is updated in line with the latest alerts)
- Compliance with visitor restrictions as per Public Health direction, including the requirements for visitors, staff, volunteers and contractors to be vaccinated against influenza
- The General Manager is responsible for ensuring that the pre-screening information at each Village is at all times current and reviews this as a minimum of weekly and updates the clinical team

- The General Manager will ensure that the appropriate information is collected as part of the screening process whilst ensuring that the information that is required to be screened is communicated to everyone prior to entering the Village.
- The General Manager will ensure that everyone entering the RFBI RACF is screened (if required) prior to entering the Village and ensure that there is no gaps or limitations within the system whilst ensuring that those that do not meet the screening criteria are not given access to the Village.
- The General Manager is responsible to ensure that only those people that meet the screening criteria enter the Village.
- The General Manager is responsible to ensure that there is a procedure in place to manage the new admissions and consumers returning who have symptoms of COVID-19 or epidemiological risk factors.

RAT for COVID-19 may be used to diagnose COVID-19 in some jurisdictions and may be used in specific settings to screen for the disease. RAT is less sensitive than PCR tests resulting in a higher rate of false negative results. The Village must be aware of the jurisdictional requirements for reporting/registering positive RAT results and should assist consumers in this process (if any).

17. Outbreak in the presence of a vaccination

When there is widespread community transmission, COVID-19 cases and exposures within an RACF are expected. The RACF and the public health response must be proportionate, balancing the risk of COVID-19 with the health and wellbeing of consumers. Key issues in decision making regarding public health measures are consumer welfare, vaccination status and a risk-based approach to managing quarantine and isolation so as to minimise as far as possible the adverse impacts of social isolation and deconditioning. The high vaccination levels in consumers and staff means that the risk of severe disease related to outbreaks is reduced. Providers should review COVID-19 risk management plans and adjust mitigation measures in response to the benefits associated with high levels of vaccination within the RACF and the lower rates of severe disease associated with the Omicron variant. This requires a transition to a risk-based

management approach with a focus on protecting the vulnerable (i.e. consumers who are immunocompromised, have comorbidities or are unvaccinated), to more independently respond to and manage COVID-19 outbreaks and a more 'business as usual' approach. Ensure any consumer who has been identified as having comorbidities and not suitable to being vaccinated by COVID-19 is advised of an outbreak and offered to self-isolate and given adequate masks with education on COVID-19 and how to reduce the risk of transmission. In a highly vaccinated population, the response to a COVID-19 outbreak should be proportionate to the risk posed by COVID-19 to the consumer population. It is essential that consumers are able to maintain physical exercise and social connection, with consideration of the rights of family and friends to visit. In particular, restrictions should be reviewed and adjusted to support visitation of partners of consumers and other essential visitors (known as partners-in-care in RACF) who regularly provide additional day-to-day care and support to consumers, as well as provision of opportunities for consumers who are not cases or contacts to safely participate in communal activities within the RACF if they so choose.

RACFs must ensure they are prepared for outbreaks of COVID-19. To prepare for COVID-19 outbreaks, RACFs should:

1. Provide staff with ongoing education, training and assessment, including in IPC and outbreak management and ensure sufficient staff with expertise in IPC are readily available at each Village.
2. Ensure staff and visitors adhere to current guidelines for standard precautions at all times.
3. Ensure adequate supplies (e.g. Personal Protective Equipment (PPE), RAT and other consumable materials).
4. Prepare an outbreak management plan that includes surge plan for workforce, PPE and testing, and regularly review it to ensure it aligns with current advice, public health directions and guidelines.
5. Consider where and how consumers can be cohorted according to risk.
6. Ensure consultation with consumers and those that care for them regarding their wishes after an exposure has occurred in the RACF. Consideration should be given to their preference for strict isolation to prevent exposure and possible infection or their desire to socialise with others of similar exposures.
7. Support consumers and staff to be fully vaccinated against COVID-19.

8. Support safe visitation to reduce the effects of social isolation and promote consumer wellbeing.
9. Develop a systematic method for detecting and recording consumers in the RACF who develop COVID-19 like symptoms, such as fever or cough. This can be the same method used for detecting influenza-like symptoms, as outlined in the CDNA Guidelines for the Prevention, Control and Public Health Management of Influenza Outbreaks in Residential Care Facilities in Australia.

Being fully vaccinated for COVID-19 reduces the risk of severe disease and vaccination of staff working in facilities is required in Australia. Completing a COVID-19 course of vaccination, is strongly recommended for every consumer and the employees. New consumers should be encouraged to be fully vaccinated. Unvaccinated people are not as well protected against severe disease. Unvaccinated people should be advised that if an outbreak occurs, different controls may be required to protect them from infection, such as a requirement to stay in their rooms for the duration of the outbreak. It is the responsibility of the RACF to maintain records of vaccination history and status for each consumer. RFBI maintain these documents in the Consumers Care Plan.

Vaccinated people can still acquire COVID-19 but usually have a milder illness. Severe disease can still occur in a small proportion of vaccinated people particularly older people and those with certain comorbidities. Vaccinated people can still spread the disease. Current evidence suggests that the initial amount of virus in a vaccinated person who acquired the disease is similar to those who are unvaccinated. However vaccinated people may have a more rapid decline in their ability to infect others in subsequent days. Please refer to local jurisdictional guidance for detail on the recommended quarantine period. It is the responsibility of the General Manager of each Village to ensure that all consumers are offered all vaccines available to the consumer including but not limited to: COVID-19, Influenza and Pneumonia vaccines, also to ensure that each vaccination is clearly documented and easily accessible. Essential visitors to exposure or outbreak affected areas of an RACF. RACFs should enable each consumer to be visited by an essential visitor at all times, even during an outbreak. Essential visitors: are people who provide one or more of physical, social and emotional support to a consumer. This may

include people who provide personal care, people who support consumers with mental health concerns, dementia or cognitive impairment or other support. Essential visitors can also be known as 'partners-in-care'. Risk based approach: should be used to facilitate, where possible, essential visitors to impacted consumers. Visitors who are usual partners-in-care, who are willing to comply with RACF required risk mitigations (such as are fully vaccinated, are willing to wear appropriate PPE, take a RAT, follow directions from the Villages IPC lead/s) and or IPC Champions should be allowed to visit affected consumers in their rooms. However, if an essential visitor is not fully vaccinated, other measures may be considered to allow that person to continue visiting and supporting the consumer.

Visitor Mitigations: should be based on RACF specific risk assessment but generally, essential visitors should not move between an affected area and an unaffected area. RACFs should offer essential visitors the opportunity to undertake basic IPC training, including use of PPE.

Non-essential visitors: those who are not usual partners-in-care or who are unvaccinated may not attend consumers who have had a high-risk exposure or who are cases. This group may be permitted as visitors through contactless visits. Where possible these visits should occur outdoors or in an area with significant natural ventilation.

Volunteers: Access to volunteers should continue during outbreaks to ensure social engagement and consumer wellbeing. In these cases, volunteers should meet the same requirements as essential visitors, including undertaking basic IPC training, completing pre-entry screening and being authorised by the RACF.

Visitors to unaffected parts of the RACF: these visitors can enter if they comply with public health and RACF requirements (which may include being fully vaccinated, completing pre-entry screening procedure, RAT testing, PPE and following instructions). They must be advised to avoid the affected parts of the RACF.

Visiting consumers who have COVID-19. Visits to consumers with COVID-19 should also be managed using a risk-based approach. It is particularly important in compassionate circumstances such as end of life care. RACF should consult with the PHU to determine appropriate mitigations to support families, carers, and pastoral supports (emotional and spiritual support) to visit cases. Mitigations may include measures such as assessment of vaccination status, use appropriate IPC and PPE and no contact with other consumers.

18. Staff Education

Each RACF must undertake regular staff training in all aspects of outbreak management before an outbreak.

Infection prevention and control (IPC) program

For a sustainable IPC program, RACFs should ensure:

- appropriate physical and administrative controls
- adequate financial resources
- professional support
- continuing staff education and training

The Commonwealth now requires Commonwealth subsidised residential aged care facilities (RACF) to have at least one IPC lead who is a member of the nursing staff and has completed an identified IPC course. For more information see Infection prevention and control lead/s. The IPC Champions can be Registered Nurses, Enrolled Nurses or Care Staff Employees who have a keen interest in Infection Prevention Control and work under the direction of the IPC lead who has completed an identified IPC course.

All staff (including casual, domestic, hospitality and volunteer workers) need to understand the advice outlined in the Infection Control Expert Group (ICEG) COVID-19 guidelines for infection prevention and control in residential care facilities. They need to be competent in implementing these measures during an outbreak. Staff should also be aware of and follow any extra jurisdictional requirements.

Understanding standard precautions

Standard precautions are IPC practices routinely implemented in healthcare and RACF to reduce the likelihood of transmission of infection. They apply to all staff, consumers and visitors. For more information, see the Australian Guidelines for the Prevention and Control of Infection in Healthcare.

In the event of an outbreak contact the RFBI Nurse Practitioners or Nurse Educators via the RFBI Education Team for education resources

19. Exposure Management and Assessment

- It is important to ensure the RACF approach is based on local guidance. In many jurisdictions' exposures within an RACF can be managed by the provider in line with the Updated COVID-19 Test and Isolate National Protocols without involvement of the PHU.
- Following an exposure, RACFs should undertake exposure assessment to determine if any staff or consumers have been exposed to the person with COVID-19 and develop an agreed management plan based on the degree of assessed risk. RACFs should refer to jurisdictional advice for guidance.
- A management plan will support workforce planning, provide additional control to prevent outbreaks and inform outbreak management planning. Where exposure management plans are required, they should be developed by the individual RACF in collaboration and consultation with staff, health professionals, consumers and families. Plans should consider:
- Mapping staff, visitor and consumer movements to assess risk
- Testing protocols for those exposed in line with jurisdictional testing guidance
- Use of appropriate controls according to assessed risk
- Defining roles and responsibilities within the RACF for assessing the risk from an exposure
- Consider site specific factors that will impact the response required
- Consider when advice of PHU may be required
- Describe and define events that would require moving to outbreak management

20.Identifying an outbreak of COVID-19

20a - Confirmed outbreak

An RACF COVID-19 outbreak is defined as either:

- Two or more consumers of a residential care RACF who have been diagnosed with COVID-19 via RAT or PCR test within 5 days and has been onsite at the residential care RACF at any time during their infectious period; or
- Five or more staff, visitors and/or consumers of the residential care RACF diagnosed with COVID-19 through RAT or PCR test within past 7 days who worked/visited during their infectious period

A symptomatic case is considered infectious from 48 hours prior to symptom onset to 7 days after the date on which the first positive specimen was collected.

An asymptomatic case is considered infectious, from 48 hours prior to the collection date of the first positive specimen to 7 days after the date on which the first positive specimen was collected. A risk assessment should occur for staff members who have worked while infectious with consideration of the type/length of exposure and controls in place (such type of mask and eye protection). If the diagnosis is not confirmed, clear and wide communication of these decisions will be important. All consumers should receive their usual ongoing medical care, including essential allied health and mental health care, during the outbreak and the outbreak recovery period. Services that maintain the physical and emotional wellbeing of consumers should continue to be provided as much as possible. Some services may be provided through remote monitoring and telehealth and RACF need to ensure that they have the technology available to support this. Good IPC practices are needed for the safe use of remote monitoring and telehealth equipment, including tablet devices. All visiting MEDICAL OFFICERs should be informed at the start of the outbreak and provided with the contact details of the clinical oversight manager. In addition to a letter to Medical Officer's, Commonwealth funded aged care facilities and disability residential services may also contact the Primary Health Network. The Primary Health Network may liaise with those providing primary medical and allied health care in the local area. They can assist in sourcing practitioners willing to attend facilities. This will ensure ongoing continuity of care where usual MEDICAL OFFICERs and allied health professionals are unable to do so. MEDICAL OFFICERs may not be aware of the role they can play during an outbreak and may be more willing to be involved once they are given information about what they can do local virtually during the COVID-19 outbreak. Facilities should be aware of local resources.

20b - Suspected outbreak

Consumers are screened for symptoms of COVID-19 as per the RFBI Screening Checklist

Refer to – Consumer Screening Checklist – Outbreak Prevention Tool

Located in the Outbreak Box

- Consumers are isolated, and contact and droplets precautions are implemented until confirmation of a negative COVID-19 test result or direction from the treating MEDICAL OFFICERs.
- The PHU can be contacted for any unwell consumer and must be contacted for any confirmed COVID-19 cases in consumers/staff/contractors or frequent attendees of an aged care RACF.

20c - Management of a deceased body

Routine processes apply to the management of deceased bodies, with the same precautions in place after death as were in place prior to death.

STAFFs are unlikely to contract COVID-19 when Transmission-Based (Contact and Droplet) Precautions are used when handling the body of a deceased person. However, the following precautionary strategies should be used to minimise risks and to prevent the spread of COVID-19 when handling or transferring deceased suspected or confirmed cases:

- Staff handling deceased bodies are to wear apron/gown, gloves, masks and face shield/goggles
- Wear appropriate PPE without contaminating environmental surfaces
- Avoid unnecessary manipulation of the body that may expel air or fluid from the lungs
- Inform family members they should not kiss or touch the deceased to minimise the risk of transmission
- If a family member does touch the body, they should wash their hands with soap and water immediately afterwards or use ABHR
- When transporting the deceased, the body must be placed and secured in a body bag or wrapping in a manner that prevents the leakage of body fluid or other substance; double bagging may be required to achieve this

Label the outer bag 'COVID-19: Handle with care'.

For more information refer to NSW Health Handling of deceased bodies with suspected and confirmed COVID-19 by hospital STAFF (non-Coroners).

21. Notification

Notify Public Health Unit (PHU)

1. The first step in a suspected or confirmed outbreak is for the General Manager to notify the PHU and establish an Outbreak Management Team. After-hours PHU contact is available.
2. The PHU should advise and, where appropriate, assist to define the outbreak setting.

PHU NSW contact details: 1300 066 055

PHU ACT contact details ACT - (02) 5124 9213 After Hours: (02) 9962 4155

Notify Crisis Management Team (CMT)

The General Manager must immediately notify to the RGM and COO. The COO notifies the CEO immediately. There is to be no delay in the escalation process at any time of day or night, The COO will notify the Nurse Practitioners.

Contact Numbers – 24 HOURS

[redacted]

Each Village are responsible for ensuring that they have a document available to all staff which includes the telephone numbers of the Outbreak Management Team within the Village. This should include as a minimum the General Manager, Care Manager and IPC lead and IPC Champions telephone numbers. The Village needs to have these telephone numbers available to them 24 hours a day in the event of a COVID-19 outbreak. It is recommended that each Village maintains a list of staff that are willing to be called in to work due to an outbreak at short notice.

In the event that the General Manager, Care Manager or IPC Leads are unable to undertake their usual duties due to the COVID-19 outbreak the CEO and COO will allocate a Senior Staff member to attend the site and ensure that there is adequate clinical coverage.

Notify the Commonwealth Department of Health

A Regional General Manager will notify the Commonwealth Department of Health of any confirmed case of COVID-19 - staff or consumer.

Email address: agedcareCOVIDcases@health.gov.au

22.Establish an Outbreak Management Team

The aged care RACF is responsible for managing the outbreak and should take a strong leadership role with support from the PHU.

1. Set up an Outbreak Management Team in conjunction with the local PHU (immediately).
2. RFBI is to co-chair daily meetings of the Outbreak Management Team until the outbreak is closed.

The Outbreak Management Team initially meets within 1 hour of the identification of a confirmed COVID-19 case and daily thereafter to:

- Direct and oversee the management of the outbreak

- Monitor the outbreak progress and initiate changes in response, as required
- Liaise with Medical Officer's and the state/territory Department of Health, as arranged.

This team should be made up of a combination of RACF staff, RFBI Head Office and external. The team members are:

- Chairperson: RFBI CEO
- Co-Chair/Incident Controller: Public Health Unit (PHU)
- Secretary (usually administration staff from the affected Village)
- Outbreak Coordinator (Nurse Practitioner)
- Infection Control Coordinator (RACF IPC) Support from Quality Team
- Workforce Co-ordinator (with support of the RFBI HR Team)
- Consumer/ NOK Communications Representative
- Stakeholder Communication Coordinator (RFBI CMO)
- PPE Support Co-ordinator
- Outside Specialists if available (General Practitioner/ Nurse Practitioner)

The team will need to meet at least daily, including weekends and public holidays, to monitor the outbreak and initiate actions.

Refer to – Daily Outbreak Meeting Agenda & Minutes Template

It considers the progress of the response, undertakes ongoing monitoring, deals with unexpected issues, and initiates changes, as required.

Roles

- Lead and manage the implementation of the Outbreak Management Plan (OMP) in response to the outbreak in the aged care RACF.
- Regularly communicate with consumers and their family members/representatives — updating them on the outbreak response, including each consumer's circumstances and preferences.

Tasks

- Notify and liaise with local PHU and Commonwealth Department of Health.
- Oversee implementation of infection prevention and control measures as per OMP.
- Restrict visitors and community (including health workers) to minimal essential requirements. Non-essential visitors will be precluded from face-to-face visits with consumers (detailed in Communicable Diseases Network Australia Guidelines). Keep a log of all visitors entering the aged care RACF, including the areas and consumers they visited.
- Manage staff including rostering and isolation measures for exposed staff.
- Ensure register is maintained of staff who have been caring for consumers with COVID-19.
- Engage surge workforce where critical staff are not available to be sourced through other avenues, if required.
- Monitor consumers' welfare and wellbeing, regularly communicate with consumers and their family members/representatives.
- Assist aged care RACF to work with Medical Officer's to review/develop advanced care plans for consumers.
- Enable access and respond to aged care advocates, provide consumers and their family members/representatives with communication, collateral and materials provided by advocacy services.
- Facilitate pathology requisition orders and timely specimen collection (under the direction of the Nurse Practitioner or senior clinician in charge).
- In coordination with the Senior Inter-governmental Oversight Group, liaise with Medical Officer's and allied health personnel to ensure approach to acute and chronic disease is addressed, and de-conditioning, grief, cognitive decline and psychiatric sequelae of isolation and loss are addressed.

Outbreak Management Team Roles and Responsibilities are outlined on Below.

23.Governance – OMT including Clinical Governances

The Clinical Governance Committee and the Clinical Governess Sub- Committee will assess each outbreak and assist each Village as required, depending on the location of the Village will depend on the hospital access and this will be managed on an individual basis (as can change from one Health Service to another). RFBI have access to two (2) Nurse Practitioners (Jennifer Watson and

Amanda Woodlands) both Nurse Practitioner are willing to be onsite at a COVID-19 outbreak and / or available through telephone conference including Lifesize. Both Nurse Practitioners are skilled at being able to assess the deteriorating Consumer. Both Nurse Practitioners are able to provide end of life care and ensure appropriate medications are charted for the Consumer.

– RFBI Educators to provide education to Registered Nurses on the deteriorating Consumer

- RFBI Educators to provide education on ISBAR to ensure that the handover process is clearly identified and communicated

23.a.1 Activation of the Outbreak Management Team

In the event of a case or suspected case in a high-risk setting, we will declare and activate the Outbreak Management Team.

23.a.2 Governance of the Outbreak Management Team

Upon declaration of an outbreak we will convene an Outbreak Management Team. The overarching objective of this team is prompt containment of the outbreak through Public Health action and timely communication. In most cases, in conjunction with a senior RFBI official, a Public Health Medical Officer may also be appointed as the Outbreak Management Team Chair and will be the incident controller of the outbreak. The Outbreak Management Team Chair is responsible for the management of the health response to the outbreak, in collaboration with the RACF. The Outbreak Management Team may include members being key Government and external stakeholders related to the health response. Responsibilities of the Outbreak Management Team Chair are outlined later in this document.

23.a.3 Structure and roles of the Residential Outbreak Management Team

The membership of the Outbreak Management Team will be dependent on the response required and the setting and will be determined by the Outbreak Management Team Chair. Potential Outbreak Management Team membership and their specific roles and responsibilities are outlined at later in this document.

Roles of the Outbreak Management Team:

- Declaring a COVID-19 outbreak in a high-risk setting, if not already declared by an identified position holder;
- Coordinating public health management and investigation of the outbreak including:
- Provide an entry and exit audit on the RACF including daily documentation of all new, isolated and cleared cases, any relevant documentation pertaining to Coronavirus (COVID-19)
- To rapidly identify, isolate and manage cases (including all documentation)
- Advising on appropriate isolation and quarantine arrangements, including the duration;

- Manage clusters and outbreaks (including all documentation)
- Ensure appropriate COVID-19testing occurs with both consumers and staff and follows through on the results including appropriate documentation and reporting to the authorities
- Ensure that all staff are educated to a high standard in the use of PPE, this will include the signing of all competencies pertaining to PPE such (but not limited) donning and doffing of gowns, hand hygiene, application and removal of gloves and eye protection
- Establishing and maintaining regular communication with the RACF throughout the outbreak and obtaining daily updates/line lists;
- Set up simulation rooms for all staff to be able to practice donning and doffing of PPE
- Set up eLearning platform for staff to be able to watch online and undertake eLearning related to infection control
- Surveillance of the RACF ensuring that there is no risk of transmission
- Ensuring that the roster is maintained and that adequate staff is rostered at all times
- Ensuring that all staff are rostered to their areas and no risk of any transmission (staff to work in their designated areas at all times).
- Identifying the need for surge workforce;
- Ensure that families, consumers and staff kept up to date with the outbreak
- Ensure adequate stock is ordered and received by the RACF, maintain a stock take/ rotation system on all equipment required for the outbreak. Under no circumstances can any out of date items be used in an outbreak. The Management Team and IPC lead is responsible for managing the "Burn Rate" to ensure that there is adequate stock for the outbreak.
- Assist the Clinical and Infection Control Leader/s in ensuring compliance within the RACF

- Oversee the RACF and the Outbreak
- Minimum of daily meetings fully documented
- Maintain documentation in relation to the pandemic
- Report to the COO daily
- Mobilising financial, logistic and human resources as required through the Outbreak Support Team
- Declaring the outbreak over; and conducting and leading an after-action review

The Maintenance Personnel will be responsible for but not limited to the following:

- Ensure the removal of both general and clinical waste from the RACF in a timely manner and ensure that it is at all times stored away from the view of the public
- Assisting where appropriate including within the affected area

23.a.4 Roles and Responsibilities of OMT

Role - OMT	Responsibility
Chairperson (including a PHU member, where possible)	The CEO (if not able to then COO and/or the Board of Directors or others) who can report on operational issues and has authority to implement the directions of the Outbreak Management Team
Secretary / Receptionist	The RACF allocates a secretary/ receptionist who organises Outbreak Management Team meetings, records and distributes action items and minutes.
PHU Lead	Assigned by the PHU to arrange testing and make decisions around isolation and cohorting of consumers (This person may also be the co-chair from the public health).
Infection Prevention and Control Practitioner (IPC)	Ensures that all infection control decisions of the Outbreak Management Team are carried out, and coordinates activities required to contain the outbreak including IPC strategy, PPE usage, Staff training and compliance, service processes and systems. This could be an employee skilled in IPC, an IPC Practitioner organised by the PHU/local health district or a First Nurse Responder organised by the Commonwealth Department of Health.
PHU Contact Tracer	Feedback progress on contact tracing, testing and isolation of healthcare workers, external visitors, contractors, volunteers, allied health professionals, doctors, agency staff etc.
PHU Epidemiologist	Provide expert opinion on containment plans, epidemiological links to other aged care facilities, epidemiological links to the community, integrate multiple lines of information including data on hospitalisation, deaths etc. with existing state databases, prepare reports and advise state health officials on the progress of outbreak

Role - OMT	Responsibility
Communications Coordinator from Head Office (Communication Team)	Follows the communication plan to inform staff, families as required under the direction of the CEO
Australian Government Department of Health case officer	The Case Officer will liaise with the Clinical Manager to assist access to primary health care and allied health through the Primary Health Network Provides access to resources to assist in the response including PPE, workforce, supplementary testing.
Aged Care Quality and Safety Commission Case Officer	Provide primary point of contact for providers and consumers in relation to quality of care. Provide education on infection control Monitors compliance education on infection control Provides access to the Chief Clinical Advisor for the ACQSC and supports care for all consumers impacted in RACFS
Care Manager RFBI Nurse Practitioner(s) and RFBI Clinical Nurse Consultant(s)	The Care Manager ensures ongoing clinical management is provided for all consumers in the RACF based on the advice of the Internal Outbreak Management Team. For the COVID-19consumers, this includes ensuring clinical assessment and management occurs including considering hospitalisation, hospital in the home or other model of care. For all consumers this means ensuring usual clinical care and managing the additional deconditioning and mental health risks associated with isolation. The Care Manager will notify the Primary Health Network, liaise with the State and Territory coordinator for local district health services and the Australian Government Department of Health Case Officer to ensure appropriate medical and allied medical continue to access consumers

Role - OMT	Responsibility
Infectious Disease Physician	A person with specialist infectious diseases expertise who may attend or advise the attending clinicians on clinical assessment and management of the person with COVID-19.
Local Health District coordinator for health care in the home (State and Territory Government)	A person from the Local Health District who coordinates the provision of state based in-reach services such as Hospital in the Home and Virtual Aged Care teams. This person has a role to source hospital in-reach capacity to back up clinical care where available.
Geriatrician (one of them is Dr Paul Regal however each RACF has their own)	Available via teleconference to attend a consultation and provide assistance with the care of any RFBI consumer in the event of an outbreak
Medical Officers	Available via teleconference to attend a consultation and provide assistance of any RFBI consumer (with or without a diagnosis of CORONAVIRUS) in the event of an outbreak if the consumers own Medical Officer is not available Nurse Partitioner maintains all discussions via email, or any telephone discussions then confirmed by email. Plan reviewed by Medical Officer and Nurse Practitioner keeps the Medical Officer updated of any changes to the COVID-19Guideline and Management Plan

23.a.5 Members Internal Outbreak Response Team

Internal Outbreak Response Team roles and responsibilities

If there is a Coronavirus (COVID- 19) outbreak at any of the RFBI RACFs then RFBI has formed an overarching Internal Outbreak Response Team which will arrive onsite at the RACF within a short time frame of a confirmed positive diagnosis (depending on location of the RACF).

Currently the Internal Outbreak Response Team for the RFBI RACF consists of the following RFBI staff:

- Louanne Riboldi (COO) media and spokesperson (if required) will oversee the communication plan at the time of an outbreak (mobile number[redacted])
- Regional General Manager of the affected RACF
- General Manager of the affected RACF
- Care Manager of the affected RACF
- IPC Leads x 2 Registered Nurses of the affected RACF and where possible IPC Champions
- [redacted]
- Plus, the COO holds a spreadsheet which is updated on a regular basis consisting of Staff willing to attend a COVID-19 outbreak at any of the RFBI RACFs, the amount of staffing for an outbreak will be dependent upon the size of the RACF with an Outbreak.
- Hospitality Manager
- Allied Health Professionals
- Educator
- The will also consist of external members such as but not limited to: Geriatrician, Medical Officers and the PHU

The Internal Outbreak Response Team will be on standby if there is an outbreak in any of the RFBI RACFs. The overall role and responsibility of the Internal Outbreak Response Team is to implement the Covid -19 Safety Plan and the coordination of the RACF with Coronavirus (COVID-19). The

Internal Outbreak Response Team has excellent clinical skills, knowledge and a positive attitude, training and experience in dealing with outbreaks within RACFs.

The Internal Outbreak Response Team will work closely with the RACF to ensure a smooth process during the outbreak. The Internal Outbreak Response Team will at all times be familiar with this document and be confident within their ability to be able to work within the Internal Outbreak Response Team to an effective standard, members of the Internal Outbreak Management Team.

RFBI is responsible for managing the outbreak and will take a strong leadership role with support from the PHU. The Internal Outbreak Response Team is engaged to direct, monitor and oversee the outbreak at the RACF. During and outbreak the Internal Outbreak Response Team will meet regularly, usually this will occur daily, (in person or by teleconference) at the height of the outbreak to monitor the outbreak, identify problems, initiate changes to response measures, and to discuss outbreak management roles and responsibilities.

The COO will report directly to the CEO and the Board of Directors and ensure that they are at all times notified of any significant changes.

The Internal Outbreak Response Team will review all departments and ensure that there is no risk of cross contamination. RFBI has frameworks and protocols for testing and isolation in the event of respiratory disease outbreaks. Outbreaks of COVID-19within a RFBI RACF should be managed with close reference to the Guidelines and Outbreak Management Plan for the use at all RFBI for consumers (including independent living), Staff Members and Volunteers.

RFBI has adequate PPE in storage at each RACF for the first 72 hours of an outbreak. In addition, there is a stockpile of PPE currently maintained at RFBI Lake Haven Masonic RACF that encompasses adequate PPE stock to cover a 60-bed RACF for up to 6 weeks. The Internal Outbreak Response Team will coordinate the distribution of this stockpile to the outbreak RACF.

It is the responsibility of the General Manager at each site to ensure that a Communication Plan is maintained in preparedness of an outbreak. The communication plan will include but not limited):

- How to best communicate with consumers, families person responsible, health care decision makers, employees, contractors, volunteers, service providers, Public Health Unit, Primary Health Networks, Pathology, Hospitals, Health Services, Medical Officer's,

Nurse Practitioners, Commonwealth, Preparedness documents including the release of any updates and frequency, phone redirection (as required, if appropriate).

23.a.6 Roles of the Internal Outbreak Response Team

Role/function	Person	Responsibilities
Case/Outbreak response coordination	Chief of Operations	• Lead the Internal Outbreak Response Team. • Coordinate activities required within the setting to contain the outbreak. • Join the multi-agency Outbreak Management Coordination Team. • Liaise with key stakeholders. • Identify risks specific to the outbreak.
Infection prevention and control coordination	Infection Control Lead at the RACF	• Liaise with the Outbreak Management Coordination Team about infection prevention and control measures. • Ensure adequate supplies of PPE and cleaning products. • Ensure staff are trained in infection prevention and control precautions. • Ensure cleaning staff are kept informed about enhanced cleaning and infection prevention and control measures. • Oversee cleaning activities; hire additional cleaners as required. • Identify places to isolate or quarantine cases/contacts while they are onsite.
Information management	Care Manager / General Manager	• Collect and collate data to help control the outbreak (e.g. number of people in the setting, number of symptomatic people, test results). • Provide daily reports for the Outbreak Management Coordination Team and other key stakeholders as requested.
Communications	CMO	Liaise closely with Public Health Services/the Outbreak Management Coordination Team about:

		• internal communications • stakeholder communications • media and public communications.
IT support	CTO	• Set up and organise IT equipment (e.g. computers, mobile devices, network access). • Resolve information technology issues.
Administration support	Local Admin team	• Organise Internal Outbreak Response Team meetings. • Record and distribute minutes of meetings. • Monitor and maintain resources, e.g. hand sanitiser, disposable tissues and stationery. • Display outbreak signage

23.a.7 Deactivation of the Outbreak Management Team

When the outbreak has been declared over, the Outbreak Management Team Chair will deactivate the Outbreak Management Team. The Outbreak Management Team Chair will notify the Public Health Unit or its delegate, Outbreak Management Team members and other relevant stakeholders of the decision.

Those activities that were being undertaken by the Outbreak Management Team should either be identified as no longer needed or as needing to be continued. The Outbreak Management Team Chair, in deactivating the Outbreak Management Team, will be responsible for ensuring that ongoing activities have been allocated to an appropriate employee as a part of return to business-as-usual arrangements.

Where can I get more information?

Call the National Coronavirus Health Information Line on 1800 020 080. The line operates 24 hours a day, seven days a week. If you require translating or interpreting services, call 131 450. The telephone number of your state or territory public health authority is available on the coronavirus page at www.health.gov.au/state-territory-contacts

24.Public Health Unit (PHU) Line List

Continue line listing of all suspected and confirmed cases among consumers and staff.

a. The PHU will provide a preferred case list ('line list') template to use when an outbreak is notified.
b. The PHU must be provided with an updated copy of the line list daily (including weekends and public holidays) or as instructed.
c. If any deaths occur during an outbreak, the Department must be notified as soon as possible and within 24 hours.
d. The line list must indicate:
    - The date the consumer became unwell
    - Their room location and whether they're in a single room or shared room

- Their updated location if moved for the purpose of cohorting.

e. Hospitalisation of consumers should be noted on the case list and sent to the Department daily

25.Isolation or Cohorting

25.1 Placement of consumers with suspected or confirmed COVID-19

Consumers with suspected or confirmed COVID-19 should be isolated and cared for in single rooms (where possible), Zoning (cohorting) refers to the grouping of consumers with the same condition in the same area. The goal of zoning or cohorting consumers (and the STAFF that attend to them) is to minimise interaction between infectious consumers and non-infected consumers as much as possible. For COVID-19 this would require keeping consumers who are confirmed COVID-19 together in the same zone that is separate from those who are not infected. Alternatively, separating into an area of COVID-19 recovered or non-COVID consumers together. If layout and staffing allow (may vary between facilities), consider the following factors before establishing zones. Where possible and if staffing permits, staff are to be cohorted into area (infectious and non-infectious). Staff need to be rostered in the same area each day during the outbreak (where possible) and not cross from infections to non-infectious or vice versa. Each area both infectious and non-infectious have a team leader who will lead the team and ensure communication is maintained to a high standard. The IPC lead will oversee the teams and ensure that (where possible) each employee remains in their allocated section for the entire outbreak.

The organisation of zones depends on factors such as:

- physical building space
- availability of single or shared rooms in a specific area to enable zoning
- ability of consumers to be relocated
- staffing capacity
- number of suspected or confirmed COVID-19 cases
- acuity of COVID-19 positive consumer
- number of contacts
- access to bathroom

The following are examples of how zoning could be applied for COVID-19:

1. Red zone - COVID-19 positive consumers
2. Amber zone - COVID-19 high risk contacts or suspected cases
3. Green zone – consumers that have been cleared of being COVID-19 cases or contacts
4. Blue zone – areas only accessed by staff

- Consumers should be isolated while they are infectious (as determined by the PHU).
- During this period, if they are ambulatory and well enough, they may leave the room for exercise. They must be supervised and avoid contact with other consumers. If consumers leave their room while infectious, they should wear a surgical mask.
- Remind staff and consumers of the need for cough etiquette and respiratory hygiene.
- Staff and visitors in contact with unwell consumers should follow contact and droplet precautions
- Supplies of PPE should be readily available and placed strategically outside the room.
- Special arrangements may be needed for the care of consumers with dementia who need to be isolated. If a single room is not available, the following principles can guide consumer placement. There are many challenges of isolating a consumer with dementia including those consumers who choose to not isolate and wander around in their unit and those with challenging behaviours. In the event of a consumer whom has a diagnosis of dementia and they choose to not isolate the following needs to occur:
  - Contact the Nurse Practitioner and the Nurse Educators for advice and support
  - Offer the Consumer with dementia a face mask
  - Offer other Consumers within the unit a face mask
  - Encourage other Consumers (who have tested negative) to stay within their own bedrooms to reduce the risk of infection especially those with comorbidities.
- Consumers with the same pathogen who are assessed by the aged care RACF as suitable roommates, can share a room (i.e. be cohorted).
- Unwell consumers sharing a room should be more than 1.5 metres apart. There should be a privacy curtain between them to minimise the risk of droplet transmission.
- Staff in direct contact with unwell consumers should follow contact and droplet precautions.

- Staff caring for consumers who have COVID-19 should be cohorted as far away as possible. This reduces the chance of the virus spreading to other staff and consumers
- Any consumer who remains well but has been in close contact with a confirmed or probable case, in the period extending 48 hours before symptoms began in the confirmed or probable case, should be quarantined in a single room for 14 days.
- They should be monitored for symptoms of COVID-19 (at least daily), complete the COVID -19 chart on Clinical Manager
- They may leave their room for exercise or activity, with supervision by a staff member if necessary, to ensure that they avoid contact with other consumers.
- If a single room is not available, consumers in quarantine can share a room. The same precautions as for room-sharing by confirmed cases apply (see above). If COVID-19 is later confirmed in one of the consumers, they should be separated. The consumer who has COVID19 should be isolated. The other consumer should remain in quarantine.
- A clear priority in managing an outbreak is to proactively limit spread to unaffected staff and consumers, while taking a risk-based least-restrictive approach to requiring isolation and quarantine so as to minimise the impact of restrictions on consumers. The principles are to:
- Avoid proximity to and contact with COVID-19 cases
- Avoid contact with potentially contaminated areas and equipment
- Optimise ventilation

To avoid contact with cases, cohorting is used to group individuals with the same clinical status in the same location. Consider re-arrangement of rooms and re-purposing of other areas. Plan how to cohort consumers together into rooms, dedicated areas or a separate wing or building, where feasible. It may be helpful to let families know in advance about any temporary moves in the case of an outbreak.

Outbreak management plans should include floor-maps which have been colour coded and labelled with instructions for how to cohort in response to infection patterns.

Ideally, there should be five areas for:

Cases in isolation -These are consumers who have confirmed COVID-19 and have not yet met the criteria for release from isolation. Isolation rooms should be limited to the shortest

time possible to reduce the risk of transmission. They may mix with other confirmed cases in isolation. In the event a consumer remains symptomatic and RACT negative post isolation period the clinicians need to consider other screenings such as acute respiratory infections (ARI's) such as (but not limited):

- Common cold
- Pharyngitis
- Epiglottis
- Laryngotracheitis
- Rhinitis
- Laryngitis
- Influenza

Contacts in quarantine -Individuals who have met the close contact/household-like contact definition. Facilities should have policy support and plans to assist in the isolation of consumers who choose to isolate and to manage those who are willing to risk exposure by continuing to mingle post exposure

Released contacts -This includes those who have completed quarantine. Groups with similar exposure or assessed risk can be considered for management in a shared space.

Recovered cases - who have been released from isolation. If cleared they may re-join other consumers. Buffer areas between potentially contaminated and non-contaminated cohorts - For example, nurses' station, corridors, staff lunchrooms, meeting rooms, drug rooms. This also includes transition points between areas where staff must put on or take off PPE.

Staff who are higher risk contacts and are returning to work during their quarantine period due to critical workforce shortages should only care for consumers who are in the higher risk exposure group or who are cases. If feasible and an entire wing or whole RACF is impacted, asymptomatic consumers may be given the choice to leave their rooms, eat in shared dining rooms (separate to or staggered from, exposed consumers) and participate in social activities (for exposed consumers). These consumers should not enter other parts of the RACF and should participate in any required risk mitigations such as daily RAT prior to leaving their rooms. Exposed and non-exposed consumers

should not mix within the RACF. Moving consumers may help reduce exposure to the virus and prevent prolonged periods in isolation by limiting the extent and duration of the outbreak. RACF should be aware of jurisdictional guidance around management of consumers in an outbreak situation (i.e. moving consumers who have COVID-19 to hospital consumers who are not infected to reduce transmission risk). Currently, many jurisdictions only transfer an infected consumer to hospital if there is a specific clinical requirement. Any transfers (other than on the basis of clinical need) should be planned and coordinated with hospital services and in consultation with the consumer, their family or alternative decision-makers and public health units. Any decision to transfer a consumer within or external to the RACF needs to be made in consultation with the consumer, and any alternate decision makers for the consumer. Consumers wishes must be accommodated where possible – some consumers who were absent from the RACF when the outbreak commenced may choose to return to their home regardless of the risk of contracting COVID-19. Consumers and families need to be kept informed of any plans or decisions to move consumers.

26.Infection Prevention Control

26.1 Infection Prevention Control (IPC) when a consumer has suspected or confirmed COVID-19

Standard Precautions

Standard precautions are IPC practices used routinely in healthcare. They should be used in aged care RACFs with a suspected or proven COVID-19 outbreak and apply to all staff and all consumers.

Key elements are:

- Hand hygiene before and after each episode of consumer contact and after contact with potentially contaminated surfaces or objects (even when hands appear clean) Gloves are not a substitute for hand hygiene. Staff should perform hand hygiene before putting gloves on and after taking them off
- Use of PPE if exposure to body fluids or heavily contaminated surfaces is anticipated (gown, surgical mask, protective eyewear and gloves)
- Cough etiquette and respiratory hygiene

- Cough into a tissue (and discard the tissue immediately) or into the bend of the elbow; perform hand hygiene.
- Regular cleaning of the environment and equipment
- Provision of alcohol-based hand sanitiser at the entrance and exit to the Village and other strategic locations.

Note: RACFs should ensure all staff are trained in the correct use of PPE, appropriate to their role. Incorrect removal of PPE increases the risk of personal contamination and spread of infection.

Transmission-based precautions are IPC practices used in addition to standard precautions, to reduce transmission due to the specific route of transmission of a pathogen. Respiratory infections, including COVID-19, are most commonly spread by contact and droplets. Airborne spread may occur during aerosol generating procedures (not limited):

- Nebulisers
- Behaviours such as yelling, screaming and / or singing

26.1.2 Contact and Droplet Precautions

- These precautions apply to: Health care workers and aged care RACF staff during the clinical consultation and physical examination of consumers with suspected or confirmed COVID-19, or who are in quarantine
- All staff when in contact with unwell consumer

Key elements are:

- Standard precautions (as above)
- Use of PPE including gown, surgical mask, protective eyewear and gloves when in contact with an unwell consumer (gown and gloves are not required if you are placing a food tray on the table or talking to the consumer where there is a minimum of 1.5 metres). This includes all COVID-19 positive and COVID -19 suspected consumers. Employee are to ensure that they hand sanitise before and after entering the room of the consumer.
- Protective eyewear can be in the form of safety glasses, eye shield, face shield, or goggles
- Enhanced cleaning and disinfection of the unwell consumer's environment

- Limit the number of staff, health care workers and visitors in contact with the unwell consumer
- Nebulisers have been associated with a risk of transmission of respiratory viruses and their use should be avoided. A spacer or puffer should be used instead. In the event the consumer is charted a nebuliser take appropriate actions to contact the consumers Medical Officer or appropriate Health Provider to have an alternative charted such as a spacer.

Refer to - High Risk Therapies – Nebulisers

Located in the Outbreak Box

Note: When caring for an asymptomatic consumer in quarantine, contact and droplet precautions should be followed (PPE includes a gown, surgical mask, protective eyewear and gloves). Eye protection is optional. If the consumer later develops symptoms or is confirmed to have COVID-19, staff who did not wear eye protection do not need to quarantine if they:

- Followed all other precautions
- Remain well
- Had no direct contact with respiratory secretions (i.e. a cough or sneeze directly into to the face).

26.1.3 Airborne Precautions

Use of P2/N95 respirators, instead of surgical masks, is recommended, in addition to all other precautions outlined above, when performing certain high-risk aerosol generating procedures on consumers with COVID-19. Their use is unlikely to be needed in an aged care RACF. Note 1: P2/N95 respirators should only be used by staff who have been trained in their use. They should be fit checked with each use to ensure an adequate face seal. It is the direct responsibility of the General Manager to ensure that the IPC lead has attended to all fit checking within the Village including all staff (with no exceptions) this must include maintenance, administration, catering ect

26.1.4 Other

Faecal shedding of the virus has been demonstrated in some cases. PPE must be worn when changing incontinence pads of an infected consumer and these items must be considered as contaminated waste. Consumers with ongoing diarrhoea or uncontained faecal incontinence who may have limited capacity to maintain standards of personal hygiene should continue to be isolated until 48 hours after the resolution of these symptoms.

27. Room Set Up

26. Make PPE, including gowns and gloves and hand sanitiser available immediately outside of the consumer's room (Do not include masks or protective eyewear as these should only be available at the entrance of the RACF), Staff should NOT be changing their mask inside the Village
27. Position a disposal receptacle near the exit inside the consumer's room to make it easy for staff to discard PPE (all with the exception of the mask and protective eyewear which remain in place as "EXTENDED HEADWEAR"
28. RFBI support the use of "EXTENDED HEADWEAR" which was introduced by the Commission of Excellence (CEC) at the onset of the COVID-19 outbreak.
29. Post signs on the door or wall outside of the consumer's room clearly describing the type of precautions needed and the required PPE, these signs should also clearly direct staff how to don and doff appropriately
30. Post signs on "How to handrub"
31. Equipment and items in consumer areas should be kept to a minimum. Ideally, reusable consumer care equipment should be dedicated for the use of an individual consumer. If it must be shared, it must be cleaned and disinfected between each consumer use. Sharing of equipment is not recommended and each Village needs to ensure that they have adequate equipment to prevent or reduce the sharing of equipment as this can potentially place a consumer at further risk. In the event that any equipment needed to be shared it must be clearly labelled POSITIVE CONSUMERS and NEGATIVE CONSUMERS (never shar equipment from a positive consumer and a negative consumer).
32. Patient care and patient assessment devices (e.g., thermometers, sphygmomanometers, glucometers, hoists, pat slides) may transmit COVID-19 if devices are shared between patients.

33. To reduce the risk of transmission, disposable or patient dedicated equipment is preferred. Equipment that is unable to be dedicated should be cleaned and disinfected after use, allowed to dry, and stored clean. See above in the routine cleaning section for advice on cleaning and disinfectant solutions.
34. Staff involved with the cleaning and storage of shared patient care equipment should be trained in cleaning techniques and choice of chemical.
35. Decisions regarding responsibility for cleaning shared patient care equipment should be documented with clear lines of accountability in each clinical area
36. Cleaning shared patient care equipment must be completed by following manufacturer's Instructions
37. The cleaning detergent and/or disinfectant must be compatible with the equipment and manufacturer's instructions
38. Minimise equipment and items to reduce clutter in the patient areas including personal items owned by the patient.

28.Isolation Room / Zone Checklist

Consider the following when setting up an isolation room/zone:

- Dedicated PPE outside of zone, consider what to store this on
- Signage appropriate for the room/zone

Refer to Poster – PPE special requirements for COVID-19 Designated Zones

Located in the Outbreak Box

- Equipment kept to a minimum including soft furnishings
- One entry point to dedicated zone (if possible) and one exit point (different locations)
- External entry (for deliveries)
- Isolated medication trolley/consumer equipment
- Cleaning products in place to accommodate shared equipment
- Adequate handwashing facilities

29. Raise Awareness / Signage

39. Inform all aged care RACF staff and support services including MEDICAL OFFICERs.
40. Keep consumers informed through regular communication.
41. Encourage reporting of all symptoms, including mild symptoms, and support personal protection measures including respiratory hygiene, cough and sneeze etiquette, and hand washing.
42. Communication representatives should make personal calls to family members/consumer representatives on a priority basis.
43. The RFBI Marketing team will assist aged care RACFs with communication to consumers and their family members/representatives as required and will manage all other stakeholder communications as per the COVID-19 Outbreak Communication Plan.
44. Signage should be placed at the entrances to rooms/units/isolation wards to identify the need for additional precautions in addition to standard precautions for infection control.
45. Signage should be placed at the aged care RACF entrance. Restrict to a single-entry point where possible

30. Workforce Management

The number of health care workers available to provide care may be reduced considerably because of isolation requirements, personal illness, concerns about transmission in the workplace, and family/caregiving responsibilities. In the event that staffing is affected by a COVID-19 outbreak, the RFBI COVID Outbreak Workforce Plan will be enacted.

Refer to - COVID Outbreak Workforce Plan

21.1 RFBI Workforce Management Strategies

- Continued Wellness Screening of all staff.
- Request to be made to the RFBI Chief of People and Culture to source additional staff and to implement staffing contingency or surge workforce as required (including contact list for casual staff members or external nursing agencies). RFBI will increase staffing levels to meet increased workload to ensure that the consumer needs are met such as hydration, medication and all clinical needs.

- Assigned dedicated staff – a register of staff members caring for consumers with COVID-19 should be maintained.
- Staff members must not move between their allocated room/section and other areas of the aged care RACF, or care for other consumers.
- Staff members must self-monitor for signs and symptoms of acute respiratory illness and self-exclude from work if unwell. Considerations when choosing dedicated staff:
- Ensure staff have recently completed infection control training
- Ensure staff have current influenza vaccination (i.e. not medically exempt)
- Do not assign staff who are at risk of having more severe disease if they are infected
- Advocate for RFBI staff to remain part of the roster arrangement for every shift to allow for continuity of care.
- Ensure that there is an allocation sheet and an outbreak roster available at Village level

Information on people who are at increased risk can be found at the link below:

https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/whatyou-need-to-know-about-coronavirus-covid-19

Contact Details			
RFBI Person Resp.:	Chief of People [redacted]	Various Agencies	

31. Consumer care and safety

If the exposure assessment identifies that a significant proportion, or all, of the staff need to quarantine or furlough, arrangements must properly ensure consumer care and safety. The outbreak management plan must include arrangements for handover to replacement staff. The RACF must make available current consumers' care/clinical records and operational information required to ensure that the safety of consumers and staff is not compromised. In an outbreak, consider ID wrist bands to assist new staff to identify consumers. Picture boards of consumers and

RACF site plans may also help staff who are unfamiliar with the RACF to assist during outbreaks. Please note ID wrist bands are only to be used if there are all new staff assigned to a unit.

32.Contingency Workforce Guidance

32.1 Emergency Induction for Agency/Surge Workforce including access to Clinical Manager

A physical (hard copy) folders should be established at Village level that will inform the external/agency workforce on the following:

- Isolation Plans
- Site Maps
- Local Contact Lists
- Staff secondary employment details
- The contact details of all of the Nursing Agencies that are used within the Village
- PPE stocktake information (available on intranet)
- High Risk Register
- Latest Line List (not in the induction folder but available for agency/surge workforce)

The Induction checklist can be accessed via PolicyConnect 038 . Induction for Agency Staff (amazonaws.com)

User access to clinical manger can be created onsite by the Administration Team or the Management Team including the Registered Nurse, training documents can be located at the following link

Course: Training documentation, Topic: Version 10.1 - 10.5 (icarehealth.com.au)

33.Cleaning and Environmental Hygiene including terminal clean

The Hotel Service Manager and the Management Team must ensure that they have a list of all employees (fulltime, par time and casual) and their best contact numbers so that they can be easily accessible with short notice in the event of an outbreak. In the event that there is no cleaning staff available onsite the Hotel Service Manager or the Management Team at the Village are to contact

the Regional General Manager of their Village who in turn will deploy appropriately skilled staff from another RFBI Village or will contract a cleaning company to work onsite during the outbreak.

Refer to – Ecolab COVID-19 Information & Action Plan

Located in the Outbreak Box

Environmental cleaning and disinfection are crucial to preventing transmission of infection in the healthcare environment. Respiratory viruses can persist on surfaces but can be effectively inactivated by appropriate disinfectants. It is important to clean before disinfecting as dirt and grime can affect how well a disinfectant works. Regular, scheduled cleaning of all consumer care areas is essential during an outbreak. Frequently touched surfaces are those closest to the consumer, and should be cleaned more often. During a suspected or confirmed COVID-19 outbreak, an increase in the frequency of cleaning with a neutral detergent is recommended. Cleaning and disinfection are required during COVID-19 outbreaks. Using a 2-step clean (using detergent first, then disinfectant) (using a combined detergent/disinfectant) is required.

Environmental cleaning and disinfection principles for Residential Care RACFs. The following principles should be adhered to:

- Enhanced cleaning practices must be implemented at the commencement of an outbreak.
- Rooms of well consumers and communal areas should be decluttered and cleaned daily
- Frequently touched surfaces should be cleaned more regularly these include: (but not limited) bedrails, bedside tables, light switches, remote controllers, commodes, doorknobs, sinks, surfaces and equipment close to the consumer
- Walking frames and sticks
- Handrails and table tops in communal areas, and nurses station counter tops
- Rooms of unwell consumers should be cleaned and disinfected daily, more often if possible
    - Frequently touched surfaces at least daily
    - Equipment before and after each use
    - Surfaces that have been in direct contact with, or exposed to, respiratory droplets
- Rooms should undergo a 'terminal clean' when an unwell consumer is moved or discharged.

Cleaners should:

- Wear appropriate PPE, including impermeable apron/gown, disposable gloves, surgical mask, plus eye protection or a face shield while cleaning. If there is visible contamination with respiratory secretions or other body fluid, the cleaners should wear a full-length disposable gown
- Adhere to the cleaning product manufacturer's recommended dilution instructions and contact time
- Use a Therapeutic Goods Administration (TGA) listed disinfectant with virucidal (kills viruses). A chlorine-based product such as sodium hypochlorite is suitable for disinfection. The manufacturer's instructions for dilution should be followed.
- The Village IPC Lead and the IPC Champions along with the Management Team (General Manager and Care Manager) must ensure that at all times that there are appropriate and adequate stock levels stored at the Village. In the event of an extended outbreak the Village can contact the supplier and have adequate supplies delivered directly to the Village. It is the responsibility of each Village to have a up to date list of their suppliers. In the event that the usual suppliers to the Village being unable to supply the individual Village is to contact Head Officer (Purchasing Department) who will arrange a delivery of required equipment directly to the affected site.
- The Village IPC and the Management Team must ensure that at all times that the staff have an understanding of movement from clean to dirty to reduce the risk of further transmission
- Equipment and items in consumer areas should be kept to a minimum. Ideally, reusable consumer care equipment should be dedicated for the use of an individual consumer. If it must be shared, it must be cleaned and disinfected between each consumer use.

Detailed information on environmental cleaning and disinfection is available in the Commonwealth Department of Health factsheet – COVID-19.

Refer to – COVID-19 Environmental cleaning and disinfecting principles for health and RACF

Located in the Outbreak Box

TERMINAL CLEAN - Terminal cleaning of rooms occupied by patients or consumer who have COVID-19 requires both thorough cleaning and disinfection to remove the virus.

- Terminally clean room/zone on discharge or transfer from inpatient units

- PPE for Contact, Droplet and Airborne Precautions should be used for rooms that may not have been rested prior to cleaning
- Always check with the nurse-in-charge before entering the room
- Following an aerosol generating procedure (AGP) on a COVID-19 patient, cleaners should only enter the room after 35-45 minutes depending on the air changes per hour within the room
- Following discharge or transfer of the patient, prior to cleaning the room, the patient's personal effects should be removed, and fabric privacy curtains and window curtains, if present, should be removed for laundering
- For disposable curtains, follow local policy or follow manufacturer's instructions including checking the expiry date
- Handle used linen and fabrics with minimum agitation to avoid contamination of air, surfaces and persons
- The room and all patient care equipment remaining in the room should be physically cleaned
- Follow or combine cleaning with a disinfectant process (see 2-step clean process)
- All furniture, patient equipment items, horizontal surfaces, frequently touched surfaces, e.g., light switches and call buttons, bathroom, toilet and shower area should be thoroughly cleaned and disinfected
- For procedural rooms with short patient stays (e.g., CT scan, MRI, fever clinics) clean and disinfect frequently touched surfaces between cases and terminally clean the area as per local policies e.g., at the end of the session/day.

34.Laundry Service

- Management of linen from a suspected or confirmed COVID-19 case should be in accordance with Standard Precautions and routine procedure. Handle all used linen as per section 4.7.1 in the Infection Prevention and Control Practice Handbook.
- Laundry Staff are to be in full PPE at all times, this includes gloves, face shield/goggles and long sleeve gown whilst handling dirty laundry items.
- Handle soiled laundry with minimum agitation to avoid contamination of the air, surfaces and persons (e.g., roll up)

- Used, soiled or wet linen should be placed into an appropriate laundry receptacle at the point of generation
- Use clear leak-proof bags to contain linen that is heavily soiled with blood, other body substances or other fluids (including water)
- Linen bags should be securely closed and not filled completely as this will increase the risk of rupture in transit and exposure of bag handlers
- Reusable linen bags must be laundered before re-use
- Hand hygiene (using soap and water for 20 seconds or ABHR) must be performed following the handling of used linen.
- Ensure that washing machines and dryers are serviced as per manufactures instructions and a record of this is kept on site
- The Hotel Service Manager is responsible to ensure that the products in which are being used are appropriate for use within an outbreak and are readily available
- Each Laundry must clearly display "clean" and "dirty" areas and ensure that they can be distinguished easily for all staff to understand allowing staff to be able to understand the traffic flow control of receiving and distributing linen and clothing.
- RFBI ensure that each Village has access to alginate bags, alginate bags are highly density translucent red polythene bags that are designed to prevent the need to personally handle potential contaminated garments. The IPC lead at each site can provide training and education to all staff at each site to ensure understanding has been achieved of the use of alginate bags.

35.Catering and Food Service Utensils

The Catering Manager is to ensure that they have a contingency plan on site at each Village for an outbreak this is to include but not limited:

- Contingency plan in the event achieved of an outbreak within the Village including a disruption to the service
- At the commencement of an outbreak the IPC lead and the Management Team must review all Consumers and where appropriate commence them on sustagen (or similar) to increase their nutritional intake (this is supplied and paid for by RFBI) during an outbreak. Sustagen is often recommended for consumers with a decreased appetite or a diminished sense of taste.

- On approx. day two (2) to three (3) the IPC lead and the Management Team are to review all consumers bowel activity (this is further to each shift reviewing the bowel activity) and commence any consumers on prunes (either whole or pureed) depending on their dietary ability and or pear juice after clinical review of bowel management. The IPC lead and the Management Team are to notify the kitchen of the change by using the "Change of diet form" on Clinical Manager.
- A detail list of all dietary requirements and an effective way of communicating this to all catering staff.
- Full knowledge and understanding of the cleaning process of all trays and trolleys prior to them being returned to the kitchen.
- In the event of an outbreak all catering staff need to be isolated away from all other staff, including having their own entry and exit to reduce the risk of transmission.
- Catering staff are to wear face shield/goggles and mask at all times whilst onsite (gowns and gloves as per Organisational Policy for Food Handling)

Disposable crockery and cutlery are not required for suspected or confirmed COVID-19 consumers

- Kitchen utensils should be cleaned using routine cleaning cycles
- Food trolleys that have been used in any COVID-19 clinical areas should be cleaned and disinfected before reuse
- The meal ordering, delivery and collection of meal trays within a COVID-19 patient zone/ward should be led and managed by the ward/clinical area and local facility management
- Food delivery staff to wear PPE as per Transmission-Based Precautions if taking trays into a patient room or area e.g., respirator and eye protection. Gown and gloves are not required if you are placing a food tray on the table or talking to the patient

Contact Details			
Catering - RFBI Person Resp.:	[redacted]	EWH – food delivery: Master Catering Services	[redacted]

Cleaning - RFBI Person Resp.:	[redacted]	Elleisha's Property Services: Facilities First:	[redacted]
Laundry - RFBI Person Resp.:	[redacted]	Elleisha's Property Services: Facilities First:	[redacted]

36. Waste Management

Waste storage, handling, labelling, containment, transport and disposal should be undertaken in accordance with routine procedures for relevant waste management.

Waste minimisation

The implementation of appropriate waste minimisation strategies, that do not compromise work standards, environmental outcomes, patient or HW safety should be considered.

Non-clinical waste disposal

General waste and should be segregated and managed according to existing waste stream definitions. Manage waste in accordance with routine procedures:
All non-clinical waste should be segregated where possible and disposed of with the appropriate general waste stream

Waste (used PPE) is considered general waste unless contaminated with large amounts of blood and/or body substances.

Clinical waste disposal

- Clinical waste should be disposed of with the appropriate clinical waste stream
- Sharps should be discarded into a sharps bin.
- Used PPE in a COVID-19 outbreak is NOT Clinical Waste

Contact Details

RFBI Person Resp.:	[redacted]	Wasteflex:	[redacted]

Note: The following RACFs have general waste being collected by their local council; Armidale, Basin View, Bathurst, Berry, Goulburn, Hawkins, Lake Haven, Leeton & West Wyalong.

Where increase collection of general waste collection is required the RACF Maintenance Department will coordinate within each Village. Each Village must ensure that there is increased collection of waste throughout the Village during an outbreak, this includes removal of waste from the premises. During an outbreak the Maintenance Team and Management Team will work together to ensure that there is a suitable area to hold waste which is designated for removal. This area must be out of the site of the general public.

RFBI will pay for additional waste collections (if required).

37. Staff stations / desk areas

Ensure the following:

- Free of clutter
- No food or drinks
- Free of personal mobile devices
- Regular shift cleaning of shared electronic equipment e.g. phones, computers
- Maintain physical distance when possible

38. Handling of consumer paper health records

The risk of paper health record contamination and subsequent exposure to COVID-19 in the absence of a spill (or similar) is thought to be unlikely and considered extremely low risk.

The available evidence does not support holding notes for any period prior to scanning. This is unnecessary and may increase the risk of delay in the documentation and communication of patient information.

It is acknowledged that some paper records/forms may require handling by patients during their hospital journey, but this can be mitigated by asking patients to perform hand hygiene before touching records/forms.

A local process should be implemented to manage these health records and the following steps may assist in reducing the risk of cross contamination of these items:

- Hand hygiene before/after contact with notes (patients and STAFFs)
- Clean pens and accessories
- Keeping desk areas clean and tidy
- Cleaning of workstations and work sites
- Attending administration areas with clean hands and no PPE
- Move to electronic notes where able
- Zone/modelling to reduce notes going directly into the patient care zone.

39. Stock control

- Monitor stock of essential supplies – discuss available stock at each OMT meeting.
- Ensure stocks of essential supplies are secured but accessible as needed.
- Escalate stock issues immediately through your supervisor.
- OMT maintain close contact with PPE Co-ordinator.

Note: If we require additional PPE during the outbreak we should contact: agedcarecovidppe@health.gov.au

RFBI Procurement team can assist with this application process.

40. Visitors to the Village

During the COVID-19 pandemic NSW healthcare facilities should continue to support consumers to receive visits from partners, family, friends, carers and/or volunteers. This also applies to participants in care. Supporting visitor access can be achieved through additional screening or testing, vaccination, education and supervision of visitors and participants in care using the correct PPE and other IPAC strategies such as hand hygiene and physical distancing.

The advice on the requirement of PPE, visitor number and visitor restriction are based on the response to the transmission risk level within NSW and acknowledgement of individual consumer needs.

Regulations for visiting the Villages:

- A visitor may be subjected to RAT testing upon entry (this depends on the location and current regulations on the time of the outbreak)
- A visitor will be asked to wear appropriate PPE and given clear direction and appropriate training from the clinical staff upon entry and exit
- A visitor will need to comply with any vaccination recommendations (if any)
- Visitors will be requested to avoid all communal areas at all times
- Visitors will be encouraged to use a designated outdoor space for visiting (where possible)
- Visitors will also be advised that there are other forms of communication such as telephone, video calls and window visits available to them, facilitated by staff

The register should include the visitor being checked for symptoms on arrival

Permitting family members or carers to visit:

- Can provide support and advocacy for the consumer
- Can provide important context and background information to enable wholistic care
- Can significantly reduce the distress, confusion and wandering experienced by consumers with cognitive impairment
- Ensure consumer, families and carers are involved in decision-making during last days of life, and enable bereavement support to occur
- Enables them to identify and escalate their concerns about changes in a consumer's condition e.g., directly to a staff member or via REACH or similar consumer and family activated response systems

- Not only benefits the consumer and family experience of care, but also the experience of staff caring for them through a partnership that contributes to safe quality care

41. Partnership in care during a COVID-19 Outbreak

A Partnership in care program supports aged care residents and their family or close friends to continue their relationships of care and companionship even during periods of an infectious outbreak.

Where a resident identifies a partner in care, the aged care home can implement a formal partnership arrangement.

Becoming a partner requires basic training in infection prevention and control. Partners also need to understand what is required to enter an aged care home during an outbreak.

We have recently updated our range of resources developed to assist partners in care and residential aged care providers.

Partners in care

- Partner fact sheet – explains partnerships in care to family and close friends of residents.
- Visiting essentials for partners in care – an online learning module exploring infection prevention and control for partners in care.
- Visiting essentials during an infectious outbreak – an online learning module focusing on keeping safe during an infectious outbreak.
- Partner information package - (updated April 2023) assists partners to build knowledge and skills in infection prevention and control. This includes videos to demonstrate hand hygiene.
- Visiting during an outbreak Quick Reference Guide (QRG) – (new resource) this A4 resource explains the key things for partners in care to remember when visiting an aged care home during an outbreak.

Residential aged care providers

- Provider fact sheet – explains Partnerships in care programs to residential aged care providers.
- Provider toolkit – supports providers to establish a Partnerships in care program in their service.
- Visiting during an outbreak poster – (new resource) this A3 poster can be used by aged care facilities during an outbreak. It explains the key things for partners in care to remember when visiting an aged care home during an outbreak

Further information can be accessed at the following: Partnerships in care | Aged Care Quality and Safety Commission

42.Admission and Transfers

41.1 Admissions

Admissions of new consumers into the affected area of the RACF during an outbreak should be avoided, where possible. Depending upon the extent and stage of the outbreak and the physical layout of the building, restrictions may be applied to one floor, a wing or the entire RACF.

41.2 Re-admission of consumers confirmed to have COVID-19

The return of consumers who have been admitted to hospital needs to be considered on a case by-case basis but should be facilitated by the RACF if possible. This also applies for those consumers who are still infectious and require isolation from others. A decision to return a consumer needs to take into account:

- the best care for the consumer
- the potential for ongoing transmission from the case
- the ability of the RACF to continue to safely isolate the case
- the level of community transmission
- hospital capacity

If the isolation period can be completed successfully in the RACF, it may be appropriate to return the consumer to the RACF for care. This will require consultation between the PHU, treating clinicians, RACF as well as the consumer and family. Refer to Release from isolation below for further details.

41..3 Re-admission of consumers/people without COVID-19

The re-admission of consumers who are not a known COVID-19 case should be considered if the consumer can be cohorted away from other consumers who have COVID-19, or are in quarantine, if consent has been obtained from the consumer and their family and the risk is understood. Re-admission to an affected area of the RACF should be avoided if possible where an outbreak is uncontrolled and ongoing cases are being detected.

If non-cases are re-admitted, the consumer and their family must be informed about the current outbreak and risk to the consumer. Adequate outbreak control measures must be in place. Consumers and families may wish to make alternative arrangements (e.g. family care) until the outbreak is over. If the consumer returns from the community when there is community transmission, they may be required to undergo temporary quarantine and testing.

41.4 Transfers

If transfer to hospital is required, the ambulance service and receiving hospital must be notified of the outbreak/suspected outbreak verbally and via a consumer transfer advice form.

Refer to RFBI COVID OMP – RFBI Transfer Advice Form

41.5 Relocation

Relocation of either well or unwell consumers may be advised to help prevent the spread of infection throughout the aged care RACF. This must be done in consultation with the consumer, their family member/representative, the General Manager, Care Manager and the PHU. In some circumstances, it may be feasible to transfer consumers who have not been exposed to COVID-19 to other settings (e.g. to family care) for the duration of the outbreak. A risk assessment should be done to understand the family circumstances and health status prior to transferring consumers. The PHU

may provide advice. Considerations will include the vaccination status of the consumer and of every member in the receiving household. If there is a requirement to quarantine, details will be needed for how this will be done and who will co-quarantine while providing care. The clinical needs of the consumer and plans for if the consumer develops COVID-19 will also need to be considered. Decisions to move consumers should be made quickly to minimise ongoing risk of exposure.

41.6 Unaffected Consumers

In some circumstances, it may be feasible to transfer consumers who are not symptomatic to other settings (e.g. family care) for the duration of the outbreak. A risk assessment should be undertaken to understand the family circumstances and health status prior to transferring consumers. The family or receiving aged care RACF should be made aware that the consumer may have been exposed to COVID-19 and is at risk of developing disease. They should be provided with information regarding the symptoms of COVID-19 and the use of appropriate personal protective measures.

Note: In residential aged care settings, security of tenure provisions of the Aged Care Act 1997 will need to be considered.

43.Monitoring Outbreak Progress

Increased and active observation of all consumers for the signs and symptoms of COVID-19 is essential in outbreak management to identify ongoing transmission and potential gaps in infection control measures.

Testing (including repeat testing) and ongoing actions for individuals in the defined setting should be undertaken in line with the CDNA National Guideline. This includes:

- Isolating and treating individuals who test positive
- Quarantining, as best as possible, and monitor symptoms for those individuals who test negative, second daily RAT testing is recommended for those who have tested negative to ensure close monitoring of the consumers
- Commencing a program of repeat testing for those in quarantine, where possible.

- Ensure all staff are RAT tested prior to commencing their shift and entering the Village and PRN (e.g. if a staff member becomes unwell during a shift initiate a further RAT test)
- Updated information will be reviewed by the PHU for evidence of ongoing transmission and effectiveness of control measures and prophylaxis. The PHU will discuss this with the OMT and advise any required changes to current outbreak control measures.

Specialised advice is available from the following sources:

- The local area health and the PHU's
- Infection control practitioners in local hospitals, state and territory health departments, or as private consultants

Geriatricians or infectious disease physicians may be approached for specialist management of complex infections.

44.Declaring the Outbreak Over

- When no new cases occur within 8 days following the onset of symptoms in the last consumer influenza case.
- 7 days after the last COVID-19 case tests positive or the date of isolation of the last COVID-19 case in a consumer, whichever is longer.
- However, additional testing or measures may be recommended by the PHU in the 7 days following an outbreak being considered "over".
- Facilities should remain on high alert and:
- Test appropriately anyone with new symptoms, no matter how mild;
- Carefully monitor consumer with high-risk exposure for behavioural changes, lack of appetite, and lethargy; and
- Ensure visitors (who may be at higher risk themselves) are aware that there has been an outbreak.

- Individual cases should remain in isolation for the required period (as per Step 4) even if the outbreak has been declared over for the RCF.
- Where there is extensive or poorly understood transmission, or where there are significant numbers of consumer not up to date with immunisations or transmission is within a memory support unit, the PHU may advise the RCF to continue to manage as an outbreak until at least 14 days have passed since the last case tested positive.
- Once an outbreak is over, facilities should evaluate the response to and management of the outbreak to identify strengths and weaknesses. Consider conducting a facility debrief with all employees and contractors involved with the outbreak.

Put up notices of the outbreak at all entrances including information to minimise unnecessary visits that may lead to inadvertent transmission. Signage should also be displayed outside the room of affected consumer

45.Review and Debrief

- After declaring an outbreak over, the RACF lead/OMT should reflect on:
- Strengths and weaknesses in the response and investigation
- Policies, practices, or procedures to improve responses for future outbreaks
- It is useful to complete an audit. Audits are used in practice as part of continuous quality improvement. They can be useful for healthcare workers to review how the outbreak was managed. Australian public health practitioners and researchers have developed an outbreak audit process, with:
- A framework for deciding which outbreak investigations to audit
- An approach for conducting a successful audit
- A template for trigger questions
- Please see Outbreak Investigation Audits to access an auditing tool. This tool helps agencies like RACF to assess their outbreak response against best practice. RACF should provide a document outlining lessons learned to the PHU and Commonwealth. This will help enable ongoing quality improvement in the management of outbreaks.

46.Key Resources

Communicable Diseases Network Australia (2020). COVID-19guidelines for outbreaks in residential aged care facilities. Australian Government Department of Health. https://www.health.gov.au/resources/publications/coronavirus-covid-19-guidelines-for-outbreaks-in-residential-care-facilities

NSW Clinical Excellence Commission. COVID-19 Infection Prevention and Control Manual COVID-19 Infection Prevention and Control Manual - Clinical Excellence Commission (nsw.gov.au)

First 24 hours- managing COVID-19 in a residential aged care RACF. https://www.health.gov.au/resources/publications/first-24-hours-managing-covid-19-in-a-residential-aged-care-RACF

Communicable Diseases Network Australia (2020). Coronavirus Disease 2019 (COVID-19). Australian Government Department of Health. https://www1.health.gov.au/internet/main/publishing.nsf/Content/cdna-song-novel-coronavirus.htm

Protocol to support joint management of a COVID-19 outbreak in a residential aged care RACF in NSW https://www.health.nsw.gov.au/Infectious/covid-19/Documents/racf-outbreak-protocol.pdf

NSW Health – COVID-19: Advice for aged care services COVID-19: Advice for aged care services - COVID-19 (Coronavirus) (nsw.gov.au)

47.Link to Documents reference in OMT

COVID Outbreak Stakeholder Communication Plan

COVID Preparedness Checklist

COVID Are you Alert and Ready? – Resource from ACQS Commission

Ecolab COVID-19 Information & Action Plan

Health NSW Incident Action Plan in response to confirmed COVID-19 in a RACF

Initial RACF report to Public Health Unit (Line List)

Outbreak Management Meeting – Agenda & Minutes Template

Outbreak Management Planning in Aged Care – Resource from ACQS Commission

PPE Items for Outbreak Kits

Priorities of care during COVID-19 Outbreak

Consumer Care Priorities during COVID-19 Outbreak

Consumer Screening Checklist - Outbreak Prevention Tool

Transfer Advice Form COVID-19

Workforce COVID Outbreak Contingent Workforce Training Standard

Appendix 1: Transfer Notification for Hospital

Transfer Letter to the Accepting Medical Officer at the Hospital

Date:

Please be advised that _____ is being transferred from a RACF where there is a cluster/outbreak of Coronavirus (COVID-19).

At this stage the outbreak is_____ confirmed (date of specimen collection): _____ or suspected on the _____

Please ensure that appropriate infection control precautions are taken upon receipt of this consumer.

At the time of transfer:

_____

_____

☐ The consumer does not have an acute respiratory illness suspected

☐ The consumer has an acute respiratory illness

☐ The consumer is a suspected case of COVID-19

☐ The consumer is confirmed case of COVID-19

The consumer personal details are attached to this letter via a Consumer Data / Admission sheet which contains all of the relevant details including the Medical Officer and the Legal contact details. Please contact the General Manager at the RACF directly on_____ if you have any further questions relating to the transfer

Yours sincerely

_____

(Name, Designation and Signature)

Royal Freemasons' Benevolent Institution

Appendix 2: Contacts and Communication Outline

2.1 Key Contacts

Use this table to list the organisation's key stakeholders to communicate with during an outbreak.

Organisation	Name and Position	Contact phone	Second Contact
Department of Health		1800 200 422	agedcareCOVIDcases@health.gov.au
Aged Care Quality and Safety Commission	[redacted]	[redacted]	[redacted]
Local Health District Coordinator			
Unions - HSU			
Union – NSWN&MA			

State	Contact Details	RACF outbreak guidance
Australian Capital Territory	Business Hours: 02 5124 9213 After Hours: 02 6207 7244	Managing COVID-19 exposures and outbreaks in residential aged care facilities - COVID-19 (act.gov.au)
New South Wales	General enquiries: 1300 066 055 Coronavirus hotline: 137 788	Residential aged care RACF outbreak management - COVID-19 (Coronavirus) (nsw.gov.au)

2.2 Communications Outline

Key stakeholder	What they need to know	How we'll communicate	Contact information
Staff (includes staff, consultants, students and volunteers)	• Level of risk, number and location of cases linked to an outbreak	• Meetings • Staff newsletter • Text messages	• Contact Information varies from each Village

	• The importance of hand hygiene, respiratory etiquette and physical distancing measures • Changes to policies and procedures; outbreak control measures being implemented, including changed arrangements for accessing the setting • Membership of the internal outbreak response team • Arrangements for accessing leave for quarantine and isolation • Expectations about not attending work if sick • Changes to staffing/rostering arrangements • Arrangements to support staff health and wellbeing	• Staff Intranet • Signage	
Consumers	• Condition of infected consumers • Welfare of infected staff • When they can talk to families	• Face to face	Contact Information varies from each Village
Families and friends	• Condition of family member • Condition of infected consumers • Welfare of infected staff • When they can talk to consumers	• Meetings • Emails • Letters	Contact Information varies from each Village
Visitors	• Condition of family member • Welfare of infected staff		Contact Information varies from each Village

Contractors and delivery personnel *(e.g. cleaners, electricians)*			Contact Information varies from each Village
Public Health Services	• Outbreak management risks specific to the setting. • Names and contact details of potential contacts of the confirmed case.	• Email • Telephone • Meetings	Contact Information varies from each Village
Clinical Manager	• Cases in staff where incident notification is required under *Work Health and Safety Regulations*	• Phone	• Incident notification to 13 10 50
Medical Officers Nurse Practitioners And Allied Health Professionals providing services to people within the setting	Clinical Staff to continue to contact the Medical Officer's, Nurse Practitioner and Allied Health Professionals in the usual manner	• Email • Telephone • Meetings	Contact Information varies from each Village

Appendix 3: Cleaning and Disinfection Following a Confirmed Case

Background

COVID-19 is spread through respiratory droplets produced when an infected person coughs or sneezes. A person can acquire COVID-19 inhaling these droplets or, less commonly, by touching a surface or object that has the virus on it and then touching their own mouth, nose or eyes. Following a confirmed case of COVID-19, thorough cleaning and disinfection of contaminated areas is needed as per our COVID-19 Safety Plan to remove the virus from environmental surfaces. There is no automatic need to close the entire RACF/setting while cleaning and disinfection is underway, particularly if the confirmed case only visited parts of the RACF/setting. Suspension of normal operations will depend on factors such as the size of the RACF, nature of the work, number of people and potential areas of contamination. Public Health Services and Clinical Manager will provide advice about cleaning and disinfection following a confirmed case of COVID-19.

Appendix 4: Daily Monitoring Checklist

RACF:		Meeting Date		Meeting Time	
Staff present					
Date of 1st case		Number affected currently	..... total	Wings / units / areas affected currently	
Current length of Outbreak	..... days		.....Consumers ..... Staff		

Item	Action required	By whom	When
Communications Public Health notified / updated; communications needed as of today	▪		
Outbreak Infection Log Commenced / updated	▪		
Outbreak Plan	▪		

Item	Action required	By whom	When
Commenced / signage in place. Any additional measures required; any concerns regarding effective containment of spread			
Event record updates *Outbreak* (for the outbreak) *Consumer Infection* (for individual affected consumers)	▪		
Consumers' clinical conditions	*Consumers with mild symptoms* ▪		
	Consumers with moderate symptoms and care plans in place ▪		

Item	Action required	By whom	When
	Consumers clinically at risk and care plans in place ▪		
	Support needed to ensure consumer care needs are met ▪ *Pathology attended (create a separate spreadsheet with a list of any consumers that have required a Coronavirus (COVID -19) swab include the consumers name, DOB, clinical presentation, date swab was collected, follow up with results, outcome*		
	Primary care service response adequate – support needed ▪		
	Consumer's with cognitive impairment management plan ▪		
Adequate supplies of PPE	▪		
Adequate cleaning equipment available	▪		

Item	Action required	By whom	When
E.g. Bleach solution / Disinfectant, disposable cloths			
Isolation Areas / consumers currently in isolation	▪		
Staffing cohorts Able to be maintained? Mitigation strategies if not Support required	▪		
Staff illness / replacement and staff morale Staff correctly applying and using PPE – training and support needed	▪		
Challenges	▪		

Item	Action required	By whom	When
Are there are problems / challenges for the following teams – agree actions Laundry / Kitchen / Cleaning / Nursing / Caregiving Is the additional cleaning of common high-touch areas being maintained? Is the food service being managed as per the outbreak plan – support needed?			
Admissions / discharges / transfers	▪		
Restricted Access What steps need to be taken	▪		

Item	Action required		By whom	When
Restricted visiting Visitor and family compliance – challenges and support needed	▪			
Complaints Any received during outbreak, support needed	▪			
The OMT will provide <u>daily</u> update to the Board of Directors, CEO, COO and CMT by 5pm daily *Cover each of these items*	▪ New affected consumers	▪ New affected staff		
	▪ Number of staff off-duty due to symptoms	▪ Number of consumers in isolation		
	▪ Update on outbreak management processes implemented, and support required	▪ Additional measures in place to contain outbreak		

NB: At each outbreak management meeting ensure all actions agreed at the previous meeting have occurred

Meeting Closed: _____ (Time) Signed: _____

Appendix 5: RACF Floor Plan requirements

The RFBI RACF will ensure that they at all times have a detailed floor plan of the RACF which clearly outlines the consumer's rooms including whether they are single or multiple occupancy, RACF exits, communal areas, food preparation areas, wings and how staff are assigned to working in these areas. An up to date excel spreadsheet of the consumer details is available to be sent to NSW & ACT Health in a COVID-19outbreak. The excel spreadsheet must include (but not limited) to the following:

- Name
- DOB
- Gender
- Wing
- Room Number
- Occupancy of the room (single or multiple)
- Vaccination status
- Medicare Number

NSW Health Posters

List of all Signage is hyperlinked below:

YOU ONLY NEED TO PLACE THE LAMINATED SIGNAGE ON THE DOOR OF THE CORONAVIRUS CONFIRMED, PROBABLE or SUSPECTED CONSUMER

Refer to RFBI COVID Outbreak Signage which is always kept updated and available on the intranet under the COVID TAB

1. You will need to place a sign (Contact and Droplet Precaution) on the door of any consumer with a suspected or positive diagnosis of Coronavirus, here is the link below:

http://cec.health.nsw.gov.au/__data/assets/pdf_file/0011/577442/Contact-and-droplet-precaution-poster-portrait-v.4.pdf

2. You will need to place a sign (Contact and Airborne Precautions) on the door of any consumer with a suspected or positive diagnosis of Coronavirus that is using a CPAP, BIPAP or a nebuliser, here is the link below:

http://cec.health.nsw.gov.au/__data/assets/pdf_file/0003/579522/Contact-and-droplet-precaution-and-airborne-poster-portrait-gown-and-gloves-separately-V.4.pdf

3. You will need to ensure that there are adequate respiratory hygiene posters which include coughing and sneezing etiquette displayed in the RACF, here is the link below:

http://cec.health.nsw.gov.au/__data/assets/pdf_file/0007/571309/Respiratory-Hygiene-A3-Poster.pdf

4. You will need to ensure that there is adequate STOP THE SPREAD posters displayed in the RACF, here is the link below:

https://www.health.nsw.gov.au/Infectious/diseases/Documents/stop-the-spread.pdf

5. You will need to display the following poster at the front door of RACF for any visitors:

COVID-19 posters and print resources - COVID-19 (Coronavirus) (nsw.gov.au)

COVID-19 Outbreak Preparedness Checklist

Planning actions	☑
Does your RACF have a COVID-19 Outbreak Management Plan that has been updated this year?	
Are RACF staff aware of the plan including their roles and responsibilities, including those on the Outbreak Management Team?	
Staff, consumer and family education	
Has your RACF staff undergone education and training in all aspects of outbreak identification and management?	
Has your RACF run staff education sessions on IPC, including PPE use?	
Has your RACF provided consumers' families with information regarding strategies to minimise the risk of introduction and transmission of COVID-19?	
Do you know which consumers may wish to live with their family during an outbreak?	
Staffing actions	
Does your RACF have a staffing contingency plan in case 20% to 50% of staff fall ill or are excluded for 14 days?	
Has your RACF developed a plan for assigning staff to cohorts in an outbreak?	
Stock levels	
Has your RACF adequate stock of PPE, hand hygiene products, nose and throat swabs and cleaning supplies for the duration of an outbreak?	
Are fit check PFRs available for all staff who may enter the consumer zone?	
Outbreak recognition actions	
Does your RACF routinely assess consumers for COVID-19 symptoms, particularly for fever or cough (with or without fever)? Do you document changes in consumer's behaviour or health?	
Does your RACF support and encourage staff to report COVID-19 symptoms during the pandemic?	

Planning actions	☑
Does a process exist to notify the RACF manager and the state/territory health department as soon as practicable (and within 24 hours) when a COVID-19 case is suspected or laboratory confirmed?	
Communication actions	
Does your RACF have a contact list for the state/territory health department and other relevant stake holders (for example, RACF MEDICAL OFFICERs and infection control consultants)?	
Does your RACF have a communications plan for an outbreak?	

Planning actions	☑
Does your RACF have a plan to restrict unwell visitors entering the RACF and limit well visitors during an outbreak to reduce risk of transmission both within the RACF and externally (e.g., security, signage, restricted access)?	
Environmental management	
Does the plan identify who is responsible for overseeing increased frequency of cleaning, liaison with contractors or hiring extra cleaners as necessary? Does the plan identify options to increase the collection and disposal of waste?	

COVID-19 Outbreak Management Checklist for the RACF

Declare an outbreak	☑
Have an RACF Outbreak Management Team meeting within hours of diagnosis	
Identify other cases	
Arrange testing for all exposed consumers and staff	
Increase observation of consumers to detect symptoms and signs of COVID-19	
Establish a screening system for symptoms in staff at the start of each shift	
Implement infection control measures – for those affected	
Isolate / cohort ill consumers in their room	
Place hand sanitiser, PPE, signage and appropriate waste bins outside consumer/s' room	
Implement infection control measures – for the entire RACF	
Display outbreak signage at entrances to RACF	
Reinforce standard precautions (hand hygiene, cough etiquette) throughout RACF. Increase access to hand sanitiser	
On advice from public health unit – require all staff to wear surgical masks or P2/N95 PFRs (until risk assessment is complete) along with other PPE	
Increase frequency of environmental cleaning (minimum twice daily) and add focus of frequently touched surfaces such as bedrails	
Ensure all staff monitor for symptoms and stay away if unwell	
Inform	
Activate the communications plan	
Inform the local Public Health Unit and all consumers' MEDICAL OFFICERs	

Declare an outbreak	☑
If a Commonwealth supported aged care RACF - inform the Commonwealth	
If a NDIS-funded residential disability RACF – notify the NDIS Quality and Safeguards Commission	
Restrict	
Restrict movement of staff between areas of RACF (where possible)	
Avoid consumer transfers	

Declare an outbreak	☑
Restrict visitors with the exception of those on compassionate grounds	
Cancel non-essential group activities during the outbreak period	
Monitor	
Continue observation of consumers for fever and/or acute respiratory illness and undertake repeat testing	
Update the case list daily at the RACF and provide to the interagency OMT where convened and public health unit daily	
Add positive and negative test results to case list	

Glossary

Terms	Glossary
AHPPC	Australian Health Protection Principal Committee
ARI	acute respiratory illness
CDNA	Communicable Diseases Network Australia
CPAP	continuous positive airway pressure
DRS	disability residential services
MEDICAL OFFICER	MO
ICEG	Infection Control Expert Group
ILI	influenza-like illness
IPC	infection prevention and control
NACAP	National Aged Care Advocacy Program
NDIA	National Disability Insurance Agency
NNDL	National Notifiable Disease List
OMT	Outbreak management team
OPAN	Older Persons Advocacy Network
PCR	polymerase chain reaction
PFR	particulate filter respirator
PHN	Primary Health Network
PHU	Public health unit
PPE	personal protective equipment
RAT	rapid antigen test
RACF	Residential aged care facility

Key documents and Resources

Aged Care Quality and Safety Commission

- Aged Care Quality Standards – The Commission expects organisations providing aged care services in Australia to comply with the Quality Standards
- Outbreak management planning in aged care practical guidance to support COVID-19 outbreak management planning and preparation in residential aged care facilities.

Australian Government Department of Health and Aged Care

- Prevent and prepare for COVID-19 in residential aged care – link to advice and resources for aged care providers.
- Emergency PPE and RAT supply for RACF COVID-19 Outbreak or Exposure– link to the Commonwealth Department of Health and Aged Care ordering form for emergency PPE and RAT supply.
- First 24 hours Checklist. COVID-19
- Being Prepared Outbreak Checklist. COVID-19
- Ensuring safe visitor access to residential aged care
- Infection prevention and control lead/s

Communicable Diseases Network Australia National Guidelines for Public Health Units

- CDNA National Guidelines for Public Health Units. Coronavirus Disease 2019 (COVID-19)
- CDNA National Guidelines for Public Health Units. Seasonal Influenza Infection
- CDNA national guidelines for the prevention and management of COVID-19 outbreaks in disability residential services - The Disability Supplement, National guidance on the prevention and management of COVID-19 outbreaks in disability residential services.
- CDNA national guidelines for the prevention, control and public health management of COVID-19 outbreaks in residential care facilities in Australia (2022). Contains useful background information and resources.

- CNDA Guidelines for the Prevention, Control and Public Health Management of Influenza Outbreaks in Residential Care Facilities in Australia (2017). Contains useful background information.

Infection, Prevention, and Control

- Australian Guidelines for the Prevention and Control of Infection in Healthcare
- Infection Control Expert Group (ICEG), endorsed infection prevention and control guidance specifically for RCF, as well as personal protective equipment guidance and advice on environmental cleaning in community settings
- COVID-19 Environmental cleaning and disinfection principles for health and residential care facilities factsheet.
- Disinfectants registered with the TGA as effective against the virus (SARS-CoV-2) are listed at TGA disinfectants use against COVID-19.
- National COVID-19 Health Management Plan for 2023 | Australian Government Department of Health and Aged Care

Treatment and prophylaxis

- Australian Government Department of Health and Aged Care. Use of Lagevrio (molnupiravir) in residential aged care
- Pharmaceutical Benefits Scheme Factsheet. Paxlovid.pdf

- National COVID-19 Clinical Evidence Taskforce. COVID-19 living guidelines. Drug treatments.
- National Prescribing Service. MedicineWise. COVID-19 oral antiviral medicines in residential aged care (nps.org.au)
- Australian Government Department of Health and Aged Care. Use of Tamiflu in residential aged care
- Health Direct. Tamiflu to RACFs
- Therapeutic Guidelines.
    - Influenza
    - COVID-19

IN THE FAIR WORK COMMISSION

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

Re Application by: Virginia Ellis, Mark Castieau, Sanu Ghimire, Paul Jones and Health Services Union; Australian Nursing and Midwifery Federation; Health Services Union

WITNESS STATEMENT OF CHRIS MAMARELIS
DATED 1 NOVEMBER 2023

I, Chris Mamarelis of 81 Belmont Rd, Glenfield New South Wales state as follows:

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

2. I am the Chief Executive Officer (**CEO**) at Whiddon. I have held this role since July 2015. Immediately prior to my appointment as CEO, I held the position of Chief Financial Officer (**CFO**) since 2011.

Whiddon

3. Whiddon is a not-for-profit organisation with a large operational scale and a history spanning over 75 years.

4. Whiddon has 20 residential aged care homes across New South Wales and Southern Queensland, each offering well-being and lifestyle services, nursing and health care and dementia care services. Many of our homes are co-located with retirement living and also act as hubs for our community care services. The largest location is our campus located in Glenfield, Southwest Sydney, accommodating around 500 residents across four separate homes.

5. Whiddon is known for its regional aged care services, with an established regional presence, including homes in locations such as Bourke, Wee Waa, Narrabri and Temora.

6. Whiddon provides:

   (a) residential aged care services to approximately 1,800 residents across our 20 residential aged care homes;

   (b) community care services to approximately 1,000 people; and

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(c) accommodates approximately 300 individuals in retirement living, mainly in co-located retirement villages. This is an independent living arrangement, so our clients maintain privacy in their home but also have access to the services and support from Whiddon.

7. Community care includes a range of flexible and personalised services to support our clients to live safely and independently in their homes. Examples of services include, help with housework or gardening and specialist health care and RN visits after a hospital stay.

8. With approximately 3,000 employees across the group, Whiddon's annual turnover is approximately $240 million dollars per annum. The organisation was founded by the Freemasons which today is recognised in its constitution and is celebrated within the history of the organisation.

9. Whiddon had been recognised and is known for its innovation and has won numerous innovation awards, including:

(a) The national Organisation Award at the 2018 LASA Awards, which recognised Whiddon's outstanding leadership, innovation and excellence in aged care services and our work on the Adult Social Care Outcomes Toolkit, a tool that measures wellbeing and the impact of care services on quality of life for older people.

(b) In 2017 and 2018, Whiddon was listed in the Australian Financial Review's Top 100 Innovative Companies, ranking 44 and 46, respectively. The accolade recognised Whiddon's MyLife Relationship Based Care Model, the approach to designing the model and implementing the program, and the fantastic outcomes being achieved around wellbeing and quality of life for older people in Whiddon care homes.

10. Whiddon continues to be actively involved in various research and innovation programs. A commitment to innovation is ingrained in our culture.

Experience in Aged Care

11. I have around 16 years' experience working in the aged care industry.

12. I began my career in health and aged care as General Manager Finance and then Chief Financial Officer (**CFO**) at Moran Health Care Group in 2007 (**Moran**). Moran, at that time, was the largest care operator in Australia.

13. I was also a Director of the NSW-ACT Leading Age Services Australia (**LASA**) for a number of years. LASA, at that time, was the peak national body that promoted quality

services, support and representation within the aged care industry, and strived to improve the political, economic and social environment in which the industry operates. LASA went on to adopt a federated model, becoming The Aged & Community Care Providers Association (**ACCPA**). Today I am a member of the ACCPA NSW / ACT Member Council.

14. My career history has allowed me to experience the challenging and intensive aspects of aged care, particularly in the context of listed entities and for-profit organisations. My transition into the not-for-profit sector was a turning point, and I developed a strong affinity for the sector. This passion for the not-for-profit sector is also supported by the successes we have achieved.

15. In addition to my operational roles, I have contributed to the industry by lecturing at Macquarie University on the topics of not-for-profits and aged care, further solidifying my commitment to the field.

Staff

16. At Whiddon we employee around 2,800 people in the following roles:

(a)	Assistant in Nursing (**AIN**)	1300
(b)	Administration	70
(c)	Enrolled Nurse (**EN**)	70
(d)	Home Care Employee	230
(e)	Registered Nurse (**RN**)	345
(f)	Recreation and Wellbeing Officers	90
(g)	Hospitality, Cleaning, Laundry	667

My Role

17. Whiddon's purpose is focused on enriching the lives of the people we care for. Our strategic plan is supported by three simple core directions:

    (a) People;

    (b) Care; and

    (c) Business.

18. Our purpose is central to our core activities and drives initiatives such as purposeful ageing and our wellbeing programs. .

19. Underpinning purpose is a genuine focus on truly providing the highest quality outcomes for the people we care for, while also supporting and enabling the caregivers themselves. This perspective is foundational to our existence as a not-for-profit entity.

20. In my role as CEO, my responsibilities include:

    (a) working closely with the Board to set, track and drive the strategic direction, goals and objectives;

    (b) setting the tone and culture within the organisation, which involves working alongside the Board to define and foster our organisation's culture;

    (c) ensuring the successful execution of strategies, maintaining our organization's sustainability, and driving a strong sense of purpose (this purpose is a driving force behind various projects, research, innovation initiatives, and their broader impact);

    (d) leading my immediate team and overseeing the broader team across the entire Whiddon group, in my role I provide ongoing support and guidance to these teams through various initiatives; and

    (e) implementing people-focused and people-centric initiatives, reflecting our commitment to the well-being and care of both the recipients and providers of care.

21. My day-to-day duties include:

    (a) serving as a conduit between the board, management and the broader organisation;

    (b) reporting to the board and addressing their requirements;

    (c) advocacy: I advocate for Whiddon, the communities we are part of and our staff;

    (d) overseeing the administration of the organisation;

    (e) representing Whiddon at government forums and various events; and

    (f) visiting the Whiddon homes and services: it is essential for me to connect with our services, residents, and people regularly. I recently returned from the Northern Rivers region, where I visited and connected with all of our regional services. Attending events and maintaining these connections is crucial.

Training

Mandatory Training

22. We maintain consistent training across all our residential aged care facilities, ensuring that all staff receive training that is consistent and in line with Whiddon's standards.

23. Whiddon has an online learning management system that offers a suite of mandatory training modules, covering topics such as:

    (a) workplace health and safety (**WHS**);

    (b) workplace bullying;

    (c) aged care quality standards (**ACQS**); and

    (d) infection control.

24. Mandatory training is completed by all staff, including care workers, indirect care workers, managers and executive leadership at Whiddon.

25. A screenshot of the *"Whiddon Training Matrix"* which sets out a complete list of Whiddon's mandatory training (some modules are *"once off"*, and others are required to be completed annually) is **annexed and marked CM-1**.

26. Each of these modules generally take around 30-60 minutes to complete and are followed by a short assessment. The mandatory training is completed in work time.

27. Being mandatory training, I also complete the training. Each year I complete around 8-10 modules, including manual handling and infection control modules

Manual Handling

28. Manual handling is another mandatory training requirement for all staff, which is delivered in person (i.e. face-to-face with a facilitator). This form of mandatory training varies based on the nature of the roles. For example, I recently underwent face-to-face mandatory training, but this did not cover the use of mobility aids to assist residents. That specialised training is reserved for direct care staff who are working directly with residents, like Assistant in Nursing (**AINs**). The training content is adapted to meet the specific needs of each cohort.

29. Manual handling takes around 1hour and 30 minutes. It is scheduled during work time. It is completed annually.

Infection Control

30. The Infection Control mandatory training modules includes topics such as:

    (a) proper hand hygiene,

    (b) the colour coding of waste,

    (c) waste management procedures,

    (d) chemicals used for cleaning,

    (e) different cleaning scenarios,

    (f) infection control protocols, and

    (g) correct usage of personal protective equipment (**PPE**).

31. The Infection Control mandatory training typically takes about an hour to complete and includes an assessment.

32. The mandatory training cycle is repeated annually to ensure ongoing compliance.

ACQS

33. Induction modules include an overview of the ACQS and these are referenced in various modules due to their overarching nature. The Board and executive are also required to complete mandatory modules from the Commonwealth's "Governing for Reform" program. These include education relating to the ACQS.

Other Training

34. In addition to the mandatory modules completed by all staff, we also provide role-specific training for various positions within the organisation, which can include both face-to-face and customised training sessions. For example for administrative positions, clinical leadership roles, catering, cleaning and laundry roles. This role-specific training is compulsory for employees working in the relevant role.

35. The content and delivery method of this specialised training may vary depending on the roles, such as those in hospitality or clinical positions.

On-the-job Training

36. Whiddon also provides on-the-job training for our staff. The purpose of this training is to provide essential hands-on experience with equipment and procedures that cannot be fully covered in online modules.

37. Those who work with specialised equipment receive specific on-the-job training to ensure they can operate and maintain the equipment safely. For example, operating lifters, catering equipment and specialised laundry and cleaning equipment.

38. We also offer job specific WHS training for roles that involve handling chemicals or other potentially hazardous materials. For example, our cleaners and laundry employees. This training is delivered in various ways including face-to-face or via our supplier driven contracts. The training may be in response to a training need or part of the induction process.

Buddy-shifts

39. To further support our new staff, we allocate buddy-shifts. This is especially important when we bring in new staff from overseas and assign to regional areas. To ensure they are confident and understand the processes set out in mandatory training and on-the-job training and, in particular, our expectations in relation to relationship-based care – they work alongside someone in their role at the start.

Relationship-Based Care

40. Relationship-based care (**RBC**) is a fundamental approach embraced and championed by Whiddon. It was introduced around 2014 and was reinforced in later years by the changes in government policy and standards following the Royal Commission.

41. A RBC approach focuses on building meaningful relationships among our entire team, including nurses, AINs, maintenance officers, and kitchen staff, who collectively provide care to our residents. Regardless of their role or function, in line with RBC principles, each employee is part of the one team.

42. Care, in this context, goes beyond addressing just the personal or clinical care needs of individuals, and extends to taking into account a resident's personal preferences and unique desires (I set out some examples below under the heading *"Responding to Resident Preferences"*). It is essentially about holistic care and knowing the individual.

43. Consistent with the RBC approach, where possible, dedicated rostering is employed in Whiddon homes. This form of rostering endeavours to allocate the same staff to the same location. This form of operating promotes continuity for the benefit of the residents and provides employees with an opportunity to get to know the residents as well. By forming these relationships, our employees are better positioned to care for our residents and clients in order to meet the specific needs and preferences of the individual.

44. In addition to ongoing education and mandatory training, Whiddon's expectations in relation to RBC is to encourage our team members to take initiative and function beyond a task-based approach to providing care. Within that scope, our team have the license to do what it takes to create a fulfilling and satisfying experience for the residents and clients at Whiddon. I now turn to some examples of how that occurs in practice in the context of responding to resident preferences.

Responding to Resident Preferences

All Staff

45. All care and wellbeing employees (i.e. PCWs/AINs, nursing employees and recreational and wellbeing officers) have access to a resident's care plan, with catering team members having limited access to aspects relating to nutrition. To enable employees to understand the specific needs and preferences and a more holistic understanding of our residents, Whiddon have implemented the following practices:

(a) **"All About Me" document:** With the resident's involvement, an "All About Me" document is prepared by the care staff. With the resident's permission, this document is posted on the resident's wall and serves as a valuable resource for anyone interacting with that resident. It contains information about the resident's history, their previous occupation, their hobbies, interests, and preferences. It acts as a common interface, facilitating meaningful interactions and connections with the resident.

(b) **"Meaningful Moments" program (previously known as "Best Week")**: The care staff work with the resident to identify what are their meaningful moments (or previously their *"best week"*), this is then documented and posted on the resident's wall (again, with permission) to show the goal of the resident. Residents work towards achieving their best week, and this can encompass a wide range of activities or experiences. For some, it might involve something as simple as obtaining a subscription to a lost favourite magazine. Others may set their sights on more adventurous pursuits, such as riding a Harley Davidson or even skydiving. It might also refer to a special meal or certain activities facilitated by leisure officers.

46. Both the *"All About me"* and *"Meaningful Moments"* practices are not limited to matters of personal care. They are an open interface that invites everyone to be part of the resident's journey. This inclusive approach fosters rapport between employees and residents, providing numerous icebreakers that encourage meaningful connections

and interactions. Redacted copies of an "All About Me" and a "Meaningful Moments" document are annexed to my statement.

A REDACTED COPY OF AN "ALL ABOUT ME" DOCUMENT IS ANNEXED AND MARKED "CM-2"

A REDACTED COPY OF A "MEANINGFUL MOMENTS" DOCUMENT IS ANNEXED AND MARKED "CM-3"

Catering Staff

47. The kitchen and catering staff are provided access to resident dietary preferences and restrictions via AutumnCare. AutumnCare is a form of clinical management software that can be accessed via computer, iPad or mobile devices with a secure login.

48. More broadly, AutumnCare plays a central role in storing and communicating information about residents to the care team. Whiddon ensures that staff members such as care and catering staff have access to information that is relevant to the work being performed.

49. Catering staff also receive training about the principle of *"dignity of risk".* This means that residents have the freedom to choose their meals to a reasonable extent. For example, if a resident has dietary restrictions but wishes to deviate from their usual pre-constituted meals and have a steak, there are procedures in place to accommodate their request, taking their preferences into consideration and ensuring they understand the risks.

A COPY OF THE WHIDDON DIGNITY OF RISK POLICY IS ANNEXED AND MARKED "CM-4"

50. When it comes to decisions that may fall outside the scope of what a catering person can manage, the care team must be consulted. If a request goes beyond the expertise or usual procedures, the clinical team take the lead on assessing the request to ensure the resident's health and well-being are safeguarded.

51. In situations where catering staff are familiar with dietary requirements and a resident makes a reasonable request that falls within their purview, such as a different meal choice for the day, they have the flexibility to accommodate it.

52. The overall approach emphasises collaboration between catering staff and the care team, ensuring that residents' dietary preferences and needs are met while adhering to safety and health guidelines. The process is designed to uphold the dignity of choice for residents in a reasonable and balanced manner.

53. Whiddon has introduced a 24-hour dining menu, offering residents a broader range of meal options beyond the traditional three meals a day. This empowers residents to have more control over their food choices, including requesting items from this extended menu.

54. Whiddon facilitate Foodies Groups at each home and these are managed by the catering team. Each Foodies Group is run by the Head Chef or Kitchen Team Leader (**the Leader**) and this group helps to drive the food choices in each home. The group of residents and families who form the Foodies Group write the fortnightly menus with the Leader to ensure that our residents are eating the food they want to eat. The group discusses the foods they like and dislike and what they would like to see more of on the menu. This also includes insight into foods that are seasonal also ensuring that the foods available are of the best and freshest nature.

55. These groups empower residents to choose their menus, provide feedback and speak with the chef about any specific requests they may have. The Foodies groups are also in place to engage residents in all aspects of the dining experience.

Responding to Incidents

56. The training and expectations for non-care staff regarding incident response and resident safety includes:

    (a) WHS training, which equips team members with foundational knowledge on safety protocols and procedures;

    (b) first aid training, enabling them to respond effectively to health-related incidents (not all staff are certified); and

    (c) risk management training, which covers different levels of preparedness and response in various situations, including emergency scenarios. This training equips staff with the skills and knowledge needed to manage risks effectively. Whiddon employs external contractors who train our teams in regard to fire safety and emergency evacuations. This form of training is practical by nature and held as a group session on site.

57. When non-care staff members in our residential aged care facilities encounter incidents, such as a resident having a fall, the primary concern is the safety and well-being of the resident. If they witness such an incident, the immediate priority is to ensure the resident's safety.

58. The established procedure communicated to non-care staff is as follows:

(a) subject to the nature of the incident, promptly attend to the resident's need to ensure there is no immediate danger or risk and provide assistance if required (subject to training, this may include providing basic first aid, but in the event of a fall, the resident is not to be moved until assessed by the RN); and

(b) then proceed to call for immediate help or notify someone more experienced to address the situation.

Non-care staff may assist care staff during the incident in our smaller homes with tasks. For example, in our smaller homes, during an emergency or an incident, the hospitality staff may stay with the residents whilst the care team assess and manage the situation, or the cleaning team assist with the cleaning that may be required after a resident has fallen, or the administration team which may assist with contacting families or assisting first responders to access the area where the incident occurred.

59. To communicate these expectations and provide ongoing awareness, staff meetings and toolbox talks are conducted. These forums create opportunities to discuss safety procedures, incident response, and risk management strategies, ensuring that all team members are informed and aware of their responsibilities in safeguarding residents' well-being. This includes everyone's responsibility to report resident or safety related concerns to the relevant care manager.

Interaction with Families

60. Interaction with families is highly encouraged in our residential aged care homes, and it is considered an essential part of providing quality care and service to our residents.

61. Families are seen as an extension of our residents' support network, and the staff, particularly those in direct care roles, are expected to engage with families in a positive and welcoming manner. There are no restrictions or directives discouraging staff from interacting with family members.

62. In many of our regional homes, daily interactions between staff and families are common. Staff members are familiar with all of the families associated with the residents, fostering a sense of community and trust. These interactions are seen as beneficial for both family members, who gain comfort and familiarity, and staff, who can better understand the residents' individual needs and preferences through engagement with their loved ones.

63. Whiddon encourages an open line of communication, and although formal communication must flow through appropriate channels, families will at times engage in conversations with staff regarding their family or loved ones. These interactions are

not discouraged and extend to all staff, not just senior managers, creating a more inclusive and responsive environment. The protocol practiced at Whiddon is as follows:

(a) If a family member makes a request within the scope of a staff member's role, that staff member is expected to address it. An example may include to turn a particular TV show on at a particular time.

(b) For matters that may be outside their scope or involve complaints, staff members are instructed to promptly escalate the issue to a care manager or the appropriate authority for resolution.

64. Whiddon values the feedback and insights provided by family members and believes that this open interaction contributes to the overall well-being and satisfaction of both residents and their families. This approach emphasises the importance of maintaining positive relationships and ensuring that families are comfortable and confident in the care provided to their loved ones.

Infection Prevention and Control

Pre-pandemic

65. Prior to the pandemic, IPC has been a priority for Whiddon. There is a structured hierarchy for obtaining, filtering, adapting, and distributing information throughout the organisation.

66. That hierarchy is as follows:

(a) Chief Operating Officer (**COO**) as the senior clinician at Whiddon;

(b) Quality Team, which consists of experienced clinical professionals. This team consists of approximately six clinicians, who are part of our Corporate Team who regularly visit our homes and services. Their sole focus is to manage and monitor quality, care, clinical management and overall compliance with the aged care standards and various regulations across the organisation.

(c) General managers and regional managers;

(d) Directors of care at the individual homes;

(e) Clinical care leaders (example, RNs);

(f) All other staff, including care and direct care workers.

67. This distribution cascades through various levels, including general managers, regional managers, and directors of care at the individual homes. This process involves reinforcing, checking, and conducting audits to ensure that the information is consistently and effectively communicated to all relevant staff.

68. Whiddon appoints clinical care leaders who have the primary responsibility for ensuring that all staff are well-informed about outbreak management, including dealing with infectious diseases such as gastro, influenza, and other illnesses. These leaders are trained and well-prepared to handle infectious disease management.

69. During the pandemic, the clinical care leaders continued to play a pivotal role in disseminating educational information to staff.

Immediate Impact of COVID-19:

70. The onset of COVID-19 had a profound impact on our infection control measures. This impact included:

(a) as the COVID-19 situation evolved, our organisation needed to adapt rapidly. New procedures and processes were developed continuously, sometimes on a weekly or fortnightly basis, to meet the ever-changing requirements of the pandemic;

(b) we were required to train and appoint an IPC Lead at each home;

(c) a COVID steering committee was established to meet regularly as a critical response team and address, communicate and provide solutions to the organisation as they emerge and as proactively as possible;

(d) an open and responsive line of communication was flowing through to all stakeholders as needed. These stakeholders included the Board, families, government and regulatory authorities;

(e) a substantial transformation in our procedures, policies, and training protocols – which had to change to be consistent with the latest advice and guidance, which impacted everyone within the organization, as it was essential to implement rigorous measures to combat the spread of the virus;

(f) all staff underwent a continuous cycle of education and received updated guidelines as often as the situation demanded. The updated material provided by Whiddon targeted all staff with a view to enhancing their knowledge and skills in IPC and outbreak management, and included updating our training modules to cover COVID-19 specific content, such as the correct use of PPE, hygiene protocols, and understanding and adhering to evolving guidelines;

(g) the surge in COVID-19 cases during the pandemic disrupted our RBC model significantly. With staff members falling ill, furloughs becoming common, and high turnover across the sector, the concept of dedicated rostering was compromised. This directly impacted our ability to maintain the same level of

continuity in resident care. Nevertheless, we adapted and sought ways to support both our employees and residents through these challenging times.

71. During the pandemic, our staff underwent a continuous cycle of education and received updated guidelines as often as the situation demanded. It was an intensive period for a couple years, with guidelines, recommendations, and procedures being updated more frequently in the initial stages and becoming more manageable as we moved into 2022.

72. Communication, particularly via text messages and mobile platforms, became essential in disseminating timely information.

73. By late 2022, the situation had improved significantly, and we had settled into a more stable routine. The frequency of guideline changes and training updates reduced as the pandemic became more manageable. We found ourselves in a more stable phase of COVID-19 management, where we could focus on a more sustained approach to infection prevention and control.

Impact as at 2023

74. Whilst the intensification of new training, information and infection control protocols has now subsided, with staff making it through the learning curve that was the pandemic, certain pandemic protocols remain:

(a) although mask mandates have been relaxed recently, Whiddon facilities continue to conduct regular rapid antigen tests (**RATs**) every 72 hours as a safety measure (Whiddon provides the RATs to employees to conduct the test at home before attending work);

(b) the mandatory training with respect to infection control has been updated and continues to incorporate additional information about PPE;

(c) the newly established IPC lead role remains;

(d) the updated outbreak management protocols still include reference to COVID-19. For example, if multiple cases are identified, the facility promptly initiates procedures to manage the outbreak within that particular wing;

(e) Whiddon continues to maintain a COVID-19 management plan; and

(f) employees are still required to follow a clear protocol if they have COVID-19 or have been in close contact with someone who does, they are instructed to not come to work.

75. Unlike the initial stages of the pandemic, where a facility-wide lockdown was required in the event of an outbreak, the approach has evolved. Now, the facility can manage outbreaks at a more localised level, typically within a specific wing or area. This change reflects the improved management of COVID-19 cases and the higher vaccination rates among staff and residents.

76. We have also experienced a shift regarding mandatory vaccinations. Initially, we insisted on mandatory vaccinations for all employees, but with changing government guidelines, this requirement is no longer in place although it is encouraged.

Additionally, the frequency of communication and updates related to COVID-19 has significantly decreased. The regular text messages to employees with COVID-19 updates are no longer required, which reflects the stabilisation of the situation.

Cleaners

77. Our cleaners typically work the day shift. In some regional areas, such as Moree, they may start and finish earlier due to the heat. However, generally, day shift.

Staffing Shortages

78. Staffing shortages, especially in the role of nurses, have been a significant issue for Whiddon's aged care facilities. Whiddon has had to rely on agency staff to meet care requirements when permanent staff fall short.

79. The impact of staffing shortages has been widespread, affecting almost all of Whiddon's aged care homes. Regional facilities, particularly in remote areas like the North West, Hunter, Kelso, Mudgee, and the Northern Rivers, faced significant staffing challenges. Whiddon relied on agency staff and overseas workers to mitigate these issues.

Agency Staff

80. Whiddon homes operate to a master roster, which are designed to meet the care and operating profile of each home, guided by mandated care minutes and financial parameters. Where the master roster has known gaps prior to publishing due to workforce shortages, agency staff are engaged proactively to enable the delivery of care and the meeting of the mandated care minutes.

81. Examples of conditions that may result in a staffing shortage:

(a) Notice of planned leave, where casuals or other employees are unavailable to fill shifts.

(b) Short term vacant shifts, such as those impacted by sick leave, may require a more urgent, reactive approach to an agency engagement.

82. In regional locations and given the nature of our staff shortages we will generally block book agency staff for 2-12 weeks. This does assist in continuity of care and general staff performance due to familiarity with our processes and procedures.

83. If agency staff are required on short notice (for example, to cover sick leave), the time for agency staff to arrive and fill that vacancy will depend on the location. For example, where agency staff are readily available, they can be deployed at short notice, perhaps within hours, however in other locations (eg Moree), there may not be an immediate solution or an agency employee may need to be deployed from a major city or regional centre. The latter requires logistical planning, travel and accommodation arrangements, all of which can lead to longer lead times. There are other cases that may take weeks to resolve resulting in other internal short-term solutions being relied on.

84. Whiddon has preferred agencies that are used with agreements in place. To ensure compliance with various internal policies, general agency engagement processes flow through a recently introduced agency portal. This process is applied to ensure that our homes only use approved agencies with terms that have been reviewed and agreed to in accordance with our policies and procedures.

85. There is no guarantee that the same agency workers will be deployed on each occasion, however, in some locations this can occur. It varies from location to location.

86. In addition to nurses, catering staff were also affected by staffing shortages. To address these challenges, Whiddon had to adopt unconventional measures, including shipping chefs from other locations and even accommodating them in hotels to ensure kitchen operations and catering services were maintained. We have an ongoing role with a Head Chef employed solely to fill vacancies across the business. Our regional hospitality team have also had to step out of their roles to fill many vacancies and unexpected leave to ensure our residents continued to receive high quality and nutritious meals.

Care Minutes

87. As mentioned, Whiddon adheres to an RBC philosophy, emphasising the holistic care journey. While staffing ratios / care minutes are one aspect of quality care, the overall resident experience considers multiple factors, including the contributions of cleaners, administrators, catering staff, and more.

Funding

88. Whiddon has experienced significant financial challenges, which were compounded by the impact of COVID-19. These challenges included declining occupancy rates, staffing issues, and increased agency staffing costs. Even before COVID-19, we faced financial difficulties with three years of consecutive losses.

89. To cope with these financial issues, we had to rely on our financial reserves. During this time, our primary budget focus was maintaining a 1.5% staff wage increase for all employees, despite the financial losses.

90. While we have seen a slight improvement in profitability during the first quarter of this year, it's still not at a sustainable level. A sustainable profit should not only cover the daily operation but also generate a surplus to cover the costs of capital expenditures, such as replacing furniture and refurbishing bedrooms and common areas. We estimate that this surplus should be approximately $8 to $10 million for our organisation, however we are currently only generating approximately half of that amount.

91. A significant challenge in the aged care sector is the uncertainty in funding, especially due to the lack of clarity regarding indexation year on year. This uncertainty makes long-term planning and providing for long-term care needs difficult. It's a systemic issue that needs to be addressed for the betterment of the sector. The emergence of the pricing commissioner, with the first year of improved indexation, is the first step towards rebuilding confidence across the sector.

92. In terms of the recent modern award increase, there still remains uncertainty in regard to how the subsequent increase to leave liabilities will be funded by the Commonwealth. Following the wage increase implementation in July 23, leave liabilities, including long service leave and annual leave, increased by approximately 15%. The Government have been slow in providing clarity and a process to fund these costs, despite making commitments to fund the modern award increase. While grants have been promised to cover these costs, the details are ambiguous and lack certainty. For smaller providers with limited financial resources, this can be a significant problem.

93. In the home care sector, leave provisions are in a similar state which has added to the financial burden for providers.

94. While I appreciate the work value process is obviously complicated, I support a significant and material funded increase to the rates of pay of our team members and those across the sector who work in these critical roles. In particular, a positive outcome for non-care employees will assist in unifying our team.

[redacted]

Chris Mamarelis

1 November 2023

CM-1

Whiddon Training Matrix		
All employees need to complete the following:		
Module Name	Delivery Method	Frequency
Induction Program	eLearning	Once off
Bullying and Harassment for employees, on-line module.	eLearning	Once off
Care at Whiddon	eLearning	Once off
Dementia: an introduction	eLearning	Once off
Our Code of Conduct	eLearning	Once off
Risk Management	eLearning	Once off
Abuse & Neglect New Reporting Under SIRS - Employees	eLearning	Annual
Personal Protective Equipment in the context of COVID	eLearning	Annual
Standard Precautions for Infection Prevention and Control	eLearning	Annual
Fire Safety and Emergency Evacuation – PEPT/Whiddon	Classroom	Annual
Additional training requirements based on role		
Select business unit		Residential Aged Care
Select Role		AIN
(RAC Only) Does your home service NDIS residents?		Yes
Module Name	Delivery Method	Frequency
Restrictive Practices	eLearning	Once Off
Safe Eating & Drinking and IDDSI	eLearning	Once Off (excludes admin & cleaning)
Safe Food Handling	eLearning	Once Off (excludes admin & cleaning)
Hand hygiene	Skills Assessment	Annual
PPE: suitable for COVID-19 Preparedness	Skills Assessment	Annual
Manual Handling Generic	Skills Assessment	Annual
Wound Management Aseptic Technique – RN Residential Care	Skills Assessment	Annual
NDIS New Worker Induction	eLearning via NDIS portal	Once Off

19

All about me

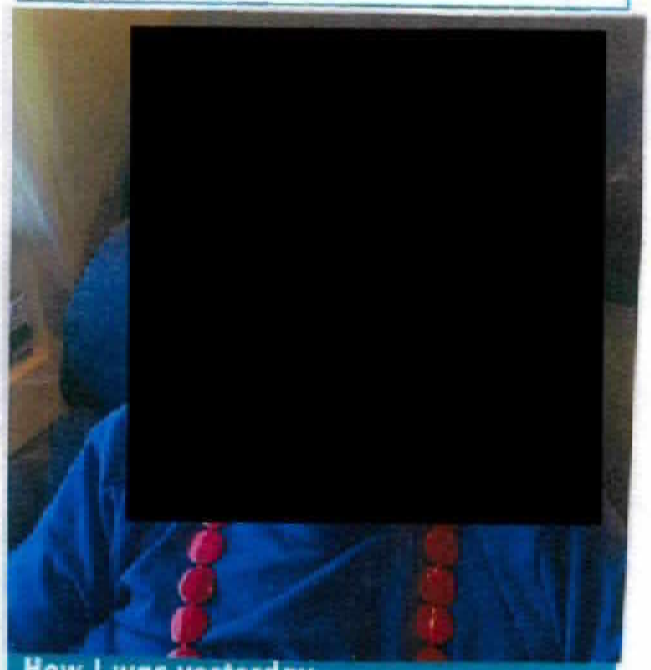
I am [redacted] and this is my life

I was born on [redacted]

What I love in life is
Being alive still and family 4 Children, 3 girls, 1 boy, 10 grandchildren, 10 great grandchildren. She loves painting.

Did you know that I
Member of the art society, very keen gardener. Was a keen singer in the church choir soprano, sang solo at midnight mass for Christmas

I like to talk about
Interesting day to day subjects. Likes to know people and there history, book discussions



How I was yesterday

The people most important to me are
My family, my children, grandchildren and great grandchildren

Something I'd love to do is
Go out to dinner, go out and paint.

The things I like to do each day are
Newspaper reading and hairdresser visits, listening to audio books, scrabble with friends.

Activities and music I currently enjoy are
Audio Books, word games, art , painting, newspaper discussions with scrabble. Favourite music is Michael Buble.

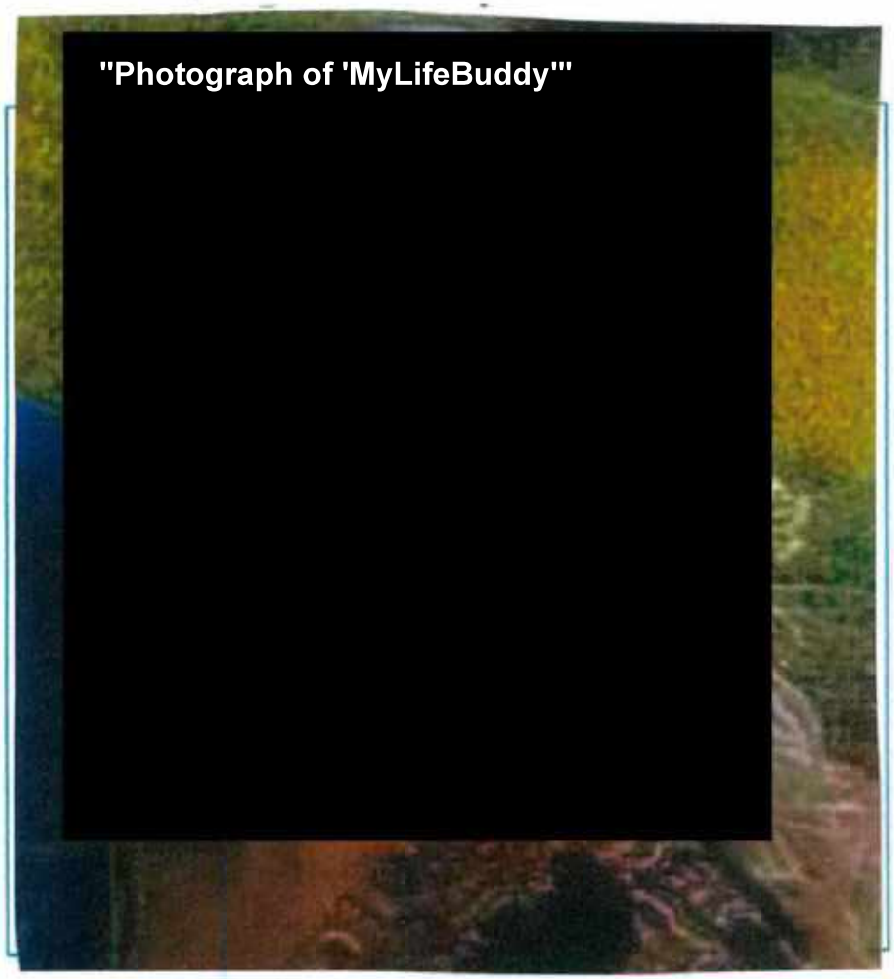
How I am today

How I would like to be tomorrow

MyLife

Whiddon

MyLife Buddy



This is me

I am from

Newcastle – Born in Maitland Hospital .

Languages I can speak

English

Things I enjoy

Working out at all females boot camp

Enjoying family time

Horse riding

Attending my children's sport and watching them thrive

LOVE shopping and spoiling my family

Loves eating out and catching up with friends at Cafes and Restaurant.

Love being near the ocean, if find it extremely calming and relaxing.

This is my life

MyLife

Whiddon

A TRIP DOWN MEMORY LANE!

CM-3

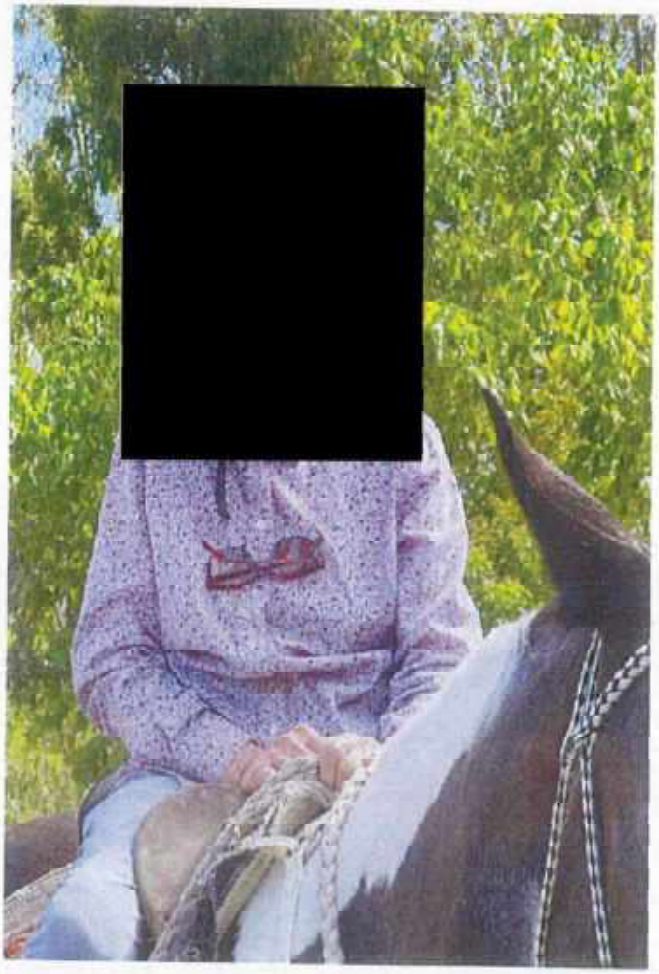
[redacted] along with a few other residents, enjoyed a trip to the Transport and Motor Museum at Inverell for his best day. [redacted] owns a lot of cars that are there and enjoyed showing everyone around and telling us the history and story of each car. It was a very special day for [redacted] and he had a wonderful time reminiscing about his life and the work he put into the cars.

"Photograph of Resident"

JUST A GIRL WHO LOVES HORSES!

[redacted] who is [redacted], had a wish to get back on a horse and go riding again.

Wade Horses Bingara, granted [redacted] that wish and we organised for her to go riding. [redacted] was extremely excited and thoroughly enjoyed her day on horseback, surrounded by family.



Policy
Dignity of Risk

Whiddon

Document Control

Title	Policy Dignity of Risk
Document Number	000
Version/Created On	1/10.5.2019
Effective Date	Updated January 2023
Review Date	January 2025
Initiating service area	Clinical Governance
Release Authority	Clinical Governance Committee

Policy Review

Date	Description of and Reason for review	Initiated by	Version
22 June 2019	New Policy	GMCG	1.0
January 2023	Addition of Risk and Mitigation Guide	GM QCC	2.0

Overview: Dignity of risk embraces the ideal that personal discretion to take reasonable risks in life are essential for the fostering of dignity and self- esteem. As such, within aged care, a resident/client choice to take reasonable risks should not be impeded by excessively-cautious care and service staff, who may feel a conflict of interest with their own basic duty of care.

This policy relates to Dignity of Risk in the context of:

The Aged Care Quality Standards	**Standard 1** Requirement (3) (c): **Each consumer is supported to exercise choice and independence, including to:** **I) make decisions about their own care and the way care and services are delivered; and** **ii) make decisions about when family, friends, carers or others should be involved in their care; and iii) communicate their decisions; and iv) make connections with others and maintain relationships of choice, including intimate relationships.** Requirement (3) (d): **Each consumer is supported to take risks to enable them to live the best life they can.**

Other standards	**Standard 1:** *Standard 1 supports all of the other Aged Care Quality Standards and is essential to providing consumer-centred care*.
Legislation or other requirements	Aged Care Act 1997 (Cth), Schedule 1 User Rights Principles 2014. Charter of Rights and Responsibilities – Residential Care Aged Care Act 1997 (Cth), Schedule 2 User Rights Principles 2014. Charter of Rights and Responsibilities – Home Care Aged Care Act 1997 (Cth), Schedule 3 User Rights Principles 2014. Charter of Rights and Responsibilities – Short-term restorative Care *Civil Liability Act 2002 (NSW)*. This Act sets out the circumstances in which a person or organisation can be considered to be negligent.

Contents

Dignity of Risk

Introduction

Dignity of risk embraces the ideal that personal discretion to take reasonable risks in life is essential for the promotion of dignity and self-esteem. As such, within aged care, a resident or community client should they nominate to take reasonable risks should not be impeded by excessively-cautious care and service staff, who may feel a conflict of interest with their own basic duty of care.

At Whiddon, all our residents and clients have the right to make their own decisions, and are assumed to have capacity to do so unless shown otherwise. Capacity should be medically assessed with the consent of the person or their substitute decision maker.

All residents and clients of Whiddon, to whom we give care, support have an equal right to make decisions and choices about things that affect their lives, their day to day experiences and their enjoyment or satisfaction from those experiences.

Making decisions and choices in everyday life involves risks. This policy is about how Whiddon respects resident and client wishes and preferences relating to the risks they choose to take, and where necessary, shares information and collaborates with the resident and client or their chosen representatives, so that informed decisions regarding those risks can be made without restrictions upon their personal, independent choices whenever possible.

This policy is designed to assist the reader to understand the importance that Whiddon places on Dignity of Risk, and how we expect and require team members to apply it when interacting with our residents and client and/or their chosen representatives. It forms the framework of our care model and service delivery, and will be generally upheld at all times, subject to unique circumstances which may have adverse impact on residents or clients and or others.

Whiddon Values

Our values direct our behaviour and delivery of care and prioritise the following attributes:

- Being progressive and innovative
- Nurturing relationships and community
- Creating exceptional impact

Whiddon encourages employees to be creative, supportive and nurturing, encouraging teams to create exceptional impact that is, supporting and enabling our residents and clients to live full and rich lives.

My Life Guiding Principles

Our seven guiding principles have evolved with the development of My Life. They are the principles that direct the way that we deliver care and enable us to achieve the My Life outcomes for residents and clients.

1. Client Self Determination
2. Caring for the whole person – a wellbeing approach
3. The importance of relationships - Relationship-centred care
4. Continuity of Care – a seamless experience for clients
5. Evidence based practice and innovation
6. Connection to Community

7. Partnership – with clients, families, their communities and strategic partners

Caring for the Whole Person – a wellbeing approach

Our aim is to enable quality of life and wellbeing whatever the resident and client journey. We recognise that each resident and client's wellbeing is dependent on a rich and individual mix of relationships, social connections, interests, places, experiences, cultural links and spiritual needs as well as the clinical care that addresses their physical and health needs.

We also understand that disability and dependency are not inevitable consequences of ageing and make no automatic assumption of deterioration. Improved wellbeing is always our aim, regardless of age or frailty.

In this broader wellbeing context, Whiddon is an enabler and partner to residents and clients finding creative and practical solutions to keep the individual connected to the people, interests and communities that matter to them. We also seek to provide evidence based holistic care.

An individual's wishes and choices always direct the care approach. We will seek to provide timely information and direct them to sources of education to enable their informed decision making. Occasionally, we may not offer the breadth of services that person requires. In these instances, we will seek to facilitate the inclusion of other providers of local aged care services and activities in the client's plan for care.

Creative ageing and wellbeing

Creative ageing is one of the ways in which we deliver exceptional care and is a good example of an approach to care that can achieve broad wellbeing outcomes regardless of age or frailty.

It covers both therapies, programs and events that are aimed at engaging residents and clients through enjoyment and encouraging self-expression.

The term creative ageing was first used by US psychiatrist Dr Gene Cohen and refers specifically to ageing well through engaging with the visual, performing and literary arts. At Whiddon we use the term more broadly to include arts and crafts, music, dance, theatre, storytelling, writing, cooking, gardening, mind games, digital technology, environmental design and lifelong learning.

To this end there may be associated risks with activities, the aim is to not eliminate activities but to evaluate risk for an individual and to support the person to make an informed decision or if they have diminished capacity provide their substitute decision maker with the information they require to make a decision (this must be within their legal authority).

Application of Policy

This policy applies to all Whiddon team members, contractors and volunteers who provide services for our organisation, whether or not they work in direct contact with our residents and clients. Team members, contractors and volunteers must comply with the law of negligence in all aspects of their work, ensuring that despite the application of this policy, they continue to also act in accordance of their personal duty of care.

Definitions

Dignity the state or quality of being worthy of honour or respect, being treated in a manner that shows the other person respect, honour and worth.

Hazard: something that is dangerous and likely to cause harm

Risk: the chance of harm occurring.

Choice: opportunity to enact a choice and take risk

Dignity of Risk: a resident/client has the opportunity to enact a choice and take risk, despite the risks associated, subject to and subsequent to being advised and discussing with their carer, the positive and negative aspects of the choice they are making, any foreseeable dangers, any foreseeable outcomes and impacts.

Capacity: the assessed cognitive state of the person to understand the risk of harm from the choice that is made Dignity of risk refers to a person's right to make choices that have risks associated with them. It is essential that the person has been fully informed of those risks and has the capacity to understand the risks. It is also important that the choices do not have the capacity to harm self and others.

Duty of Care: an obligation to avoid acts or omissions, which could be reasonably foreseen to injure or harm other people. This means anticipating risks for consumers and taking care to prevent them coming

to harm. Duty of care needs to be balanced against the resident and client right to make choices that have associated risks.

Consumers, Residents, Clients, Recipients: People that receive care and or services by an aged care provider.

Policy

Whiddon is committed to enabling older people's right to choose: their care, services, activities and how they wish to live their lives, taking into consideration obstacles that may be due to personal circumstances.

Making personal choices means taking risks based on personal risk appetite. We at Whiddon believe all aged care consumers have the same rights as other members within society to take risks when making choices, Whiddon team members will assist residents and clients to make their own informed choices, to enjoy the broadest range of life opportunities and experiences possible for them and their circumstances, in an environment of care, support, and information.

Whiddon will ensure that strategies are in place to assist and enforce employees, contractors and volunteers, to provide a standard of care commensurate with their position that contributes towards best outcomes for each older person whilst respecting the person's right to choose to take risks.

Strategies to consider

- Senior managers, general practitioners will be involved in the discussions with residents, and clients and or their substitute decision makers when determining risk versus duty of care.
- Provide supports to be put in place, to assist residents, clients and or their substitute decision makers to understand the process of risk assessment, consultation, informed decision making and the importance of a multidisciplinary case conference
- Collaboration with aged care consumers is to be embedded into employee and consumer day to day interactions. Enforcement may be via education, position description, management interventions and other appropriate and relevant means.
- Duty of Care issues are to be recorded on resident and client files.
- Appropriately skilled and qualified employees are to assist consumers to make informed choices by providing relevant information, in appropriate formats where required, about the benefits and risks involved in activities
- Where duty of care is an issue, the decision-making processes and the implementation of each stage of the process is to be documented by the senior registered nurse or service manager or community care manager in a resident and clients care notes and care plans
- If at the end of the decision making process, the resident and client does not have the necessary skills (mental, physical and/or other), to carry out the activities, care regime or services they have chosen, Whiddon team members will continue to undertake risk assessments, collaborate with key stakeholders, communicate and negotiate and work towards mutually agreeable actions.
- Residents, clients and or their substitute decision maker, employees and all other key stakeholders, must have the request in writing and the associated risks clearly communicated with them. This may include a formal letter being given to the residents, client and or substitute decision maker, a signed risk assessment, relevant information and a medical review.
- Where a resident or client chooses to undertake an activity that could harm him or her but understands the risks involved, a senior manager must note this decision on the resident or client file and have all relevant documentation provided to the resident and client. Such as the risk assessment, medical review, allied health review, activity risks and clear direction on mitigation strategies recommended

- Where a resident and client chooses to undertake an activity that could harm him or her and does not understand the risks involved, the service manager or their delegate must ensure their duty of care to the consumer is implemented and that any action is documented, as well as clear rationale.

Additional Considerations

- Registered Nurses must be aware of the health and safety of all consumers and their reporting responsibilities if a consumer is placed at risk or harmed.
- Registered Nurses and care employees will receive appropriate ongoing training to support them to identify consumers who are at risk of poor health or any form of abuse or neglect.
- Where necessary the registered nurse must ensure that appropriate medical, therapy or nutritional attention and information and advice is obtained. Any such information is to be recorded in the progress notes.
- Whiddon has a policy and guide regarding 'challenging behaviours' this includes persons who are a danger to himself or herself or others. Employees must refer to this or seek appropriate external professional consultation

Managing Risk and Capacity

Whiddon has a comprehensive process for the recording and reviewing accidents and injury to resident's and clients.

Whiddon proactively manages risk by identifying the hazards associated with a resident's and client's choices that enhance their quality of life. Further; Whiddon ensures that residents and clients are provided with all available options and the potential consequences before making a decision.

Capacity is considered when risk taking decisions are being made. Decisions on capacity are documented. Residents and clients have the same rights as everyone even though they may have impaired cognition. If there are any concerns, capacity must be assessed according to the jurisdiction's laws and by appropriately qualified health and legal professionals – it is not a matter of employee /family opinion. It is critical to understand that impaired capacity to make one type of decision does not preclude capacity to make a decision about a different matter capacity is decision-specific.[1] In some circumstances where capacity is impaired, a guardian or power of attorney may be appointed as a substitute decision-maker.[2]

Whiddon has a structured approach to managing Dignity of Risk, and as such Whiddon-

1. Identifies the context. For example; what is the activity, when is it, where is it, who is involved, what consent is required and what information is required?
2. Identifies the risk, its sources, and potential consequences. Who is involved, are they qualified, is there insurance notification required? Who needs to know?
3. Analyse the risk. Considering causes/sources of risk, their positive and negative consequences; the likelihood that these consequences will occur, and what might alter the likelihood of consequences eventuating?
4. Evaluates the risk. What is the worst-case scenario?

[1] Attorney General's Department of NSW. Capacity toolkit. NSW: Attorney General's Department of NSW; 2009. Available from: https://www.justice.nsw.gov.au/diversityservices/Documents/capacity_toolkit0609. Pdf.
Accessed 28 May 2019.

[2] ibid

5. Manages or “treats” the risk. What do we do to reduce risk?
6. Monitors and reviews the risk. [3]

Consultation and decision making will be recorded comprehensively and reflected in the client and resident’s record. All consent’s in relation to risk taking will be duly witnessed and recorded in writing and attached to the electronic record of the client and residents. Agreements in relation to risk taking will be recorded as a component of the resident and client’s care plan.

The service manager and or their delegate will ensure all decisions and or outcomes will be clearly communicated to the resident and client and or their substitute decision maker.

All stakeholders will agree on a desired timeframe that considers and includes time for the process of a risk assessment to be undertaken, the referral of a medical consultation if required and or the referral of an allied health review if required.

This will provide the resident, client and or their substitute decision maker with all the information required to make an informed decision. Further this information will provide the home with information on what risk mitigation strategies and support can be provided in the interest of resident and client safety and the wellbeing and safety of employees and others.

Decisions in relation to individual risk taking will be reviewed as a component of the standard care plan review undertaken on a regular basis and as required.

Process

EXAMPLE: Resident or Client has made a choice to e.g. Refuse care, smoke without a safety apron, ride a motor scooter on the road, eat soft boiled eggs, jump out of a plane, use an electric blanket etc.

1. Identify what the resident or client is wanting, needs and preferences – obtain all of the information and document the request clearly

2. Identify who will be the person to case manage the request (recommended to have one senior person coordinating the process)

3. Identify who the key stakeholders are with the resident or client e.g. General Practitioner, substitute decision maker (if the person has diminished capacity), support person, allied service person, advocate

4. Organise an initial case conference with Resident or client and other key stakeholders to discuss the request and process to be take (this must be agreed by the resident or client)
5. Determine and agree on a timeframe.

6. If there is clinical concern regarding resident or client capacity to understand action and consequence, risk to self and others, a medical review is indicated.

7. A suitably qualified professional is to undertake a comprehensive risk assessment. The assessment is of the activity requested and assessment of the resident capacity to partake in the activity.

8. Once the assessments and information is collated, reconvene a case conference with the resident or client and or their substitute decision maker to discuss the assessments, risks and mitigation strategies.

9. Once a decision is made a care plan is to be agreed on, a signed care plan by the resident or client and or their substitute decision maker must be made available to all relevant employees and a copy provided to the resident or client and or their substitute decision maker.

10. Ensure you establish review dates, process of monitoring and expected outcome for the resident or client.

11. Document, document and document, if you have concerns do not hesitate to engage with regional managers or the executive for guidance.

12. At all times consider the legal rights in decision making.

Risk and Mitigation Guide Potential Risk and Strategies to Mitigate Risk

NB the below is to be used as a guide only, it is <u>not an</u> exhaustive list of all risks. Each consumer's needs will need to be assessed individually and have tailored interventions based on their individuals needs

Examples	Risk and Mitigation Flow Chart for Informing Consent.		
Activity / Action	Reason	Potential Risk	Strategies used to mitigate risk
Bed Against Wall	Consumer preference (RP) Rolling off bed Layout of room Maximise space	• Mattress moves -causing Entrapment risk • Cords from blinds/curtains • Strangulation risk • Unable to access call bell easily • Unable to access personal items easily • Skin trauma/Bruising/Skin tears • Pressure injury - (If RP) • Difficulty getting out of bed (If RP)	Physio/OT review/assessment Mattress bracket welded on bed to minimise mattress movement Remove/Shorten cords Pendant call bell Move items to an accessible place Limb protectors Exit side of bed - dominant side
Bed Rails	Consumer preference (RP) Rolling off bed Manual handling assistance	• Entrapment • Strangulation • Suffocation • Climbing over rails • Falls • Increased confusion • Fractures • Skin trauma/Bruising/Skin tears • Pressure Injuries • Restraint preventing mobilising • Difficulty accessing call bell	Physio/OT review/assessment Pendant buzzer Floor line bed Bed rail covers Limb protectors 1/3 bed rails instead of full Only 1 rail to allow mobility

Approved June 2019

Bus Outings	• Consumer Rights Maintain independence	• Accident involving others • Falls causing serious injury while embarking or disembarking from the bus Absconding • Motion sickness • Choking while eating	Physio/OT review/assessment Escorted outings Bus Outing Guidelines and Checklist followed
Consuming Food / Fluids Against Recommendations	Consumer preference (RP) Quality of life Weight loss	• Choking Distress • Aspiration pneumonia • Chest infections • Death	Choice of different food/ fluid options Sitting upright during meals Eating drinking slowly, teaspoon
Declining Recommended Care	Prefer not being disturbed Pain	• Pressure areas • Skin infection • Wounds • Incontinence associated dermatitis • Falls	• Pressure relieving devices • Use of barrier creams •
	Decline Antivirals Decline Vaccination	• Increased risk of developing an acute respiratory distress secondary to Covid-19. Which may result irreversible decline and result in death • Risk to other residents and potential transmission within the Home • Risk of developing an ARI may contribute to deterioration in resident's clinical condition which despite all medical support may be irreversible and result in death	Analgesia/Pain review Agreed times for care, e.g., 4/24

Approved June 2019

Electric Scooter/ Wheelchair	• Consumer rights Maintain independence Quality of life	• Accident involving others • Falls causing serious injury • Loss of independence • Crush injuries • Motor vehicle collisions • Resident collisions causing serious injury	OT review/assessment Limit speed Only drive hard surfaces Insurance for injury to others Increased outings Self-Propelled wheelchair
Excessive Alcohol	• Consumer Rights Maintain independence Quality of Life	• Falls • Injury from Falls e.g. head injury • Increased aggression	Low alcohol beverage Alcohol free Beverage Limiting intake Counselling support
Floor Line Bed	Rolling off bed Falls	• Immobility • Pressure injuries • Difficulty accessing call bell	Physio/OT review/assessment Fall out mats Lo Lo bed to aid mobility Pendant buzzer
Medication / Pharmacy	Prefer pharmacy to supply medications. Supplying own Medications	• Supply issues • Missing medications • Increased risk of medication errors due to different systems Unable to supply urgent medications e.g., for pain	All medications must be labelled appropriately Urgent medication availability Use preferred pharmacy provider of Home
Medication - Self	Consumer Rights Maintain independence Quality of Life	• Taking incorrect medication • Overdose • Forgetting medication	Staff supply medication Resident self-medication assessment
Outings Alone	• • Consumer rights Maintain independence Quality of life	• Unable to find way home • Falls and injury • Pedestrian accident • Misadventure	Physio/OT review/assessment Monitor Mobile Phone Card with accommodation details and phone contacts Escorted outings

Approved June 2019

Smoking	• Consumer rights Maintain independence Quality of life	• Burns • Anxiety/Agitation	Use dedicated smoking area with fire protection Smoking apron Supervision
Social Outings during periods of increased Acute Respiratory Infections (ARI) in the local community Declining to wear mask	Resident social outings with family members during periods of increased risk in the community Maintain decision making Maintain independence • Quality of Life •	• Increased risk of becoming infected and developing an acute respiratory infection (ARI) If infectious will be required to isolate when in the Home • Risk to other residents and potential transmission within the Home • Risk of developing an ARI may contribute to deterioration in resident's clinical condition which despite all medical support may be irreversible and result in death	Delay social outings to high-risk venues until risk has reduced Social outings to family home and gatherings preferred Avoid densely populated venues such as busy restaurants, clubs, football matches where physical distancing is not guaranteed Wear a surgical face mask for duration of outing in public places Use alcohol-based hand gel Practise respiratory hygiene: Cover mouth and nose with a tissue when coughing or sneezing If resident does not have a tissue, cough, or sneeze into elbow Use the nearest waste bin to dispose of the tissue after use Perform hand hygiene after having contact with respiratory secretions and contaminated objects/materials

Approved June 2019

IN THE FAIR WORK COMMISSION

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

Re Application by: Virginia Ellis, Mark Castieau, Sanu Ghimire, Paul Jones and Health Services Union; Australian Nursing and Midwifery Federation; Health Services Union

WITNESS STATEMENT OF STUART HUTCHEON
DATED 31 OCTOBER 2023

I, Stuart Hutcheon of Level 2, Tower 1/495 Victoria Ave Chatswood, New South Wales state as follows:

Background

1. I am currently a Partner at StewartBrown, Chartered Accountants and I am an accountant and auditor by trade.

2. I commenced with StewartBrown in March 1995. During this period, I have had several relevant experiences including:

   (a) A number of secondments as a Management Consultant within large, medium and small businesses to manage the accounting and finance function.

   (b) Acting as a registered company auditor for over two hundred not for profit organisations and being responsible for the approach, planning and completion including attending a significant number of meetings with those charged with governance.

3. My qualifications include a

   (a) Bachelor of Commerce (Accounting)

   (b) Chartered Accountant, Member of Chartered Accountants Australia and New Zealand (Member no. 46168)

   (c) Registered Company Auditor (Registration no. 309885)

4. I have particular experience and involvement in the Aged Care Sector (sector) and my client portfolio includes numerous audit consulting projects for providers, the Department of Health and Aged Care with specific focus on financial sustainability at government, provider and consumer levels as well as policy development including extensive stakeholder consultations.

5. In my role I have an ongoing professional relationship within excess of 300 aged care providers, the Department of Health and Aged Care, Australian Quality and Safety Commission, Productivity Commission, aged care peak bodies, consumers and sector panels.

Lodged by: Joint Employers
Telephone: 0482 181 223
Address for Service: Level 7, 8 Chifley Square, Sydney, NSW 2000
Email: Nigel.Ward@ablawyers.com.au; Alana.Rafter@ablawyers.com.au

6. My professional involvement within the sector includes external and internal audit and risk, payroll compliance, financial modelling and analysis, governance reviews, systems reviews and implementations, accounting projects, financial statements preparation and analysis, Board and management workshops, facilitations and presentations, strategic planning and numerous sector conference and forum presentations.

7. I have acted as registered company auditor for 80 plus aged care organisations.

Instructions

8. On 19 September 2023, I was sent correspondence from the Aged & Community Care Providers Association (**ACCPA**) asking me to provide my opinion in answer to certain questions (**letter of instruction**).

   A COPY OF THE LETTER OF INSTRUCTION (TOGETHER WITH ANNEXURES) IS ANNEXED AND MARKED "SH-1"

9. On 25 October 2023, I was sent further correspondence from ACCPA, that included further instructions.

   A COPY OF THE FURTHER INSTRUCTIONS ISSUED IS ANNEXED AND MARKED "SH-2".

Report

10. I have prepared a report dated 30 October 2023, entitled: *"ACCPA Expert Witness Report: Financial Effect of FWC Award Increase"* (**the Report**).

    A COPY OF THE REPORT IS ANNEXED AND MARKED "SH-3".

11. The opinions I have expressed in the Report are based wholly or substantially on specialised knowledge arising from my training, study and experience.

12. I have made all the enquiries that I believe are desirable and appropriate and no matters of significance which I regard as relevant have, to the best of my knowledge and belief, been withheld from the Fair Work Commission.

    The letter of instruction attached a copy of the Federal Court of Australia Expert Evidence Practice Note dated 25 October 2016. I confirm I have read and understood the Practice Note. I agree to be bound by it and have complied with it in preparing the Report.

[redacted]

Stuart Hutcheon

Dated: 31 October 2023

Aged & Community Care Providers Association
Suite 3/42, Macquarie Street,
Barton ACT, Australia 2600
ABN 19 659 150 786

19 September 2023

PRIVATE AND CONFIDENTIAL

Stuart Hutcheon
Partner
Audit & Assurance Division
StewartBrown
Level 2, Tower 1/495 Victoria Ave
Chatswood, New South Wales 2067
PO BOX 5515, Chatswood, NSW, 2057

Dear Mr Hutcheon,

APPLICATIONS TO VARY MODERN AWARDS – WORK VALUE - AGED CARE INDUSTRY AM2020/99, AM2021/63, AM2021/65

The Aged & Community Care Providers Association (**ACCPA**) is participating in the Work Value Case - Aged Care Industry (**Work Value Case**) proceedings conducted by the Fair Work Commission (the **Commission**).

1. BACKGROUND

1.1 Following Stage 1 and Stage 2 of the *Work Value Case*, the Commission published two decisions[1] that had the effect of varying the *Aged Care Award 2010*, *Nurses Award 2020* and *Social, Community, Home Care and Disability Services Industry Award 2010* (**SCHADS Award**) (collectively, **the Awards**) on the basis of work value reasons. This included increasing the minimum award wages of the following classifications by 15%:

(a) personal care workers (**PCWs**) under the *Aged Care Award*;

(b) home care employees providing services to an aged person under the *Social, Community, Home Care and Disability Services Industry Award 2010* (**SCHADS Award**);[2]

(c) nursing employees working in aged care under the *Nurses Award*;[3]

[1] *Stage 1 decision* [2022] FWCFB 200; *Stage 2 decision* [2023] FWCFB 40.
[2] By reasons for decision ([2023] FWCFB 93), the Commission confirmed that home care employees levels 4 and 5 in the SCHADS Award are *"direct care workers*".
[3] The *Nurses Award* was also varied to include a definition of *"aged care employee"* – namely, an employee engaged in the provision of: services for aged persons in a hostel, nursing home, aged care independent living units, aged care serviced apartments, garden settlement, retirement village or any other residential accommodation facility; or services for an aged person in a private residence (see clause 2 of the *Nurses Award*).

(d) *"Head Chefs/Cooks"* under the *Aged Care Award* (Aged care employee levels 4-7 provided the employee is the most senior chef or cook engaged in a facility); and

(e) recreational activities officers/lifestyle officers (**RAOs**) under the *Aged Care Award*.

1.2 The increase of 15% to the minimum award wages in the Awards took effect from 30 June 2023 and was described as an *"interim increase"*, with a final determination about wage increases to be made at the completion of Stage 3 of the *Work Value Case*. These issues will need to be determined before the *Work Value Case* is finalised.

1.3 On 2 August 2023, the Commission published a timetable together with a summary of issues for Stage 3 of the *Work Value Case*. The balance of the proceedings have been divided into two tranches:

(a) wage adjustment issues; and

(b) classifications and allowance issues.

1.4 Both sets of issues will be determined by an Expert Panel appointed by President Hatcher.

Status of Applications before the Commission: Wage Adjustment Issues

1.5 The table below outlines the minimum wage increases sought by the union parties with respect to each classification under the Awards.

Employees subject to the Claim	**Minimum Wage Increase proposed by Claim**
PCWs under the *Aged Care Award*	10%
RAOs under the *Aged Care Award*	10%
Home care employees (providing services to an aged person) under the *SCHADS Award*	10%
Assistants in nursing (**AINs**) working in aged care under the *Nurses Award.*	10%
The general and administrative services stream in the *Aged Care Award,* including: laundry, cleaning, maintenance, gardening, and administrative employees.	25%
The food services stream in the *Aged Care Award,* including: food assistants, servery employees, kitchenhands, cooks, and chefs.	25%

1.6 For the purposes of Stage 3, the employees classified under the *Aged Care Award* that perform work in the general and administrative services stream or food services stream are collectively referred to as *"indirect care workers"*.

1.7 On 25 July 2023, the ANMF intimated it intends to file an amended application that would seek *"a benchmarking of the Registered Nurse Level 1, pay point 1, with the C1(a) of the Metals Framework"* (as opposed to a further 10% for the remaining nursing employees working in aged care).[4] Consistent with the observations made by the Full Bench in the *Stage 1 decision*,[5] the ANMF submitted that the consequence of that course would be *"a 35% [wage] increase"* for the registered nurse working in aged care.[6]

1.8 In submissions dated 15 September 2023, the ANMF submitted that upon making that benchmarking adjustment to the registered nurse level 1 pay point 1, the Commission should retain the internal relativities of all other classifications applicable to enrolled nurses (including student enrolled nurses), registered nurses and nurse practitioners working in aged care. As at the date of this letter of instruction, the ANMF are yet to file an amended application.

1.9 The Commission has directed ACCPA (jointly with Australian Business Industrial) to file evidence and submissions in relation to the wage adjustment issues by **5:00pm (AEST) on Friday 27 October 2023**.

2. INSTRUCTIONS

2.1 We need you to provide an expert report that addresses the following questions:

Current Financial Status of the Age Care Sector

1. What is the current financial status of the aged care sector (both residential and home care)?

Direct care workers (including RAOs)

2. If the *Aged Care Award*, *Nurses Award* and *SCHADS Award* are varied such that the modern award rates that apply to PCWs, AINs (working in aged care), RAOs and home care employees (providing services to an aged person) under the Awards are increased by 10%, what will be the economic impact on the aged care sector (both residential and home care)?

3. If the *Aged Care Award, Nurses Award* and *SCHADS Award* are varied such that the modern award rates that apply to PCWs, AINs (working in aged care), RAOs and home care employees (providing services to an aged person) under the Awards are increased by 10%, will there be any difference in the financial impact to the aged care sector between residential care and home care?

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[4] Transcript of Proceedings - AM2020/99, AM2021/63, AM2021/65 (9.30am, Tuesday, 25 July 2023) at PN63.
[5] See *Stage 1 decision* [2022] FWCFB 200 at [945].
[6] Ibid.

4. If the *Aged Care Award*, *Nurses Award* and *SCHADS Award* are varied such that the modern award rates that apply to PCWs, AINs (working in aged care), RAOs and home care employees (providing services to an aged person) under the Awards are increased by 10%, will any particular part of the aged care sector (for example, private, not for profit, small, large) be impacted more than others and if so how and why?

5. If the *Aged Care Award*, *Nurses Award* and *SCHADS Award* are varied such that the modern award rates that apply to PCWs, AINs (working in aged care), RAOs and home care employees (providing services to an aged person) under the Awards are increased by 10%, what is the ability for the aged care sector to financially tolerate a 10% increase that is not fully funded by the Federal Government?

Indirect care workers (excluding RAOs)

6. If the *Aged Care Award* is varied such that the modern award rates that apply to food services employees[7], general services employees[8] and administrative services employees are increased by 25%, what will be the economic impact on the aged care sector?

7. If the *Aged Care Award* is varied such that the modern award rates that apply to food services employees[9], general services employees[10] and administrative services employees are increased by 25%, will any particular part of the aged care sector (for example, private, not for profit, small, large) be impacted more than others and if so how and why?

8. If the *Aged Care Award* is varied such that the modern award rates that apply to food services employees[11], general services employees[12] and administrative services employees are increased by 25%, what is the ability for the aged care sector to financially tolerate a 25% increase that is not fully funded by the Federal Government?

Nursing employees: ENs, RNs and NPs

9. If the *Nurses Award* is varied such that the modern award rates that apply to enrolled nurses, registered nurses and nurse practitioners working in aged care[13] are increased by 35%, what will be the economic impact on the aged care sector (both residential and home care)?

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[7] This includes food assistants, servery employees, kitchenhands, cooks and chefs.
[8] This includes laundry, cleaning, maintenance and gardening employees.
[9] This includes food assistants, servery employees, kitchenhands, cooks and chefs.
[10] This includes laundry, cleaning, maintenance and gardening employees.
[11] This includes food assistants, servery employees, kitchenhands, cooks and chefs.
[12] This includes laundry, cleaning, maintenance and gardening employees.
[13] An *"aged care"* nursing employee under the *Nurses Award* is engaged in the provision of services for aged persons *"in a hostel, nursing home, aged care independent living units, aged care serviced apartments, garden settlement, retirement village or any other residential accommodation facility"* or *"in a private residence".*

10. If the *Nurses Award* is varied such that the modern award rates that apply to enrolled nurses, registered nurses and nurse practitioners working in aged care[14] are increased by 35%, will there be any difference in the financial impact to the aged care sector between residential care and home care?

11. If the *Nurses Award* is varied such that the modern award rates that apply to enrolled nurses, registered nurses and nurse practitioners working in aged care[15] are increased by 35%, will any particular part of the aged care sector (for example, private, not for profit, small, large) be impacted more than others and if so how and why?

12. If the *Nurses Award* is varied such that the modern award rates that apply to enrolled nurses, registered nurses and nurse practitioners working in aged care[16] are increased by 35%, what is the ability for the aged care sector to financially tolerate a 35% increase that is not fully funded by the Federal Government?

Staffing in the aged care sector

13. For employers/providers in the aged care sector, what is the current state of the employment market in the aged care sector with respect to the supply and demand for staff in both residential and home care. To the extent possible, please make reference to the following categories of employee:

    (a) PCWs (including AINs) working in residential aged care facilities;

    (b) enrolled nurses working in aged care[17];

    (c) registered nurses working in aged care[18];

    (d) nurse practitioners working in aged care[19];

    (e) food services employees (including food assistants, servery employees, cooks and chefs) in residential aged care facilities;

    (f) general services employees (including cleaning, laundry, maintenance and gardening employees) in residential aged care facilities;

    (g) administrative employees in residential aged care facilities; and

    (h) home care employees (providing services to an aged person).

2.2 Annexed to this letter and marked **"A"** is a copy of the Federal Court's Practice Note regarding the use of Expert Witnesses in the Federal Court of Australia, together with a copy of the Harmonised Expert Witness Code of Conduct, which applies to any expert witness engages to provide an expert report or to give opinion evidence in

[14] Ibid.
[15] Ibid.
[16] Ibid.
[17] Ibid.
[18] Ibid.
[19] Ibid.

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proceedings. Could you please ensure that you have read and understand the Practice Note and comply with the Practice Note in the provision of your expert report.

If you have any questions, please do not hesitate to contact me.

Yours sincerely,

Claire Bailey

Head of Workplace Relations

Aged & Community Care Providers Association Ltd

EXPERT EVIDENCE PRACTICE NOTE (GPN-EXPT)

General Practice Note

1. INTRODUCTION

1.1 This practice note, including the *Harmonised Expert Witness Code of Conduct* ("**Code**") (see **Annexure A**) and the *Concurrent Expert Evidence Guidelines* ("**Concurrent Evidence Guidelines**") (see **Annexure B**), applies to any proceeding involving the use of expert evidence and must be read together with:

(a) the Central Practice Note (CPN-1), which sets out the fundamental principles concerning the National Court Framework ("**NCF**") of the Federal Court and key principles of case management procedure;

(b) the Federal Court of Australia Act 1976 (Cth) ("**Federal Court Act**");

(c) the *Evidence Act 1995* (Cth) ("**Evidence Act**"), including Part 3.3 of the Evidence Act;

(d) Part 23 of the *Federal Court Rules 2011* (Cth) ("**Federal Court Rules**"); and

(e) where applicable, the Survey Evidence Practice Note (GPN-SURV).

1.2 This practice note takes effect from the date it is issued and, to the extent practicable, applies to proceedings whether filed before, or after, the date of issuing.

2. APPROACH TO EXPERT EVIDENCE

2.1 An expert witness may be retained to give opinion evidence in the proceeding, or, in certain circumstances, to express an opinion that may be relied upon in alternative dispute resolution procedures such as mediation or a conference of experts. In some circumstances an expert may be appointed as an independent adviser to the Court.

2.2 The purpose of the use of expert evidence in proceedings, often in relation to complex subject matter, is for the Court to receive the benefit of the objective and impartial assessment of an issue from a witness with specialised knowledge (based on training, study or experience - see generally s 79 of the Evidence Act).

2.3 However, the use or admissibility of expert evidence remains subject to the overriding requirements that:

(a) to be admissible in a proceeding, any such evidence must be relevant (s 56 of the Evidence Act); and

(b) even if relevant, any such evidence, may be refused to be admitted by the Court if its probative value is outweighed by other considerations such as the evidence

being unfairly prejudicial, misleading or will result in an undue waste of time (s 135 of the Evidence Act).

2.4 An expert witness' opinion evidence may have little or no value unless the assumptions adopted by the expert (ie. the facts or grounds relied upon) and his or her reasoning are expressly stated in any written report or oral evidence given.

2.5 The Court will ensure that, in the interests of justice, parties are given a reasonable opportunity to adduce and test relevant expert opinion evidence. However, the Court expects parties and any legal representatives acting on their behalf, when dealing with expert witnesses and expert evidence, to at all times comply with their duties associated with the overarching purpose in the Federal Court Act (see ss 37M and 37N).

3. INTERACTION WITH EXPERT WITNESSES

3.1 Parties and their legal representatives should never view an expert witness retained (or partly retained) by them as that party's advocate or "hired gun". Equally, they should never attempt to pressure or influence an expert into conforming his or her views with the party's interests.

3.2 A party or legal representative should be cautious not to have inappropriate communications when retaining or instructing an independent expert, or assisting an independent expert in the preparation of his or her evidence. However, it is important to note that there is no principle of law or practice and there is nothing in this practice note that obliges a party to embark on the costly task of engaging a "consulting expert" in order to avoid "contamination" of the expert who will give evidence. Indeed the Court would generally discourage such costly duplication.

3.3 Any witness retained by a party for the purpose of preparing a report or giving evidence in a proceeding as to an opinion held by the witness that is wholly or substantially based in the specialised knowledge of the witness[1] should, at the earliest opportunity, be provided with:

(a) a copy of this practice note, including the Code (see Annexure A); and

(b) all relevant information (whether helpful or harmful to that party's case) so as to enable the expert to prepare a report of a truly independent nature.

3.4 Any questions or assumptions provided to an expert should be provided in an unbiased manner and in such a way that the expert is not confined to addressing selective, irrelevant or immaterial issues.

[1] Such a witness includes a "Court expert" as defined in r 23.01 of the Federal Court Rules. For the definition of "expert", "expert evidence" and "expert report" see the Dictionary, in Schedule 1 of the Federal Court Rules.

4. ROLE AND DUTIES OF THE EXPERT WITNESS

4.1 The role of the expert witness is to provide relevant and impartial evidence in his or her area of expertise. An expert should never mislead the Court or become an advocate for the cause of the party that has retained the expert.

4.2 It should be emphasised that there is nothing inherently wrong with experts disagreeing or failing to reach the same conclusion. The Court will, with the assistance of the evidence of the experts, reach its own conclusion.

4.3 However, experts should willingly be prepared to change their opinion or make concessions when it is necessary or appropriate to do so, even if doing so would be contrary to any previously held or expressed view of that expert.

Harmonised Expert Witness Code of Conduct

4.4 Every expert witness giving evidence in this Court must read the *Harmonised Expert Witness Code of Conduct* (attached in Annexure A) and agree to be bound by it.

4.5 The Code is not intended to address all aspects of an expert witness' duties, but is intended to facilitate the admission of opinion evidence, and to assist experts to understand in general terms what the Court expects of them. Additionally, it is expected that compliance with the Code will assist individual expert witnesses to avoid criticism (rightly or wrongly) that they lack objectivity or are partisan.

5. CONTENTS OF AN EXPERT'S REPORT AND RELATED MATERIAL

5.1 The contents of an expert's report must conform with the requirements set out in the Code (including clauses 3 to 5 of the Code).

5.2 In addition, the contents of such a report must also comply with r 23.13 of the Federal Court Rules. Given that the requirements of that rule significantly overlap with the requirements in the Code, an expert, unless otherwise directed by the Court, will be taken to have complied with the requirements of r 23.13 if that expert has complied with the requirements in the Code and has complied with the additional following requirements. The expert shall:

(a) acknowledge in the report that:

(i) the expert has read and complied with this practice note and agrees to be bound by it; and

(ii) the expert's opinions are based wholly or substantially on specialised knowledge arising from the expert's training, study or experience;

(b) identify in the report the questions that the expert was asked to address;

(c) sign the report and attach or exhibit to it copies of:

(i) documents that record any instructions given to the expert; and

(ii) documents and other materials that the expert has been instructed to consider.

5.3 Where an expert's report refers to photographs, plans, calculations, analyses, measurements, survey reports or other extrinsic matter, these must be provided to the other parties at the same time as the expert's report.

6. CASE MANAGEMENT CONSIDERATIONS

6.1 Parties intending to rely on expert evidence at trial are expected to consider between them and inform the Court at the earliest opportunity of their views on the following:

(a) whether a party should adduce evidence from more than one expert in any single discipline;

(b) whether a common expert is appropriate for all or any part of the evidence;

(c) the nature and extent of expert reports, including any in reply;

(d) the identity of each expert witness that a party intends to call, their area(s) of expertise and availability during the proposed hearing;

(e) the issues that it is proposed each expert will address;

(f) the arrangements for a conference of experts to prepare a joint-report (see Part 7 of this practice note);

(g) whether the evidence is to be given concurrently and, if so, how (see Part 8 of this practice note); and

(h) whether any of the evidence in chief can be given orally.

6.2 It will often be desirable, before any expert is retained, for the parties to attempt to agree on the question or questions proposed to be the subject of expert evidence as well as the relevant facts and assumptions. The Court may make orders to that effect where it considers it appropriate to do so.

7. CONFERENCE OF EXPERTS AND JOINT-REPORT

7.1 Parties, their legal representatives and experts should be familiar with aspects of the Code relating to conferences of experts and joint-reports (see clauses 6 and 7 of the Code attached in Annexure A).

7.2 In order to facilitate the proper understanding of issues arising in expert evidence and to manage expert evidence in accordance with the overarching purpose, the Court may require experts who are to give evidence or who have produced reports to meet for the purpose of identifying and addressing the issues not agreed between them with a view to reaching agreement where this is possible ("**conference of experts**"). In an appropriate case, the Court may appoint a registrar of the Court or some other suitably qualified person ("**Conference Facilitator**") to act as a facilitator at the conference of experts.

7.3 It is expected that where expert evidence may be relied on in any proceeding, at the earliest opportunity, parties will discuss and then inform the Court whether a conference of experts and/or a joint-report by the experts may be desirable to assist with or simplify the giving of expert evidence in the proceeding. The parties should discuss the necessary arrangements for any conference and/or joint-report. The arrangements discussed between the parties should address:

(a) who should prepare any joint-report;

(b) whether a list of issues is needed to assist the experts in the conference and, if so, whether the Court, the parties o r the experts should assist in preparing such a list;

(c) **t**he agenda for the conference of experts; and

(d) arrangements for the provision, to the parties and the Court, of any joint-report or any other report as to the outcomes of the conference ("**conference report**").

Conference of Experts

7.4 The purpose of the conference of experts is for the experts to have a comprehensive discussion of issues relating to their field of expertise, with a view to identifying matters and issues in a proceeding about which the experts agree, partly agree or disagree and why. For this reason the conference is attended only by the experts and any Conference Facilitator. Unless the Court orders otherwise, the parties' lawyers will not attend the conference but will be provided with a copy of any conference report.

7.5 The Court may order that a conference of experts occur in a variety of circumstances, depending on the views of the judge and the parties and the needs of the case, including:

(a) while a case is in mediation. When this occurs the Court may also order that the outcome of the conference or any document disclosing or summarising the experts' opinions be confidential to the parties while the mediation is occurring;

(b) before the experts have reached a final opinion on a relevant question or the facts involved in a case. When this occurs the Court may order that the parties exchange draft expert reports and that a conference report be prepared for the use of the experts in finalising their reports;

(c) after the experts' reports have been provided to the Court but before the hearing of the experts' evidence. When this occurs the Court may also order that a conference report be prepared (jointly or otherwise) to ensure the efficient hearing of the experts' evidence.

7.6 Subject to any other order or direction of the Court, the parties and their lawyers must not involve themselves in the conference of experts process. In particular, they must not seek to encourage an expert not to agree with another expert or otherwise seek to influence the outcome of the conference of experts. The experts should raise any queries they may have in relation to the process with the Conference Facilitator (if one has been appointed) or in

accordance with a protocol agreed between the lawyers prior to the conference of experts taking place (if no Conference Facilitator has been appointed).

7.7 Any list of issues prepared for the consideration of the experts as part of the conference of experts process should be prepared using non-tendentious language.

7.8 The timing and location of the conference of experts will be decided by the judge or a registrar who will take into account the location and availability of the experts and the Court's case management timetable. The conference may take place at the Court and will usually be conducted in-person. However, if not considered a hindrance to the process, the conference may also be conducted with the assistance of visual or audio technology (such as via the internet, video link and/or by telephone).

7.9 Experts should prepare for a conference of experts by ensuring that they are familiar with all of the material upon which they base their opinions. Where expert reports in draft or final form have been exchanged prior to the conference, experts should attend the conference familiar with the reports of the other experts. Prior to the conference, experts should also consider where they believe the differences of opinion lie between them and what processes and discussions may assist to identify and refine those areas of difference.

Joint-report

7.10 At the conclusion of the conference of experts, unless the Court considers it unnecessary to do so, it is expected that the experts will have narrowed the issues in respect of which they agree, partly agree or disagree in a joint-report. The joint-report should be clear, plain and concise and should summarise the views of the experts on the identified issues, including a succinct explanation for any differences of opinion, and otherwise be structured in the manner requested by the judge or registrar.

7.11 In some cases (and most particularly in some native title cases), depending on the nature, volume and complexity of the expert evidence a judge may direct a registrar to draft part, or all, of a conference report. If so, the registrar will usually provide the draft conference report to the relevant experts and seek their confirmation that the conference report accurately reflects the opinions of the experts expressed at the conference. Once that confirmation has been received the registrar will finalise the conference report and provide it to the intended recipient(s).

8. CONCURRENT EXPERT EVIDENCE

8.1 The Court may determine that it is appropriate, depending on the nature of the expert evidence and the proceeding generally, for experts to give some or all of their evidence concurrently at the final (or other) hearing.

8.2 Parties should familiarise themselves with the *Concurrent Expert Evidence Guidelines* (attached in Annexure B). The Concurrent Evidence Guidelines are not intended to be exhaustive but indicate the circumstances when the Court might consider it appropriate for

concurrent expert evidence to take place, outline how that process may be undertaken, and assist experts to understand in general terms what the Court expects of them.

8.3 If an order is made for concurrent expert evidence to be given at a hearing, any expert to give such evidence should be provided with the Concurrent Evidence Guidelines well in advance of the hearing and should be familiar with those guidelines before giving evidence.

9. FURTHER PRACTICE INFORMATION AND RESOURCES

9.1 Further information regarding Expert Evidence and Expert Witnesses is available on the Court's website.

9.2 Further information to assist litigants, including a range of helpful guides, is also available on the Court's website. This information may be particularly helpful for litigants who are representing themselves.

J L B ALLSOP
Chief Justice
25 October 2016

Annexure A

HARMONISED EXPERT WITNESS CODE OF CONDUCT[2]

APPLICATION OF CODE

1. This Code of Conduct applies to any expert witness engaged or appointed:

   (a) to provide an expert's report for use as evidence in proceedings or proposed proceedings; or

   (b) to give opinion evidence in proceedings or proposed proceedings.

GENERAL DUTIES TO THE COURT

2. An expert witness is not an advocate for a party and has a paramount duty, overriding any duty to the party to the proceedings or other person retaining the expert witness, to assist the Court impartially on matters relevant to the area of expertise of the witness.

CONTENT OF REPORT

3. Every report prepared by an expert witness for use in Court shall clearly state the opinion or opinions of the expert and shall state, specify or provide:

   (a) the name and address of the expert;

   (b) an acknowledgment that the expert has read this code and agrees to be bound by it;

   (c) the qualifications of the expert to prepare the report;

   (d) the assumptions and material facts on which each opinion expressed in the report is based [a letter of instructions may be annexed];

   (e) the reasons for and any literature or other materials utilised in support of such opinion;

   (f) (if applicable) that a particular question, issue or matter falls outside the expert's field of expertise;

   (g) any examinations, tests or other investigations on which the expert has relied, identifying the person who carried them out and that person's qualifications;

   (h) the extent to which any opinion which the expert has expressed involves the acceptance of another person's opinion, the identification of that other person and the opinion expressed by that other person;

   (i) a declaration that the expert has made all the inquiries which the expert believes are desirable and appropriate (save for any matters identified explicitly in the report), and that no matters of significance which the expert regards as relevant have, to the

[2] Approved by the Council of Chief Justices' Rules Harmonisation Committee

knowledge of the expert, been withheld from the Court;

(j) any qualifications on an opinion expressed in the report without which the report is or may be incomplete or inaccurate;

(k) whether any opinion expressed in the report is not a concluded opinion because of insufficient research or insufficient data or for any other reason; and

(l) where the report is lengthy or complex, a brief summary of the report at the beginning of the report.

SUPPLEMENTARY REPORT FOLLOWING CHANGE OF OPINION

4. Where an expert witness has provided to a party (or that party's legal representative) a report for use in Court, and the expert thereafter changes his or her opinion on a material matter, the expert shall forthwith provide to the party (or that party's legal representative) a supplementary report which shall state, specify or provide the information referred to in paragraphs (a), (d), (e), (g), (h), (i), (j), (k) and (l) of clause 3 of this code and, if applicable, paragraph (f) of that clause.

5. In any subsequent report (whether prepared in accordance with clause 4 or not) the expert may refer to material contained in the earlier report without repeating it.

DUTY TO COMPLY WITH THE COURT'S DIRECTIONS

6. If directed to do so by the Court, an expert witness shall:

(a) confer with any other expert witness;

(b) provide the Court with a joint-report specifying (as the case requires) matters agreed and matters not agreed and the reasons for the experts not agreeing; and

(c) abide in a timely way by any direction of the Court.

CONFERENCE OF EXPERTS

7. Each expert witness shall:

(a) exercise his or her independent judgment in relation to every conference in which the expert participates pursuant to a direction of the Court and in relation to each report thereafter provided, and shall not act on any instruction or request to withhold or avoid agreement; and

(b) endeavour to reach agreement with the other expert witness (or witnesses) on any issue in dispute between them, or failing agreement, endeavour to identify and clarify the basis of disagreement on the issues which are in dispute.

ANNEXURE B

CONCURRENT EXPERT EVIDENCE GUIDELINES

APPLICATION OF THE COURT'S GUIDELINES

1. The Court's Concurrent Expert Evidence Guidelines ("**Concurrent Evidence Guidelines**") are intended to inform parties, practitioners and experts of the Court's general approach to concurrent expert evidence, the circumstances in which the Court might consider expert witnesses giving evidence concurrently and, if so, the procedures by which their evidence may be taken.

OBJECTIVES OF CONCURRENT EXPERT EVIDENCE TECHNIQUE

2. The use of concurrent evidence for the giving of expert evidence at hearings as a case management technique[3] will be utilised by the Court in appropriate circumstances (see r 23.15 of the *Federal Court Rules 2011* (Cth)). Not all cases will suit the process. For instance, in some patent cases, where the entire case revolves around conflicts within fields of expertise, concurrent evidence may not assist a judge. However, patent cases should not be excluded from concurrent expert evidence processes.

3. In many cases the use of concurrent expert evidence is a technique that can reduce the partisan or confrontational nature of conventional hearing processes and minimises the risk that experts become "opposing experts" rather than independent experts assisting the Court. It can elicit more precise and accurate expert evidence with greater input and assistance from the experts themselves.

4. When properly and flexibly applied, with efficiency and discipline during the hearing process, the technique may also allow the experts to more effectively focus on the critical points of disagreement between them, identify or resolve those issues more quickly, and narrow the issues in dispute. This can also allow for the key evidence to be given at the same time (rather than being spread across many days of hearing); permit the judge to assess an expert more readily, whilst allowing each party a genuine opportunity to put and test expert evidence. This can reduce the chance of the experts, lawyers and the judge misunderstanding the opinions being expressed by the experts.

5. It is essential that such a process has the full cooperation and support of all of the individuals involved, including the experts and counsel involved in the questioning process. Without that cooperation and support the process may fail in its objectives and even hinder the case management process.

[3] Also known as the "hot tub" or as "expert panels".

CASE MANAGEMENT

6. Parties should expect that, the Court will give careful consideration to whether concurrent evidence is appropriate in circumstances where there is more than one expert witness having the same expertise who is to give evidence on the same or related topics. Whether experts should give evidence concurrently is a matter for the Court, and will depend on the circumstances of each individual case, including the character of the proceeding, the nature of the expert evidence, and the views of the parties.

7. Although this consideration may take place at any time, including the commencement of the hearing, if not raised earlier, parties should raise the issue of concurrent evidence at the first appropriate case management hearing, and no later than any pre-trial case management hearing, so that orders can be made in advance, if necessary. To that end, prior to the hearing at which expert evidence may be given concurrently, parties and their lawyers should confer and give general consideration as to:

   (a) the agenda;

   (b) the order and manner in which questions will be asked; and

   (c) whether cross-examination will take place within the context of the concurrent evidence or after its conclusion.

8. At the same time, and before any hearing date is fixed, the identity of all experts proposed to be called and their areas of expertise is to be notified to the Court by all parties.

9. The lack of any concurrent evidence orders does not mean that the Court will not consider using concurrent evidence without prior notice to the parties, if appropriate.

CONFERENCE OF EXPERTS & JOINT-REPORT OR LIST OF ISSUES

10. The process of giving concurrent evidence at hearings may be assisted by the preparation of a joint-report or list of issues prepared as part of a conference of experts.

11. Parties should expect that, where concurrent evidence is appropriate, the Court may make orders requiring a conference of experts to take place or for documents such as a joint-report to be prepared to facilitate the concurrent expert evidence process at a hearing (see Part 7 of the Expert Evidence Practice Note).

PROCEDURE AT HEARING

12. Concurrent expert evidence may be taken at any convenient time during the hearing, although it will often occur at the conclusion of both parties' lay evidence.

13. At the hearing itself, the way in which concurrent expert evidence is taken must be applied flexibly and having regard to the characteristics of the case and the nature of the evidence to be given.

14. Without intending to be prescriptive of the procedure, parties should expect that, when evidence is given by experts in concurrent session:

(a) the judge will explain to the experts the procedure that will be followed and that the nature of the process may be different to their previous experiences of giving expert evidence;

(b) the experts will be grouped and called to give evidence together in their respective fields of expertise;

(c) the experts will take the oath or affirmation together, as appropriate;

(d) the experts will sit together with convenient access to their materials for their ease of reference, either in the witness box or in some other location in the courtroom, including (if necessary) at the bar table;

(e) each expert may be given the opportunity to provide a summary overview of their current opinions and explain what they consider to be the principal issues of disagreement between the experts, as they see them, in their own words;

(f) the judge will guide the process by which evidence is given, including, where appropriate:

(i) using any joint-report or list of issues as a guide for all the experts to be asked questions by the judge and counsel, about each issue on an issue-by-issue basis;

(ii) ensuring that each expert is given an adequate opportunity to deal with each issue and the exposition given by other experts including, where considered appropriate, each expert asking questions of other experts or supplementing the evidence given by other experts;

(iii) inviting legal representatives to identify the topics upon which they will cross-examine;

(iv) ensuring that legal representatives have an adequate opportunity to ask all experts questions about each issue. Legal representatives may also seek responses or contributions from one or more experts in response to the evidence given by a different expert; and

(v) allowing the experts an opportunity to summarise their views at the end of the process where opinions may have been changed or clarifications are needed.

15. The fact that the experts may have been provided with a list of issues for consideration does not confine the scope of any cross-examination of any expert. The process of cross-examination remains subject to the overall control of the judge.

16. The concurrent session should allow for a sensible and orderly series of exchanges between expert and expert, and between expert and lawyer. Where appropriate, the judge may allow for more traditional cross-examination to be pursued by a legal representative on a particular issue exclusively with one expert. Where that occurs, other experts may be asked to comment on the evidence given.

17. Where any issue involves only one expert, the party wishing to ask questions about that issue should let the judge know in advance so that consideration can be given to whether

arrangements should be made for that issue to be dealt with after the completion of the concurrent session. Otherwise, as far as practicable, questions (including in the form of cross-examination) will usually be dealt with in the concurrent session.

18. Throughout the concurrent evidence process the judge will ensure that the process is fair and effective (for the parties and the experts), balanced (including not permitting one expert to overwhelm or overshadow any other expert), and does not become a protracted or inefficient process.

SH-2

Dear Mr Hutcheon,

APPLICATIONS TO VARY MODERN AWARDS – WORK VALUE - AGED CARE INDUSTRY AM2020/99, AM2021/63, AM2021/65

We refer to our letter of instruction dated 19 September 2023 (**the Letter**).

The Letter included four questions in relation to enrolled nurses (**ENs**), registered nurses (**RNs**) and nurse practitioners (**NPs**) working in aged care, in circumstances where the modern award rates that apply to those classifications were increased by *"35%"* (see Questions 9-12 at [2.1] of the Letter). As noted at [1.7]-[1.8] of the Letter, those questions were formulated by reference to an earlier submission of the ANMF.

Since providing the Letter, we have had the opportunity to review the following material filed by the ANMF in Stage 3 of the Work Value Case:

1. A Draft Determination for the Nurses Award prepared by the ANMF (**ANMF Draft Determination**); and

2. A marked-up copy of the Nurses Award, incorporating the variations set out in the ANMF Draft Determination (**Marked-up Award**).

For your review, we **attach** copies of both documents to this email.

Having reviewed the ANMF Draft Determination and Marked-up Award (see pages 21-24), we note that the ANMF propose an increase of **18.11%** to the minimum award rates for all EN, RN and NP classification levels working in aged care (including student ENs working in aged care).

FURTHER INSTRUCTIONS

We request that in answering Questions 9-12 of the Letter that you replace each reference to *"35%"* with *"18.11%"*.

If you have any questions, please do not hesitate to contact me.

Yours sincerely,

Claire

Claire Bailey
Head of Workplace Relations

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DARLINGHURST NSW 2010

ACCPA Expert Witness Report
Financial Effect of FWC Award Increase

October 2023

CONTENTS

1. Executive Summary

1.1 Background

The Aged & Community Care Providers Association (ACCPA) is participating in the Work Value Case - Aged Care Industry (*Work Value Case*) proceedings conducted by the Fair Work Commission (the Commission).

Following Stage 1 and Stage 2 of the *Work Value Case*, the Commission published two decisions that had the effect of varying the *Aged Care Award 2010*, *Nurses Award 2020* and *Social, Community, Home Care and Disability Services Industry Award 2010* (SCHADS Award) (collectively, the Awards) on the basis of work value reasons.

This included increasing the minimum award wages of the following classifications by 15%:

(a) Personal Care Workers (PCWs) under the Aged Care Award 2010;
(b) Home Care employees providing services to an aged person under the SCHADS Award;
(c) Nursing employees working in aged care under the Nurses Award 2020;
(d) "Head Chefs/Cooks" under the Aged Care Award chef or cook engaged in a facility);
(e) Recreational activities officers/lifestyle officers (RAOs) under the Aged Care Award.

The increase of 15% to the minimum award wages in the Awards took effect from 30 June 2023 and was described as an "interim increase", with a final determination about wage increases to be made at the completion of Stage 3 of the *Work Value Case*.

1.2 Purpose of the Expert Witness Report

ACCPA have asked Stuart Hutcheon, Managing Partner, StewartBrown, to provide an Expert Witness Report (refer *Appendix A* Letter of Instruction) to address the following specific areas:-

- Current financial position of the aged care sector
- Analysis with respect to 10% increase in *Aged Care Award*, *Nurses Award* and *SCHADS Award*
- Analysis with respect to 25% increase in Indirect Care workers
- Analysis with respect to 18.11% increase in *Nurses Award (as per amended letter of instruction)*
- Analysis with respect to staffing in the aged care sector

1.3 Conclusion

Section 3 includes an analysis with respect to the areas noted above. A summary of the analysis is as follows:-

- The current financial position and sustainability of the aged care sector is at a very vulnerable level. Residential aged care has experienced significant operating losses for over the last four years with the operating deficit for the 2022-23 financial year representing $1.05 billion ($16.54 per bed day). Home care operating results have declined to be of a marginal level and were $3.14 per client day
- A 10% increase for direct care workers (including ROAs) would increase staffing costs by an estimated $1,148 million per annum and the aged care sector would not have the ability to absorb this without being fully funded by the Government
- A 25% increase for residential indirect care workers would increase staffing costs by a further estimated $763 million per annum (excluding the impact of the 10% increase noted above) and the residential aged care sector would not have the ability to absorb this without being fully funded by the Government
- A 18.11% increase for nursing employees covered by the *Nurses Award* would increase staffing costs by a further estimated $1,074 million per annum (excluding the impact of the 10% increase and 25% increase noted above) and the aged care sectors would not have the ability to absorb this without being fully funded by the Government
- There exists a significant workforce shortage which impacts the ability of residential aged care and home care Providers to maintain adequate staffing levels without using agency staff or overtime which comes at a significant additional cost

2. Aged Care Financial Performance Survey

2.1 StewartBrown

StewartBrown is a medium sized Chartered Accounting firm principally located in Chatswood, Sydney (www.stewartbrown.com.au). The firm currently consists of 10 Partners and over 90 employees providing professional services including Audit, Consulting, Business Services, Taxation and Financial Planning.

StewartBrown provides these professional services nationally to a range of clients, however, we have a speciality expertise in aged care and community services, social services, independent schools, children's services and disability services.

With respect to aged care and community services, StewartBrown have more than 45 professional staff actively providing professional services to the sector nationally including:

- Audit and assurance;
- Preparation of general purpose financial statements;
- Annual Prudential Compliance audits;
- Government Community Grant Acquittals;
- Governance reviews (including Board and Executive);
- Finance systems and process reviews;
- Financial modelling and forecast assignments;
- Finance secondments;
- Conference presentations and sector workshops; and
- Briefings to Department of Health and the Aged Care.

StewartBrown is not an advocate for any stakeholder in the sector and has relationships with the Department of Health and Aged Care (DoHAC), sector peak bodies (including ACCPA and COTA), Provider organisations, aged care staff and aged care residents and clients.

The primary agenda of StewartBrown is that all financial policy and related public commentary should be evidenced based, objective and supported by accurate data.

2.2 StewartBrown Aged Care Financial Performance Survey

StewartBrown undertakes the largest financial performance benchmarking survey covering the aged and community care sector in Australia. This Survey includes detailed operational, equity and staffing data on a quarterly basis for residential aged care facilities and home care packages. The *Aged Care Financial Performance Survey* (Survey) commenced in 1995 and has grown substantially due to the benefits for Boards and executive management to be able to compare their operations to that of other facilities and programmes within the sector.

Subscribers to the Survey include some of the largest Providers nationally, independent stand-alone Providers, faith-based and community Providers, for-profit (FP) Providers, culturally specific Providers, as well as Government bodies, including the DoHAC, aged services sector peak bodies, consumer bodies and other service Providers.

The Survey provides quarterly financial and non-financial data for residential (by aged care home) and home care (by program) at a granular level. In addition, the Survey obtains specific segment information and key balance sheet information at organisation (approved provider) level every six months.

The Survey now incorporates detailed financial and supporting data from over 1,200 Residential Aged Care Homes and over 600 Home Care programs (over 71,000 packages) across Australia. The quarterly Survey gives invaluable insights into the trends and drivers of financial performance at the sector level, and at the individual home or program level, representing over 40% of the residential aged care sector and over 30% of the home care package sector.

The Survey includes a broad range of residential aged care Providers, including all of the largest not-for-profit (NFP) Providers, a majority of medium to small sized NFP Providers, Community Providers and a representative range of FP Providers subject to the exclusion of outliers as noted below). The Survey participants do not include the ASX listed entities, two large FP Providers and Government owned Providers.

Over the years, the format of the results of the Survey has become more granular in content and has become an integral part of the strategic, budgeting, forecasting, financial management and review processes within the participant Provider organisations.

StewartBrown's involvement in the aged care sector over 30 years has provided a unique and comprehensive knowledge of the financial performance of Providers and of the financial performance and viability of the aged care sector.

Aged Care Survey Reports

StewartBrown issues a range of reports based on Survey and other data. Regular reports include:

Report Name	Report Description	Frequency
Sector Report	Commentary on both residential aged care and home care and organisational data (where collected) including trends and commentary around sustainability, reforms and other observations	Quarterly
Residential Care Report	Aimed at residential aged care participants of the Survey and contains more granularity in relation to statistics presented particularly in relation to benchmark revenue bands and geographic location	Quarterly
Home Care Report	Aimed at home care package participants of the Survey and contains more granularity in relation to statistics presented particularly in relation to benchmark revenue bands and geographic location	Quarterly
Corporate Administration Costs	Analysis of the corporate administration costs of aged care Providers (separate data set to main Survey)	Annually
Listed Entity Report	Analysis of results of aged care entities listed on ASX based on published reports	Six Monthly

A range of other ad-hoc reports and fact sheets are also released. The respective Survey reports provide commentary on sector trends, specific observations regarding individual KPIs or other metrics as well as a considerable number of data tables and trend graphs to support the commentary and allow for stakeholders to undertake their own analysis. Participants in the Survey also receive a detailed report on individual benchmarks which they can use as part of their internal reporting or to use to undertake their own analysis of their financial performance against specific benchmarks.

The Survey is primarily for the benefit of aged care Providers in reviewing their financial performance and considerations of strategic direction on an individual aged care facility basis and home care package program basis and the participant reports are designed for that purpose.

Providers compare their performance on a number of metrics with facilities (in this instance) through a range of data attributes, including resident mix and acuity, staffing levels (cost and hours/minutes), geographic region, age of building, size of building, number of places (beds), accommodation pricing and administration costs. Home care has a similar specific range of metrics. The Survey participants utilise an interactive website with high level dashboards, business intelligence tools and the ability to drill down on all data fields as required.

A secondary benefit is that the aggregate of the data provides a significant level of trend data and detailed analysis as included in the Survey reports and more recently through independent analysis undertaken by the University of Technology (UTS Ageing Research Collaborative) which provides an additional level of academic rigour.

This aggregate data is the basis for the Sector reports which is aimed more at providing insights on how the aged care sector, or segments of it, are performing financially. It is not as concerned with providing commentary at an individual facility level - this type of analysis is contained in the participant reports. The sector reports are focused on overall trends at the Approved Provider and sector levels. This includes the effects of Government policy and changes in the operating environment on financial performance.

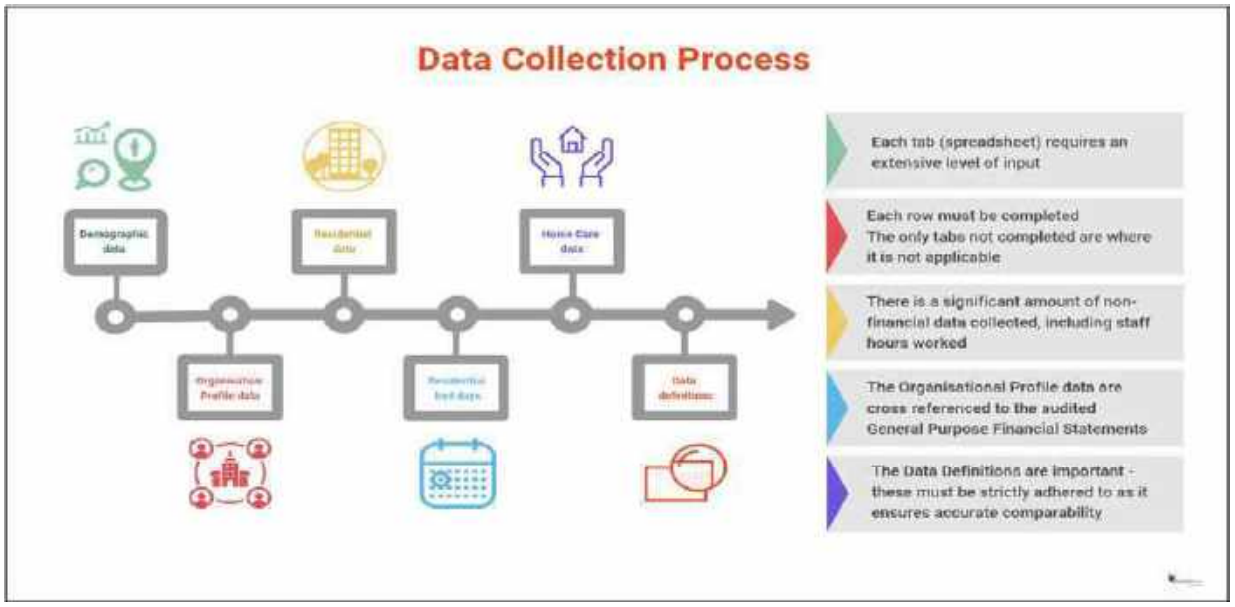
The Survey reports are drafted using graphics and data tables and this is prepared by members of the StewartBrown data analyst team. The information contained in the graphs and tables and other sources is then disseminated and the reports are then written by or reviewed by Stuart Hutcheon before release to the participants or in the case of the Sector report, to the public.

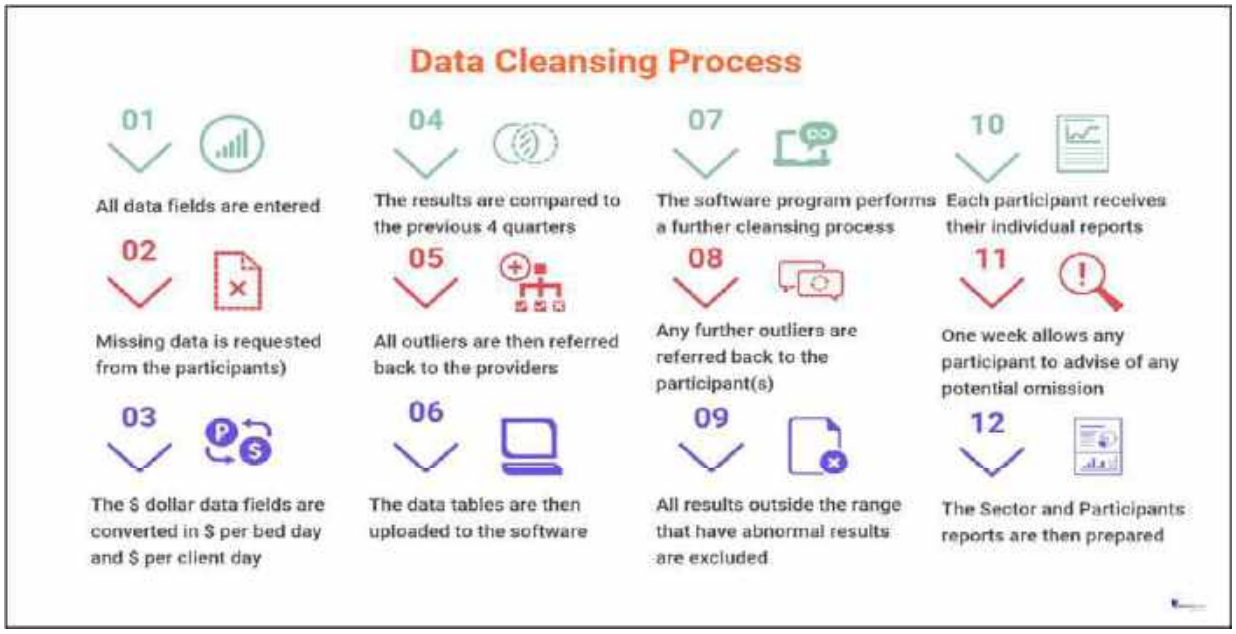
Additionally, for each quarter a separate briefing is provided to DoHAC on the latest results and financial trends. Prior to the release of the Sector reports a comprehensive quality control review is performed by two other StewartBrown Partners and senior personnel within the firm.

Data Collection and Cleansing Process

Data is collected from participants using an Excel workbook which contains all input cells as well as detailed instructions for completion and definitions for each line item of data being collected. The workbook is returned to StewartBrown and then undergoes a detailed cleansing process by a team of 10 analysts before data is imported to the database software. The cleansed data is further reviewed by Stuart Hutcheon and other Partners at this stage, and again prior to drafting the Sector report. The following diagrams outline the data collection and cleansing processes.

It should be noted that Survey data has been scrutinised and utilised by the Productivity Commission and the Royal Commission into Quality and Safety in Aged Care including for the periods which is the focus of this expert report.





As noted above, the primary purpose of the Survey is for participating Providers to benchmark individual aged care facility and home care programs against similar de-identified comparators using a range of metrics. To ensure accurate and relevant benchmark comparisons, all outlier aged care facilities and home care programs are excluded from the Survey results. Examples of outliers include:

- Facilities/programs under sanction
- Facilities with significant infectious disease outbreaks (such as Covid-19)
- Facilities undergoing major refurbishment
- Newly built facilities still in the commissioning stage
- Recently acquired facilities/programs undergoing structural operation changes
- Facilities/programs closed during the financial year (and reporting period)

Using Survey Data to Assess Financial Performance

The considerable data outcomes from the Survey enables the participating Provider to access detailed comparisons of their performance to groups of other homes with similar characteristics such as:

- Size of home or Provider
- Location or other geographical features
- Revenue base (at a home level or at a Provider level)
- Asset base (at a Provider level)
- Age of home

The comparisons are generally made using ratios or by breaking the data into common units, in the case of aged care homes, “dollars per occupied bed day”. By using a common denominator such as occupied bed days it allows for the financial performance of homes or groups of homes to be compared across multiple periods and to other homes, groups of homes, or the sector generally.

The Survey is widely acknowledged as being good indicator of the financial performance of aged care homes and the sector generally. This acknowledgement is demonstrated by the referencing of Survey data by various bodies including the (former) Aged Care Financing Authority, Department of Health and Aged Care, Royal Commission into Aged Care Quality and Safety and more recently the Minister for Aged Care, Anika Wells MP as well as by Providers, peak industry bodies and other sector stakeholders.

3. Responses to Letter of Instruction

3.1 Current Financial Status of the Aged Care Sector

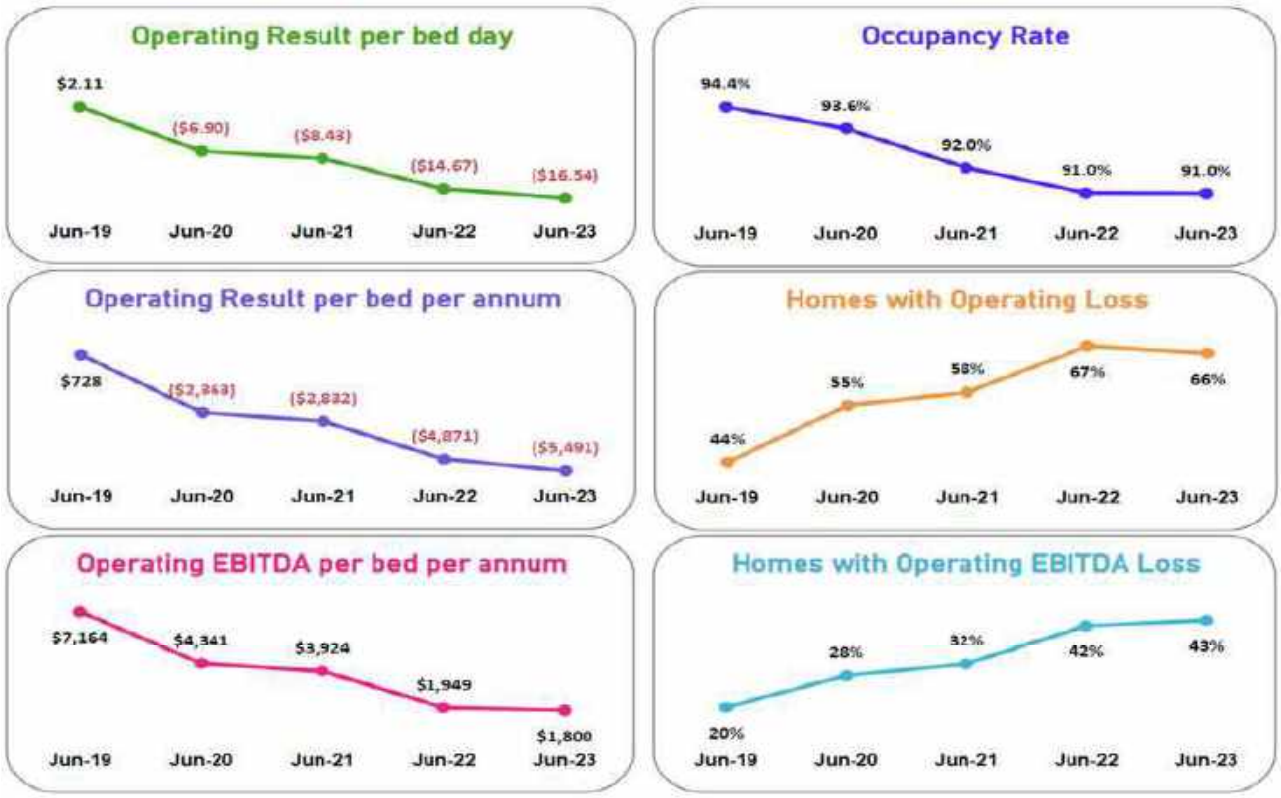
Residential Aged Care

The current financial performance of the aged care sector based on the results of the recent Survey Report comprising data for the financial year ended 30 June 2023 (refer *Appendix B*) is summarised below.

The average operating results for residential aged care homes across all geographic sectors was an operating loss of $16.54 per bed day *(FY22 $14.67 pbd loss)*. This represents an operating loss of $5,491 per bed per annum, and a continuation of losses for over four successive years. Extrapolating the deficit per bed represents a **loss in the residential aged care segment in excess of $1.05 billion** for the 2022-23 financial year.

The below graphs provide a summary of the key financial indicators.

Figure 1: Residential Aged Care FY23 key financial indicators (Source: StewartBrown Survey, June 2023)

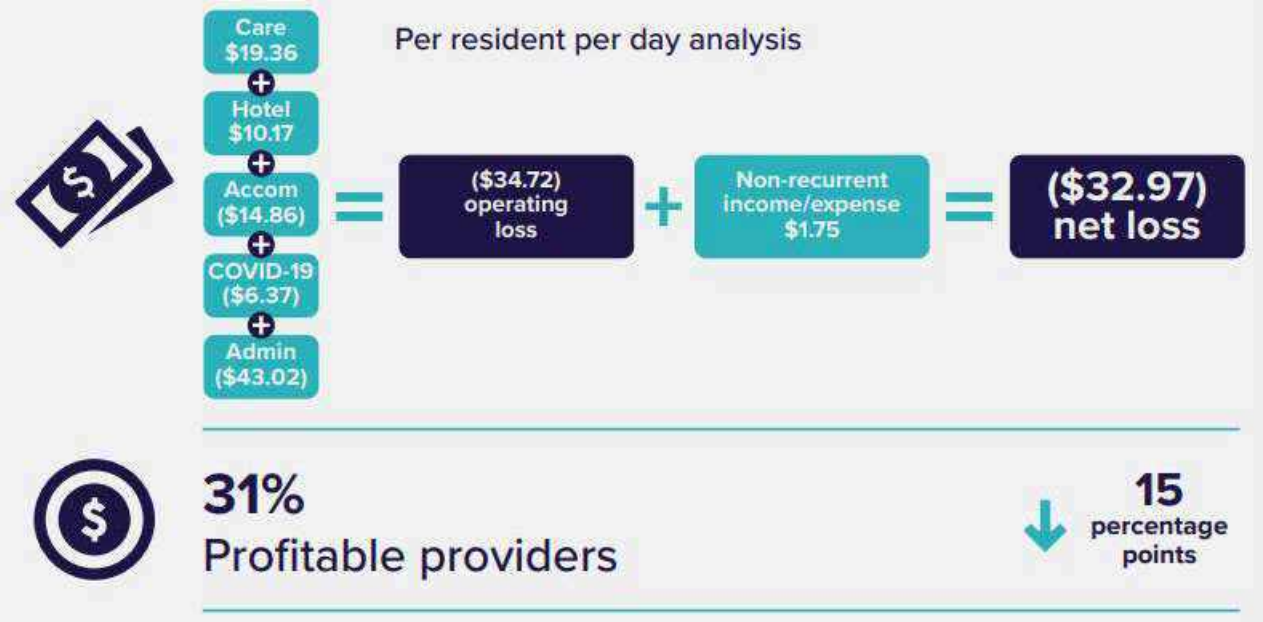


Financial Report on the Australian Aged Care Sector

The Department of Health and Aged Care "*2021-22 Financial Report on the Australian Aged Care Sector*" (Department Report) was released in August 2023 and covered the 2021-22 financial year. The financial performance was sourced from the Aged Care Financial Report that Approved Providers must lodge with the Department as required under the *Aged Care Act 1997*.

The Department Report confirms the overall results from the StewartBrown Survey for the 2022 financial year, and states "The residential care sector operated at a loss of $2.264 billion in total" (page 9). The Department Report also notes that only 31% of Providers were profitable (refer *Figure 2*).

Figure 2: FY22 Residential Aged Care Financial Performance (Source: Department of Health and Aged Care)



Home Care Packages

The home care package (HCP) financial performance has continued to decline over recent years with the national average operating result for FY23 being $3.14 per client per day (FY22 $3.98 per client day). Revenue utilisation (amount of funding actually utilised providing care services) was 84.3% (meaning the remaining 15.7% was effectively not used to provide care services).

Unspent funds (being the corollary of revenue utilisation) amounted to an average of $12,604 per client (in excess of $2.9 billion nationally). Over 96% of unspent funds are not utilised by the recipient and, accordingly, returned to the Government.

The below graphs provide a summary of the key financial indicators.

Figure 3: HCP FY23 key financial indicators

The Department Report for FY22 notes "The home care sector remains profitable, however there was a decrease in profitability for the 2021–22 financial year. In 2021–22, EBITDA per home care recipient per year was $1,232, down from $1,792 in 2020–21." (page 10).

3.2 Direct Care Workers (including ROAs)

If the *Aged Care Award*, *Nurses Award* and *SCHADS Award* are varied such that the modern award rates that apply to PCWs, AINs (working in aged care), RAOs and home care employees (providing services to an aged person) under the Awards are increased by 10%.

Table 1: Impact of 10% increase for direct care workers (including ROAs and excluding RNs)

	Sector $ million	For Profit $ million	Not For Profit $ million	1 Home $ million	1-6 Homes $ million	7-19 Homes $ million	20+ Homes $ million
Residential (PCW/ROA)	**923**	363	512	177	201	208	338
Home Care workers	**225**						
	1,148						

In summary the impact of a 10% increase in the award will have the following estimated effect:-

- $1,148 million increase in staffing costs
- $923 million increase in residential staffing costs and $225 million increase in home care staffing costs. The variance in $ terms is due to the higher number of residential staffing costs, but the overall financial effect will be similar in percentage terms for both segments
- The impact on home care is different to the extent that the price charged to the consumer (care recipient) will be required to be increased to meet the increased staff costs and this will introduce a possible time lag issue for home care Providers that is not present for residential care even if funding is aligned to the increase
- For-profit (private) Providers will have a slighter higher impact due to the requirement to remit payroll tax. In an aggregate sense, *Table 1* shows the estimated impact for each segment, however from an individual Provider perspective the impact between each segment will be less due to the relationship between the subsidy funding and the staffing cost are materially similar

The ability for the aged care sector to financially tolerate a 10% award increase that is not fully funded by the Federal Government is virtually nil. *Figure 4* below shows that for residential aged care the FY23 average operating deficit of $16.54 per bed day would deteriorate to a deficit $29.98 per bed day.

Figure 5 shows that for home care the FY23 average operating surplus of $3.14 per client day would deteriorate to a small surplus of $0.90 per client day which is marginal and insufficient to remain sustainable in the short to medium term. This also assumes that Providers can pass on the effect of the increase to consumers through higher service prices.

Figure 4: Impact of 10% award increase for PCW/ROA workers in residential aged care ($ per bed day)

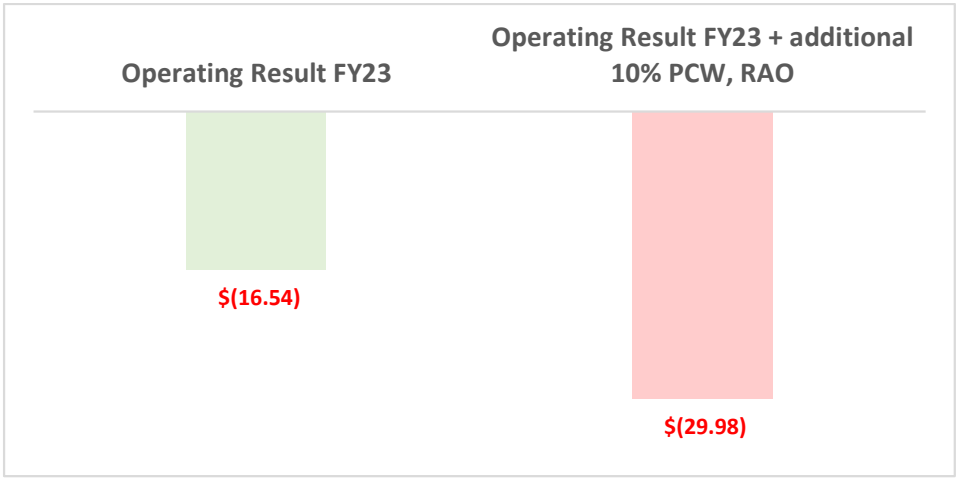
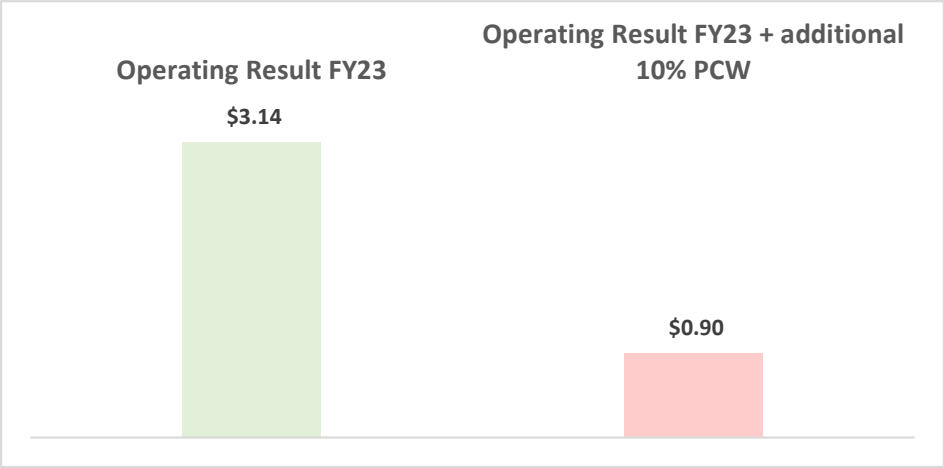


Figure 5: Impact of 10% award increase for home care employees ($ per client day)



3.3 Indirect Care Workers (excluding ROAs)

If the *Aged Care Award* is varied such that the modern award rates that apply to food services employees, general services employees and administrative services employees are increased by 25%.

Table 2: Impact of 25% increase for indirect care workers (excluding ROAs)

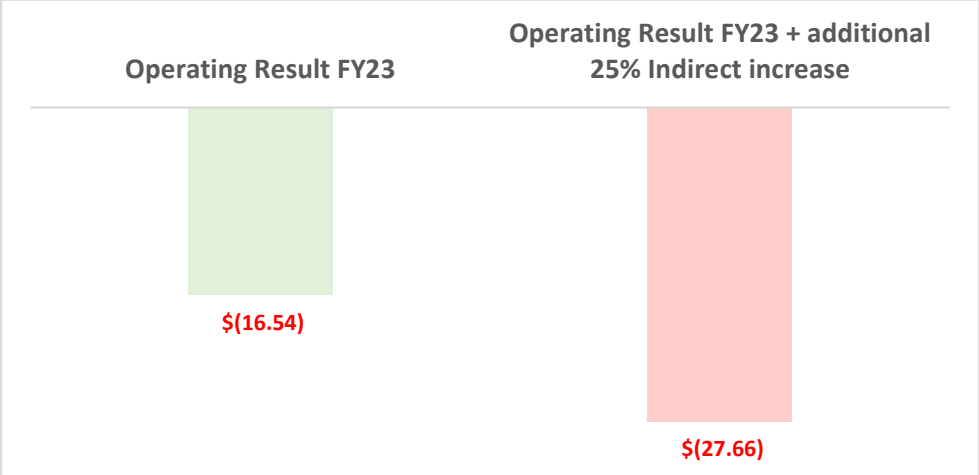
	Sector $ million	For Profit $ million	Not For Profit $ million	1 Home $ million	1-6 Homes $ million	7-19 Homes $ million	20+ Homes $ million
Residential (Indirect care)	**763**	326	421	200	173	169	251

In summary the estimated impact of a 25% increase in the award will have the following effect:-

- $763 million increase in staffing costs
- For-profit (private) Providers will have a slighter higher impact due to the requirement to remit payroll tax. In an aggregate sense, *Table 2* shows the impact for each segment, however from an individual Provider perspective the impact between each segment will be less due to the staffing costs providing indirect care services are substantially the same (percentage wise)

The ability for the aged care sector to financially tolerate a 25% award increase that is not fully funded by the Federal Government is virtually nil. *Figure 6* below shows that for residential aged care the FY23 average operating deficit of $16.54 per bed day would deteriorate to a deficit $27.66 per bed day. *This excludes the impact of the 10% increase for residential direct care workers as detailed in Table 1 and Figure 4.*

Figure 6: Impact of 25% award increase for indirect care workers in residential aged care ($ per bed day)



3.4 Nursing Employees: ENs, RNs and NPs

If the Nurses Award is varied such that the modern award rates that apply to enrolled nurses, registered nurses and nurse practitioners working in aged care are increased by 18.11%.

Table 3: Impact of 18.11% increase for nursing employees (RN/EN/NP)

	Sector $ million	For Profit $ million	Not For Profit $ million	1 Home $ million	1-6 Homes $ million	7-19 Homes $ million	20+ Homes $ million
Residential (RN/EN/NP)	**858**	356	474	170	183	201	308
Home Care workers	**216**						
	1,074						

In summary the estimated impact of a 18.11% increase in the award will have the following effect:-

- $1,074 million increase in staffing costs
- $858 million increase in residential staffing costs and $216 million increase in home care staffing costs. The variance in $ terms is due to the higher quantum of residential staffing costs, but the overall financial effect will be similar in percentage terms for both segments
- The impact on home care is different to the extent that the price charged to the consumer (care recipient) will be required to be increased to meet the increased staff costs and this will introduce a possible time lag issue for home care that is not present for residential care even if funding is aligned to the increase
- For-profit (private) Providers will have a slighter higher impact due to the requirement to remit payroll tax. In an aggregate sense, *Table 3* shows the impact for each segment

The ability for the aged care sector to financially tolerate a 18.11% award increase that is not fully funded by the Federal Government is virtually nil. *Figure 7* below shows that for residential aged care the FY23 average operating deficit of $16.54 per bed day would deteriorate to a deficit $29.05 per bed day.

Figure 8 shows that for home care the FY23 average operating surplus of $3.14 per client day would deteriorate to a marginal surplus of $0.99 per client day.

This excludes the impact of the 10% increase for direct care workers as detailed in Table 1 and Figures 4 and 5, and the 25% increase for residential aged care indirect care workers as detailed in Table 2 and Figure 6.

Figure 7: Impact of 18.11% award increase for nursing employees in residential aged care ($ per bed day)

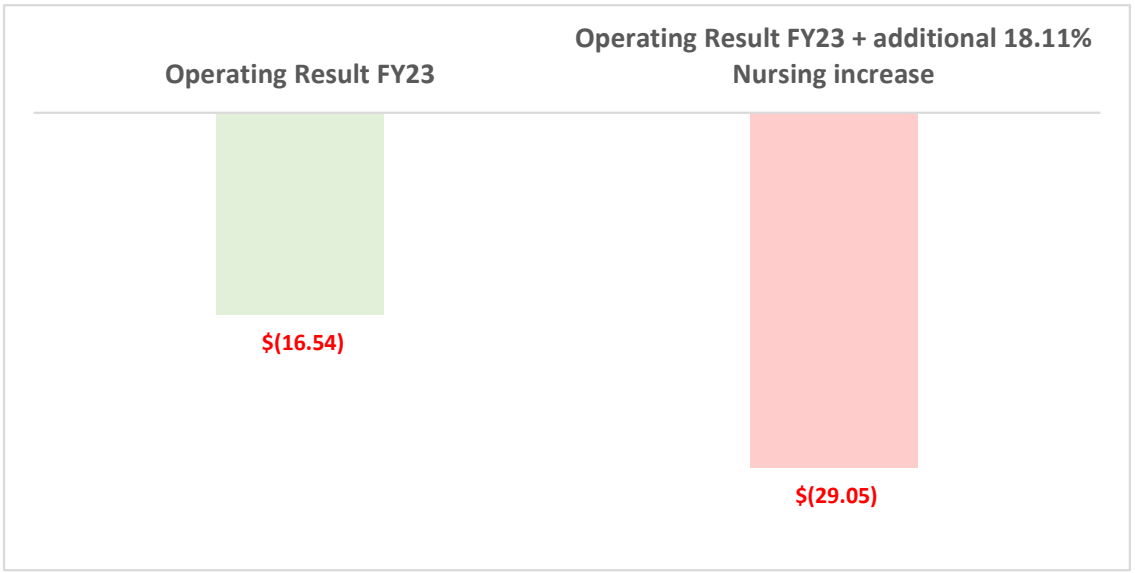
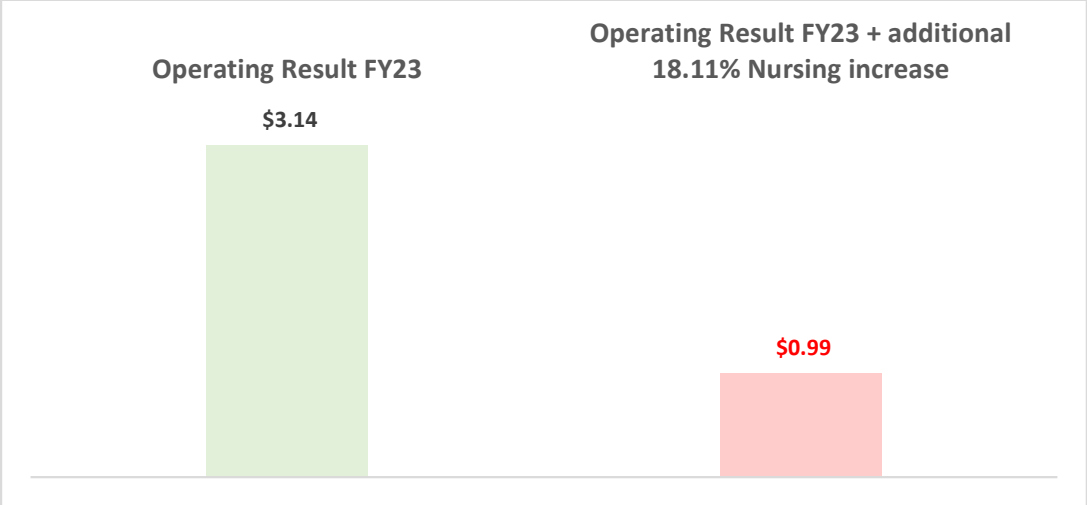


Figure 8: Impact of 18.11% award increase for nursing employees in home care ($ per client day)



3.5 Staffing in the Aged Care Sector

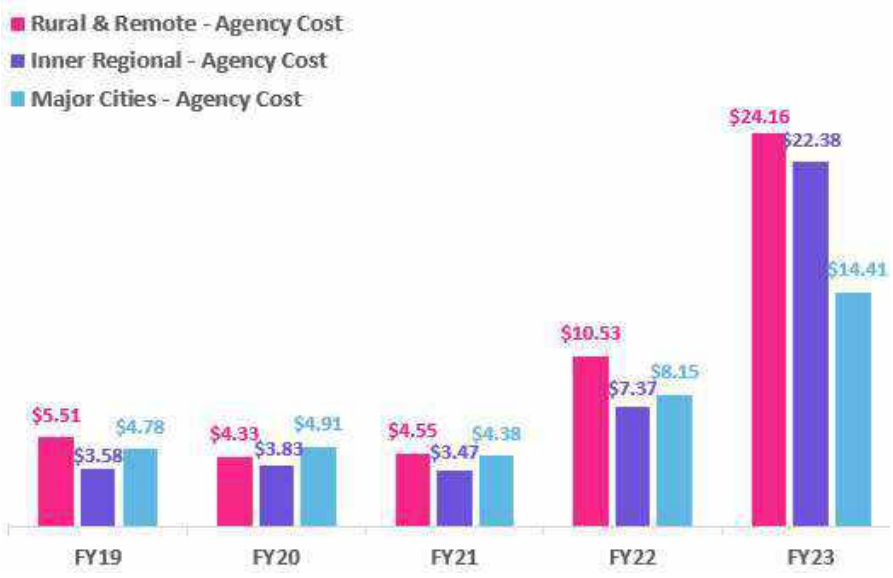
The DoHAC provides no specific data in relation to workforce staffing and shortages in particular. The Committee for Economic Development of Australia (CEDA) released a report "*Duty of Care: Aged-Care Sector Running on Empty*" (2023) which included the following comments:-

- "Workforce shortages in the aged-care sector are driving low occupancy rates and many facilities are unable to operate at full capacity" (page 3)
- "Consultation with a wide range of industry stakeholders including aged-care Providers, industry groups and other stakeholders, suggests some homes are now operating at just 50 per cent capacity due to workforce shortages. At the same time, demand is high, with long wait lists" (page 5)

Whilst not specifically stated, the workforce shortages referred to in the CEDA report would encompass each of the staffing categories for aged care employees in both residential aged care and home care.

The StewartBrown Survey Report for FY23 included the following graph (page 17) which highlighted the increased agency costs for the residential direct care staff (RN/EN/PCW). The increase in agency costs is a direct reflection of the workforce shortages as agency staff are used to cover absences in shifts and enable proper care to be delivered to the residents.

Figure 9: Agency Direct Care staff costs trend by region ($ per bed day)



Aged & Community Care Providers Association
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19 September 2023

PRIVATE AND CONFIDENTIAL

Stuart Hutcheon
Partner
Audit & Assurance Division
StewartBrown
Level 2, Tower 1/495 Victoria Ave
Chatswood, New South Wales 2067
PO BOX 5515, Chatswood, NSW, 2057

Dear Mr Hutcheon,

APPLICATIONS TO VARY MODERN AWARDS – WORK VALUE - AGED CARE INDUSTRY AM2020/99, AM2021/63, AM2021/65

The Aged & Community Care Providers Association (**ACCPA**) is participating in the Work Value Case - Aged Care Industry (**Work Value Case**) proceedings conducted by the Fair Work Commission (the **Commission**).

1. BACKGROUND

1.1 Following Stage 1 and Stage 2 of the *Work Value Case*, the Commission published two decisions[1] that had the effect of varying the *Aged Care Award 2010*, *Nurses Award 2020* and *Social, Community, Home Care and Disability Services Industry Award 2010* (**SCHADS Award**) (collectively, **the Awards**) on the basis of work value reasons. This included increasing the minimum award wages of the following classifications by 15%:

(a) personal care workers (**PCWs**) under the *Aged Care Award*;

(b) home care employees providing services to an aged person under the *Social, Community, Home Care and Disability Services Industry Award 2010* (**SCHADS Award**);[2]

(c) nursing employees working in aged care under the *Nurses Award*;[3]

[1] *Stage 1 decision* [2022] FWCFB 200; *Stage 2 decision* [2023] FWCFB 40.
[2] By reasons for decision ([2023] FWCFB 93), the Commission confirmed that home care employees levels 4 and 5 in the SCHADS Award are *"direct care workers"*.
[3] The *Nurses Award* was also varied to include a definition of *"aged care employee"* – namely, an employee engaged in the provision of: services for aged persons in a hostel, nursing home, aged care independent living units, aged care serviced apartments, garden settlement, retirement village or any other residential accommodation facility; or services for an aged person in a private residence (see clause 2 of the *Nurses Award*).

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(d) *"Head Chefs/Cooks"* under the *Aged Care Award* (Aged care employee levels 4-7 provided the employee is the most senior chef or cook engaged in a facility); and

(e) recreational activities officers/lifestyle officers (**RAOs**) under the *Aged Care Award*.

1.2 The increase of 15% to the minimum award wages in the Awards took effect from 30 June 2023 and was described as an *"interim increase"*, with a final determination about wage increases to be made at the completion of Stage 3 of the *Work Value Case*. These issues will need to be determined before the *Work Value Case* is finalised.

1.3 On 2 August 2023, the Commission published a timetable together with a summary of issues for Stage 3 of the *Work Value Case*. The balance of the proceedings have been divided into two tranches:

(a) wage adjustment issues; and

(b) classifications and allowance issues.

1.4 Both sets of issues will be determined by an Expert Panel appointed by President Hatcher.

Status of Applications before the Commission: Wage Adjustment Issues

1.5 The table below outlines the minimum wage increases sought by the union parties with respect to each classification under the Awards.

Employees subject to the Claim	**Minimum Wage Increase proposed by Claim**
PCWs under the *Aged Care Award*	10%
RAOs under the *Aged Care Award*	10%
Home care employees (providing services to an aged person) under the *SCHADS Award*	10%
Assistants in nursing (**AINs**) working in aged care under the *Nurses Award.*	10%
The general and administrative services stream in the *Aged Care Award,* including: laundry, cleaning, maintenance, gardening, and administrative employees.	25%
The food services stream in the *Aged Care Award,* including: food assistants, servery employees, kitchenhands, cooks, and chefs.	25%

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1.6 For the purposes of Stage 3, the employees classified under the *Aged Care Award* that perform work in the general and administrative services stream or food services stream are collectively referred to as *"indirect care workers"*.

1.7 On 25 July 2023, the ANMF intimated it intends to file an amended application that would seek *"a benchmarking of the Registered Nurse Level 1, pay point 1, with the C1(a) of the Metals Framework"* (as opposed to a further 10% for the remaining nursing employees working in aged care).[4] Consistent with the observations made by the Full Bench in the *Stage 1 decision*,[5] the ANMF submitted that the consequence of that course would be *"a 35% [wage] increase"* for the registered nurse working in aged care.[6]

1.8 In submissions dated 15 September 2023, the ANMF submitted that upon making that benchmarking adjustment to the registered nurse level 1 pay point 1, the Commission should retain the inter icable to enrolled nurses (including student urse practitioners working in ged care. As a ANMF are yet to file an ame d application.

1.9 The Comm as directed ACC ness Industrial) to file evidenc missions in rela ssues by **5:00pm (AEST) on tober 2023**.

2. INSTRUCT

2.1 We need y ort that addresse g questions:

Current Fi e Sector

1. Wh e aged care sect oth residential and hom

Direct care

2. If th *ADS Aw d* are varied such that the modern award rates that apply to PCWs, AINs (working in aged care), RAOs and home care employees (providing services to an aged person) under the Awards are increased by 10%, what will be the economic impact on the aged care sector (both residential and home care)?

3. If the *Aged Care Award, Nurses Award* and *SCHADS Award* are varied such that the modern award rates that apply to PCWs, AINs (working in aged care), RAOs and home care employees (providing services to an aged person) under the Awards are increased by 10%, will there be any difference in the financial impact to the aged care sector between residential care and home care?

[4] Transcript of Proceedings - AM2020/99, AM2021/63, AM2021/65 (9.30am, Tuesday, 25 July 2023) at PN63.
[5] See *Stage 1 decision* [2022] FWCFB 200 at [945].
[6] Ibid.

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4. If the *Aged Care Award*, *Nurses Award* and *SCHADS Award* are varied such that the modern award rates that apply to PCWs, AINs (working in aged care), RAOs and home care employees (providing services to an aged person) under the Awards are increased by 10%, will any particular part of the aged care sector (for example, private, not for profit, small, large) be impacted more than others and if so how and why?

5. If the *Aged Care Award*, *Nurses Award* and *SCHADS Award* are varied such that the modern award rates that apply to PCWs, AINs (working in aged care), RAOs and home care employees (providing services to an aged person) under the Awards are increased by 10%, what is the ability for the aged care sector to financially tolerate a 10% increase that is not fully funded by the Federal Government?

Indirect care workers (excluding RAOs)

6. If the *Aged Care Award* is varied such that the modern award rates that apply to food services employees[7], general services employees[8] and administrative services employees are increased by 25%, what will be the economic impact on the aged care sector?

7. If the *Aged Care Award* is varied such that the modern award rates that apply to food services employees[9], general services employees[10] and administrative services employees are increased by 25%, will any particular part of the aged care sector (for example, private, not for profit, small, large) be impacted more than others and if so how and why?

8. If the *Aged Care Award* is varied such that the modern award rates that apply to food services employees[11], general services employees[12] and administrative services employees are increased by 25%, what is the ability for the aged care sector to financially tolerate a 25% increase that is not fully funded by the Federal Government?

Nursing employees: ENs, RNs and NPs

9. If the *Nurses Award* is varied such that the modern award rates that apply to enrolled nurses, registered nurses and nurse practitioners working in aged care[13] are increased by 35%, what will be the economic impact on the aged care sector (both residential and home care)?

ADF REVIEW

[7] This includes food assistants, servery employees, kitchenhands, cooks and chefs.
[8] This includes laundry, cleaning, maintenance and gardening employees.
[9] This includes food assistants, servery employees, kitchenhands, cooks and chefs.
[10] This includes laundry, cleaning, maintenance and gardening employees.
[11] This includes food assistants, servery employees, kitchenhands, cooks and chefs.
[12] This includes laundry, cleaning, maintenance and gardening employees.
[13] An *"aged care"* nursing employee under the *Nurses Award* is engaged in the provision of services for aged persons *"in a hostel, nursing home, aged care independent living units, aged care serviced apartments, garden settlement, retirement village or any other residential accommodation facility"* or *"in a private residence"*.

10. If the *Nurses Award* is varied such that the modern award rates that apply to enrolled nurses, registered nurses and nurse practitioners working in aged care[14] are increased by 35%, will there be any difference in the financial impact to the aged care sector between residential care and home care?

11. If the *Nurses Award* is varied such that the modern award rates that apply to enrolled nurses, registered nurses and nurse practitioners working in aged care[15] are increased by 35%, will any particular part of the aged care sector (for example, private, not for profit, small, large) be impacted more than others and if so how and why?

12. If the *Nurses Award* is varied such that the modern award rates that apply to enrolled nurses, registered nurses and nurse practitioners working in aged care[16] are increased by 35%, what is the ability for the aged care sector to financially tolerate a 35% increase that is not fully funded by the Federal Government?

Staffing in the aged care sector

13. For employers/providers in the aged care sector, what is the current state of the employment market in the aged care sector with respect to the supply and demand for staff in both residential and home care. To the extent possible, please make reference to the following categories of employee:

    (a) PCWs (including AINs) working in residential aged care facilities;

    (b) enrolled nurses working in aged care[17];

    (c) registered nurses working in aged care[18];

    (d) nurse practitioners working in aged care[19];

    (e) food services employees (including food assistants, servery employees, cooks and chefs) in residential aged care facilities;

    (f) general services employees (including cleaning, laundry, maintenance and gardening employees) in residential aged care facilities;

    (g) administrative employees in residential aged care facilities; and

    (h) home care employees (providing services to an aged person).

2.2 Annexed to this letter and marked **"A"** is a copy of the Federal Court's Practice Note regarding the use of Expert Witnesses in the Federal Court of Australia, together with a copy of the Harmonised Expert Witness Code of Conduct, which applies to any expert witness engages to provide an expert report or to give opinion evidence in

[14] Ibid.
[15] Ibid.
[16] Ibid.
[17] Ibid.
[18] Ibid.
[19] Ibid.

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proceedings. Could you please ensure that you have read and understand the Practice Note and comply with the Practice Note in the provision of your expert report.

If you have any questions, please do not hesitate to contact me.

Yours sincerely,

Claire Bailey

Head of Workplace Relations

Aged & Community Care Providers Association Ltd

APPENDIX A

Dear Mr Hutcheon,

APPLICATIONS TO VARY MODERN AWARDS – WORK VALUE - AGED CARE INDUSTRY AM2020/99, AM2021/63, AM2021/65

We refer to our letter of instruction dated 19 September 2023 (**the Letter**).

The Letter included four questions in relation to enrolled nurses (**ENs**), registered nurses (**RNs**) and nurse practitioners (**NPs**) working in aged care, in circumstances where the modern award rates that apply to those classifications were increased by *"35%"* (see Questions 9-12 at [2.1] of the Letter). As noted at [1.7]-[1.8] of the Letter, those questions were formulated by reference to an earlier submission of the ANMF.

Since providing the Letter, we have had the opportunity to review the following material filed by the ANMF in Stage 3 of the Work Value Case:

1. A Draft Determination for the Nurses Award prepared by the ANMF (**ANMF Draft Determination**); and

2. A marked-up copy of the Nurses Award, incorporating the variations set out in the ANMF Draft Determination (**Marked-up Award**).

For your review, we **attach** copies of both documents to this email.

Having reviewed the ANMF Draft Determination and Marked-up Award (see pages 21-24), we note that the ANMF propose an increase of **18.11%** to the minimum award rates for all EN, RN and NP classification levels working in aged care (including student ENs working in aged care).

FURTHER INSTRUCTIONS

We request that in answering Questions 9-12 of the Letter that you replace each reference to *"35%"* with *"18.11%"*.

If you have any questions, please do not hesitate to contact me.

Yours sincerely,

Claire Bailey
Head of Workplace Relations

Aged & Community Care Providers Association Ltd
p: 1300 222 721 **d:** 0292911163 **m:** 0413186762
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Suite 1, Level 9, 1 Oxford Street
DARLINGHURST NSW 2010

APPENDIX A

StewartBrown

Integrity + Quality + Clarity

Aged Care Financial Performance Survey Report

APPENDIX B



Twelve months ended 30 June 2023

The StewartBrown 2023 Financial Year (twelve months) Aged Care Financial Performance Survey incorporates detailed financial and supporting data from **1,237 Aged Care Homes (100,972 beds/places)** & **71,269 Home Care Packages** across Australia

The quarterly survey is the **largest financial benchmark** in the aged care sector and provides invaluable insights into the **trends and drivers of financial performance** at the sector level and at the aged care home or program level

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1. EXECUTIVE SUMMARY

Abstract

The *Aged Care Financial Performance Survey* (Survey) Sector Report for the 2023 financial year (FY23) provides an overview of the financial performance of the aged care sector in Australia.

Survey Overview

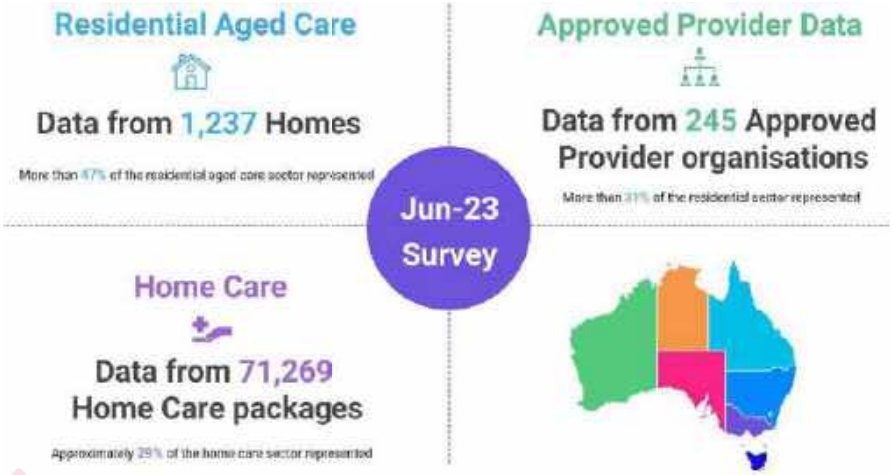
The Survey is derived from detailed financial and non-financial granular data submitted each quarter by providers to benchmark their performance and Key Performance Indicators (KPIs) with comparable residential facilities and home care programs, and accordingly, the financial results are from the provider's perspective.

The primary objective of the Survey Report is that all financial policy and related public commentary should be evidenced based, objective and supported by accurate data. The Survey provides the results from an extensive data base.

Refer to the Glossary, which provides a graphical depiction of the Data Collection and Data Cleansing processes as well as explanations for some of the key terms and metrics used throughout this report.

Survey Metrics

The aggregated StewartBrown Survey results for the year ended 30 June 2023 are derived from data contributed by the following:



Commentary

The Government has demonstrated a strong commitment to continuing the much-needed reform agenda for the delivery of quality aged care services for elderly Australians.

The Royal Commission highlighted a significant number of areas of concern and provided key recommendations to lift the standards and processes, and these have been foremost in the Government's legislative and structural design implementation.

Whilst the declining financial performance was noted by the Royal Commission, the recommendations fell short in providing a clear direction to ensure the financial sustainability for the sector. The aged care sector, and the residential aged care segment in particular, is continuing to have considerable concerns over financial viability, with sustained financial operating losses now extending to over five successive years.

EXPENDITURE

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There remains a severe shortage in staffing capacity which impacts care service delivery across all levels of aged care. Investment in the sector, be it through innovation, technology, staff recruitment, accommodation and structural design has eroded significantly, and consolidation is occurring more through attrition than for strategic growth.

Concern about financial sustainability is acknowledged in the Aged Care Taskforce Terms of Reference (Aged Care Taskforce Terms of reference) which has as one of its main objectives to provide recommendations that will help ensure "aged care providers are sustainability funded and benefit from introducing innovative care delivery approaches that meet older Australian's preferences".

StewartBrown has advocated for a number of years that increased funding is essential, which must also involve a greater level of consumer contribution for indirect care (everyday living) and accommodation services in particular. To be successfully implemented, these reforms will require unilateral support from all stakeholders and increased community understanding of the financial aspects of providing aged care services.

As these reforms will take a while to be considered and, hopefully, implemented we will continue to provide our rationale in each Survey Report as an *Appendix*.

The underlying issue for providers is that there is a lag period of some years between the date of implementation of reforms such as these and when any positive impact on financial performance will be felt. This is why pressure on financial viability and performance will continue to occur and short-term remedial assistance may be required.

It is the opinion of StewartBrown that after more than six years of significant aggregate operating losses in the residential aged care sector, structural funding reforms (including increased and appropriate care recipient co-contribution) are required. In the interim period, however, to avoid closure of homes and reduced service delivery, especially in regional locations, an emergency funding package also needs to be considered in the short-term to ensure current viability and allow for the necessary funding reforms to be properly implemented.

Financial Results Overview

Summary

The Survey for the twelve months ending June 2023 concludes that there is continued financial instability in the sector, with residential aged care continuing to be at a **difficult financial position** for many Providers.

The average operating results for residential aged care homes across all geographic sectors was an operating loss of $16.54 per bed day *(FY22 $14.67 pbd loss)* for mature homes (which exclude the outliers). This represents an operating loss of $5,491 per bed per annum, and a continuation of losses for over six successive years. Extrapolating the deficit per bed represents a **loss in the residential aged care segment in excess of $1.05 billion** for the financial year.

The introduction of the AN-ACC funding model together with the mandated minutes being included in the subsidy has had a very positive effect in relation to direct care staffing levels delivered to residents. This is a major initiative which has seen direct care staffing minutes increase by 12.71 minutes per resident per day. This represents an increase of 7.18% from the previous year.

Staffing, though, has had significant challenges, with staffing shortages being required to be managed with increased levels of agency staff and overtime for existing staff. Agency staff now represents $17.10 per bed day (14.62 direct care minutes per resident per day), an increase of $6.20 per bed day compared to the same period in 2022 (FY22 $8.42 per bed day).

Occupancy has remained stable at 91.0% of *available* beds for mature homes (FY22 91.0%). *The Survey reports on beds that are available to be filled by residents, rather than using approved places as the denominator due to there being a large number of places (beds) not available due to refurbishment, new builds, sanctions or approved places allocated and never utilised.* The fixed costs per bed increase when occupancy declines to these levels and further erodes financial performance.

This all equates to the concerning statistic that 66% of aged care homes operated at a loss (67% at FY22) and 43% operated at an EBITDA (cash loss) (42% at FY22) with these percentages not increasing due to the short-term benefit of the AN-ACC subsidy *(refer below)*.

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In summary, the residential aged care sector continues to make significant losses through the delivery of everyday living and accommodation services. The funding for direct care (AN-ACC and formerly ACFI) has been historically sufficient to meet the costs of providing direct care services and this should continue due to the important role of the Independent Hospital and Aged Care Pricing Authority (IHACPA) in determining the ongoing direct care subsidy required.

To meet the costs of providing appropriate daily living and accommodation services will require strong consideration of what mechanisms and reforms are required to fund this gap and provide a sufficient margin for financial sustainability.

Home Care continues to operate in a climate of operating issues. Uncertainty as to design of the Support at Home program (implementation date is 1 July 2025) and the potential implications, have caused a policy void which has led to a stagnation of innovation for many providers.

Consistent with residential aged care, staffing remains the most crucial concern, and this coupled with the current complicated regulatory environment has seen the financial performance declining.

The current operating result has decreased to a surplus of $3.14 per client per day *(FY22 $3.98 pcpd).* Revenue utilisation has decreased to 84.3% of available package funding and unspent funds have increased to an average of $12,604 for every care recipient *(unspent funds are now in excess of an aggregate $2.9 billion)*.

Average staffing hours in providing direct home care services has continued to reduce to now be 5.16 hours per client per week *(FY22 5.28 hours)* and is well short of the average hours delivered before the introduction of the Consumer Directed Care model, where average hours delivered were greater than 9 hours per week.

An interesting aspect of home care is that even though revenue utilisation is less than 85% (meaning that 15% of funding is not utilised by the recipient and the majority is returned to the Government) the average revenue received for service provided to each recipient is lower than FY20 and FY21 (FY23 $69.57 pcpd, FY21 $72.08 pcpd).

Consumer contributions to home care continue to decline and represent less than 2.5% of the overall funding envelope.

Effect of Fair Work Commission 15% Award Increase

Background:

The Fair Work Commission (FWC) interim "work value case" ruling increased the minimum award wage by 15% for direct care staff in the aged care sector. For employees affected by the FWC ruling this meant that the minimum wage changed from the first pay period commencing on or after 30 June 2023.

The FWC ruling applied to direct care employees working in aged care in the following award classifications:

- Aged Care Award: personal care workers (PCWs) and recreation/lifestyle activities officers
- Nurses Award: nursing assistants, enrolled nurses, registered nurses, nurse practitioners working in aged care
- SCHADS Award: home care workers working in aged care

The FWC 15% award increase also applies to the most senior food services employee (levels 4-7):

- covered by the Aged Care Award
- working at a particular aged care facility or site

Financial Effect

The increase in the individual pay rates for each employee covered by the FWC ruling meant that the leave entitlements (annual/sick/long service) were increased, and a corresponding staff cost expense was also required to be posted.

The Australian Accounting Standard *AASB 19 Employee Benefits* dictates that this entry be posted on the date of the award increase (30 June 2023) even though it will actually relate to the FY24 period.

Federal Budget Measure

The 2023 Federal Budget announced that $98.7 million was set aside to fund leave liabilities (including sick leave). This was to represent 50% of the increased employee entitlement liability.

Accounting Treatment

There was no uniform treatment within the sector as to how and when to post the leave entitlement adjustment. A slight majority of Providers indicated that they have posted the increase in their FY23 financial statements (including the Survey), others only posted it in the financial statements, and other Providers chose to post the adjustment in FY24.

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Survey Result Implications

For Providers who posted the adjustment in FY23 this affected both the year-to-date result and the quarter result. Based on responses from the Survey participants, the following financial effect was:

- For Providers who posted the increase, the FY23 YTD staff costs were increased by an average of $3.40 per bed day for their individual results
- For the Survey *overall average*, the net effect was that staff costs were increased by $1.02 per bed day (as this includes those that did not post the increase)

Transition Effect of AN-ACC subsidy

As reported in the previous Survey reports, the introduction of the AN-ACC subsidy model from 1 October 2022 has had, on average, a transitional financial benefit, due to the subsidy including funding for additional direct care staffing minutes, with these mandated minutes not being obligatory until 1 October 2023.

The financial effect of this transition benefit is shown in *Table 1*. As anticipated, each quarter since the introduction of AN-ACC has seen the Direct Care result decline where the staffing costs have increased transitioned towards meeting the targeted mandated minutes.

Table 1: Comparison of AN-ACC to ACFI (Sep-22) by quarter ($ pbd)

Direct Care - Average Result (a)	Sep-22 (Q1)	Dec-22 (Q2)	Mar-23 (Q3)	Jun-23 (Q4)
Direct Care Revenue	**$196.99**	**$216.52**	**$219.04**	**$217.77**
Direct Costs				
Staff costs	$161.00	$165.25	$164.26	$176.68
Agency staff	$13.15	$15.04	$19.92	$17.81
Other	$6.27	$6.21	$8.48	$12.06
Expenditure - Direct Care Services	***$180.43***	***$186.50***	***$192.66***	***$206.55***
Operational Overheads	$16.45	$16.39	$18.18	$18.12
Direct Care Expenditure	**$196.88**	**$202.89**	**$210.84**	**$224.67**
Direct Care Result	**$0.11**	**$13.63**	**$8.19**	**($6.90)**
FWC 15% additional expense (b)	n.a.	n.a.	n.a.	$4.05
FWC 15% additional expense (c)	n.a.	n.a.	n.a.	$13.00
Total Direct Care staffing minutes (a)	**186.48**	**184.94**	**190.58**	**190.56**

(a) Includes 969 aged care homes that submitted data for each quarter
(b) The average additional expense for all providers (includes those who did not post the increase)
(c) The average additional expense for only those providers who posted the increase

As noted in the previous section, the financial effect of the FWC 15% award increase for direct care workers needs to be considered.

For statistical accuracy, *Table 1* only includes aged care homes that provided data for each Survey quarter (therefore excludes new participants during the year and those that did not provide data for a particular quarter(s)).

The Jun-23 quarter has seen the erosion of the transition benefit as staff costs increased, and the full effect of the respective Enterprise Agreement and award increases for all direct care employees which occurred progressively throughout the financial year were realised.

When considering the Jun-23 quarter in isolation, the direct care deficit of $6.90 pbd includes a net additional expense due to the FWC ruling of $4.05 pbd, so the adjusted result by excluding this would be a deficit of $2.85 pbd.

The Survey does not report on quarterly results, only year-to-date results, so the overall net effect of the FWC award increase for the Survey results is $1.02 pbd spread over the 12 month results.

The increased AN-ACC transition benefit had the following effect on the overall operating results for the sector for FY23 (operating results includes direct care, indirect care and accommodation results).

The operating result for FY23 was a loss of $16.54 pbd with the transition benefit from AN-ACC as highlighted in *Figure 1* showing the uplift in the Dec-22 quarter being progressively reduced each subsequent quarter.

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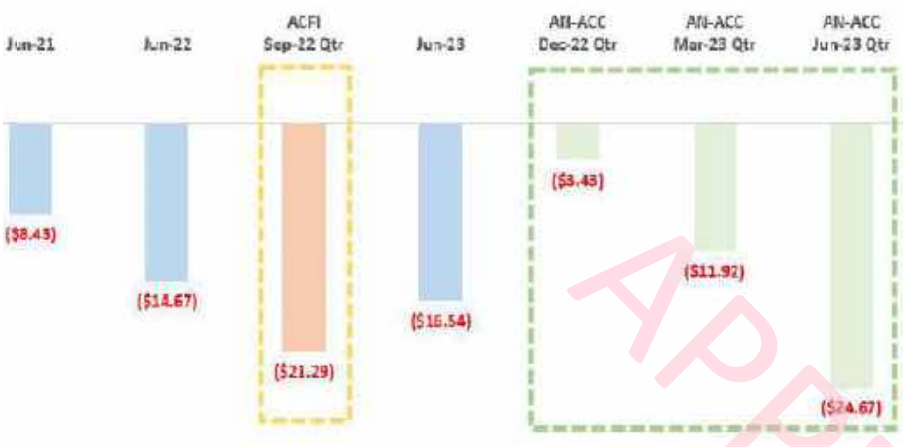
Figure 1: Comparison of Operating Results for ACFI and AN-ACC quarters ($ pbd)



Indirect Care (Everyday Living)

Indirect care includes hotel services (catering/cleaning/laundry), utilities and an administration cost allocation. The major revenue components comprise the Basic Daily Fee (BDF), BDF subsidy supplement and additional/extra services charged in some facilities (where applicable).

A characteristic of these services is that the BDF (calculated at 85% of the single pension) is the same for all residents irrespective of financial means and acuity. The costs of providing these services are greater than the revenue earned and currently the sector average result is a $6.62 loss per resident per day.

StewartBrown has consistently advocated for a higher consumer contribution being levied for those residents with the financial ability to pay for these everyday living services at a rate that is commensurate with the quality of services provided.

Accommodation

The accommodation results represent the major component of the poor financial performance, and the sector averaged a $13.05 loss per resident per day for FY23. Depreciation represented $21.03 per bed day, and whilst it is a non-cash component (and excluded from EBITDA calculations) it is a critical expense that needs to be recovered given the cost associated with maintaining, refurbishing and eventual replacement of an aged care facility.

StewartBrown has consistently advocated for changing the accommodation model to be more focussed on a "rental" payment for accommodation whereby the rent amount is determined by the actual upfront contribution paid. The underlying principle is that a rental portion is paid irrespective of whether a full contribution (currently a RAD) is paid.

Aged Care Reform Process

The aged care sector is undergoing a major reform agenda, largely stemming from the Royal Commission recommendations with the Government having a strong emphasis on implementation. Whilst reform is disruptive and costly, it will ensure that the sector moves forward to delivering quality aged care services that are equitable, contemporary, transparent, and sustainable.

A brief summary of upcoming reforms is as follows:-

- October 2023: Direct care minutes become mandated. Average of 40 Registered Nurse (RN) minutes and 200 total direct care minutes (RN/EN/PCW)
- October 2023: Residential and home care Providers must lodge Provider Operations report
- December 2023: New governance responsibilities for aged care Providers including Aged Care Advisory Body with stronger requirements with respect to Board clinical experience, independence and key personnel
- December 2023: 24/7 coverage of RNs to be published alongside Star Ratings
- December 2023: Aged Care Taskforce final report completed with options for consideration and a recommended package
- January 2024: Publication of residential Providers financial information to be included on *My Aged Care* site
- July 2024: Rights based *Aged Care Act* and regulatory framework including a new system for the registration of Providers
- July 2024: New quality standards framework to commence
- July 2024: Residential aged care places assigned to consumer (removal of Aged Care Approvals Round (ACAR)for allocation of residential approved places)
- July 2024: Single Assessment system commences
- October 2024: Total average mandated direct care minutes to increase to 215 of which an average of 44 minutes to be provided by a RN
- July 2025: Support at Home program commences

APPENDIX B

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FY23 Results Snapshot

Approved Provider - Aggregate

(1.74%) negative
Operating surplus return on assets
(June 2022:(2.28%) negative

($3.5m) deficit
Operating result
(June 2022:$4.4m deficit)

0.06%
Operating EBITDA (cash) return on assets
(June 2022:0.19%)

($1.45m) deficit
DoHAC average NPBT result June 2022
(June 2021:$0.85m deficit)

27.36%
Cash + financial assets as a percentage of debt
(June 2022:28.69%)

$130k
Operating EBITDA
(June 2022: $373k deficit)

Residential Aged Care

Home Care

APPENDIX B

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FY23 Financial Performance Analysis

Approved Provider (Organisation) Results

Net Profit Before Tax (NPBT)	The average result (NPBT) per Approved Provider for the financial year was a **$977k deficit**. This is an improvement on the FY22 average result per provider, which was a deficit of $2,607k. Net non-recurrent result was a surplus of $2,549k (FY22 $1,775k).
Net COVID Result	The average net COVID result per provider for FY23 was a **surplus of $66k** (FY22 deficit $469k). The accounting treatment for the COVID-19 grants varied between providers, however for the purposes of the Survey all grants claimed/claimable but not received by 30 June 2023 were accrued to ensure matching of revenue and expenditure. The impact of the Omicron variant has continued to create significant staffing and costs issues for the aged care sector.
Operating Result	The average financial performance continued to remain at unsustainable levels for many providers. The FY23 results show that the average operating result per provider was a **deficit of $3,526k** (FY22 $4,383k deficit). This result means that the operations of the sector continue to have an under-recovery of the cost of the capital employed. Whilst revenue increased (due to the higher AN-ACC subsidy from 1 October 2022, the additional staff costs and compliance costs offset much of the increased revenue.
Operating EBITDA	The average operating average EBITDA (cash) result for the FY23 was a minor **surplus of $130k** (FY22 deficit of $373k), which is not sufficient to maintain the standard of accommodation and care delivery. Due to the operating result being in deficit the depreciation and financing costs are not being recovered. The average property assets for each provider was $152 million and the small EBITDA return creates a heightened financing risk profile for providers. The low EBITDA return remains a significant deterrent to future investment in the sector from institutional lenders.
Staff Costs as % of Operating Revenue	Aged care operators continue to manage staffing and rosters as effectively as possible in the current difficult operating climate including the continuing impact of Omicron and significant staffing shortages. Staffing costs as a percentage of operating revenue were 70.7%. This ratio is lower than the 71.6% for FY22 due to the increased AN-ACC subsidy which had a transition benefit.
Depreciation Rate	Average depreciation rate of 2.7% (37 years effective life) has reduced from FY22 (3.0%). StewartBrown continues to consider that depreciation rate is low and should be at least 4% pa for buildings and 10% or higher for furniture and equipment.
Gearing ratio	Liquid cash assets (cash and cash equivalents + financial assets) as a percentage of debt (resident refundable loans + government debts + external debt) had reduced to 27.4% at FY23 from 28.7% at FY22 reflecting the increased deficit and low EBITDA. With the residential prudential requirements a significant proportion of the liquid cash assets is effectively quarantined under the prudential rules for permitted uses of RADs meaning gearing ratios and financing lines of credit are impacted.

PREVIEW

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Residential Aged Care Results

Revenue	• Average Care subsidy (AN-ACC and ACFI and supplements) was $213.19 pbd an increase of 9.5% from FY22 ($194.77 pbd) *(due to AN-ACC subsidy including uplift for mandated direct care staffing average 200 minutes per resident per day from 1 October 2022)* • Indirect care (everyday living) revenue *including the BDF supplement* was $70.53 pbd an increase of 6.3% from FY22 ($66.33 pbd) • Accommodation revenue was $36.41 pbd an increase of 10.9% from FY22 ($32.84 pbd)
Expenses	• Direct care labour costs (RN/EN/PCA) averaged $159.86 pbd an increase of 15.1% from FY22 ($138.88 pbd) • Other direct care labour costs (Care Management/Allied Health/Lifestyle) averaged $25.37 pbd a decrease of 4.0% from FY22 ($26.43 pbd). *This may be as a result of some reallocation of lifestyle/recreation staff to personal care workers as a result of the mandated minutes target* • Other direct care costs averaged $7.57 pbd a decrease from FY22 ($15.16 pbd) *(due to less covid-19 costs)* • Indirect care (everyday living) costs was $77.15 pbd an increase of 9.0% (FY22 $70.78 pbd) • Catering expenditure averaged $37.55 pbd an increase of 8.8% (FY22 $34.51 pbd) *(this is as a result of the targeted BDF supplement and inflationary pressures)* • Administration costs averaged $46.62 pbd an increase of 13.8% (FY22 $40.98 pbd) *(due to increase quality, reporting and compliance requirements, and the introduction of AN-ACC having transitional costs)* • Accommodation expenditure averaged $49.46 pbd (depreciation $21.03 pbd) compared to FY22 $44.91 pbd (depreciation $19.54 pbd)
Operating Result	• Direct care result for FY23 increased by $1.28 pbd to a surplus of $3.13 pbd (including administration) from FY22 $1.85 pbd (*refer AN-ACC commentary below)* • *The effect of the AN-ACC subsidy increase not being fully offset by the requirement to meet the average 200 mandated minutes per resident per day (this not being required until 1 October 2023) resulted in an improved direct care surplus from FY22.* • Indirect care result declined to a deficit of $6.62 pbd (including administration) (FY22 deficit $4.45 pbd) • Accommodation result (including administration) was a deficit of $13.05 pbd (FY22 deficit $12.06 pbd) • Operating result was a **deficit of $16.54 pbd** (FY22 operating deficit $14.67 pbd) *(refer AN-ACC comment above)* • Operating EBITDA averaged $1,800 pbpa (FY22 EBITDA $1,949 pbpa)
Additional Trends	• Direct care minutes (RN/EN/PCA) was **189.62 minutes per resident per day** (FY22 176.91 minutes) • Occupancy for mature homes **remained stable 91.0%** (FY22 91.0%) *(occupancy based on actual available beds)* • Occupancy for all homes slightly increased to 90.1% (FY22 89.7%) *(occupancy based on approved places)* • Supported resident ratio remained constant at 46.0% (FY22 45.3%) • Average full RAD received for FY23 was $472,803 (FY22 $455,006) • Proportion of full RADs received for non-supported residents was 28.0%, full DAPs was 50.7% and Combinations (RAD/DAP) was 21.3%

AGEING WELL

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Home Care Package (HCP) Results

Revenue	• Revenue was $69.57 per client per day a slight increase from FY22 ($68.98 pcpd) • Care management revenue as a proportion of total revenue was 18.5% (FY22 18.7%) • Package management revenue as a proportion of total revenue was 11.6% (FY22 10.7%) • Revenue utilisation **decreased by 0.7% to 84.3%** of funding received (FY22 85.0%)
Expenses	• Direct service costs increased by $1.41 pcpd to be 60.1% of total revenue (FY22 58.6%) • Care management cost as % of revenue has decreased to 10.5% of revenue (FY22 11.8% of revenue) • Administration and support costs represent 24.2% of revenue (FY22 23.1%)
Unspent Funds	• The amount of unspent funds per client (care recipient) has continued to rise and now averages **$12,604 per client** (FY22 $10,736 per client) • In aggregate across the sector, this represents **in excess of $2.9 billion** of funds that have not been utilised.
Operating Result	• Operating results have declined by $0.84 per client per day to $3.14 pcpd (FY22 $3.98 pcpd) • The profitability margin has declined from 5.8% for FY22 to 4.5% for FY23 • Profitability decline is being driven by the decrease in revenue utilisation
Other Trends	• Average staff hours per week was **5.16 hours** (FY22 5.28 hours) • The number of packages in the survey has increased to represent 68,129 packages for FY23 (FY22 60,630 packages)

APPENDIX B

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2. FINANCIAL RESULTS - KEY METRICS

Organisation (Approved Provider)

Trend Graph (average by Provider)

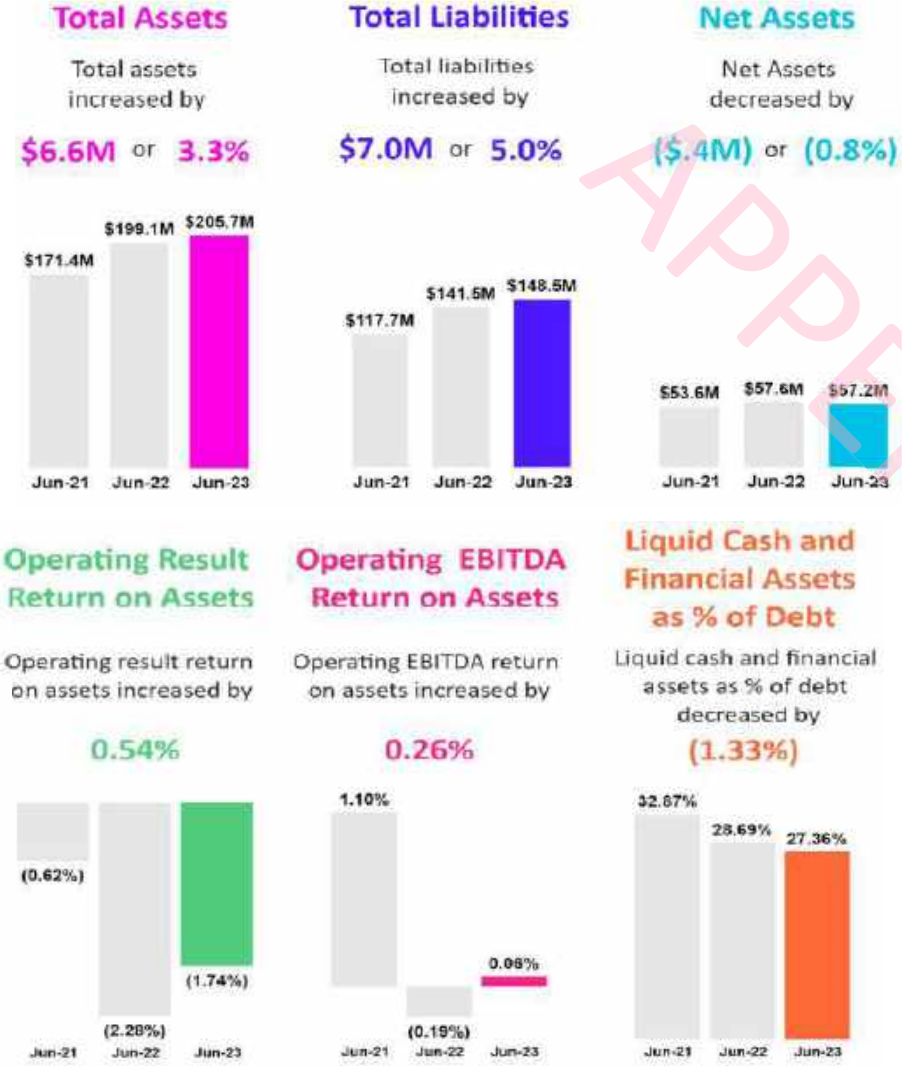

Table 2: Income & Expenditure Comparison (average by Approved Provider)

	Survey FY23 (223 Providers) (Average) $'000	Survey FY22 (223 Providers) (Average) $'000
Income & Expenditure		
Revenue		
Service revenue	63,646	56,482
Investment revenue	1,212	695
Total operating revenue	**64,858**	**57,178**
Expenses		
Employee expenses	45,831	40,921
Depreciation and amortisation	4,246	4,399
Finance Costs	894	584
Other expenses	17,413	15,655
Operating Expenses	**68,384**	**61,561**
Operating Result	**(3,526)**	**(4,383)**
Total Non-Recurrent Income	3,522	3,445
Total Non-Recurrent Expenses	973	1,669
Net Non-Recurrent Result	**2,549**	**1,775**
Total Result	**(977)**	**(2,607)**
Operating EBITDA	**130**	**(373)**
EBITDA	**2,678**	**1,402**
Ratios		
EBT return on assets (ROA)	*(0.48%)*	*(1.36%)*
Operating result return on assets (ROA)	*(1.74%)*	*(2.28%)*
Operating EBITDA return on assets	*0.06%*	*(0.19%)*
Operating result % of operating revenue	*(5.44%)*	*(7.67%)*
Employee expenses % of operating revenue	*70.66%*	*71.57%*
Depreciation as % of property assets	*2.69%*	*3.00%*

** EBITDA calculations exclude AASB 16 Leases accounting entries*

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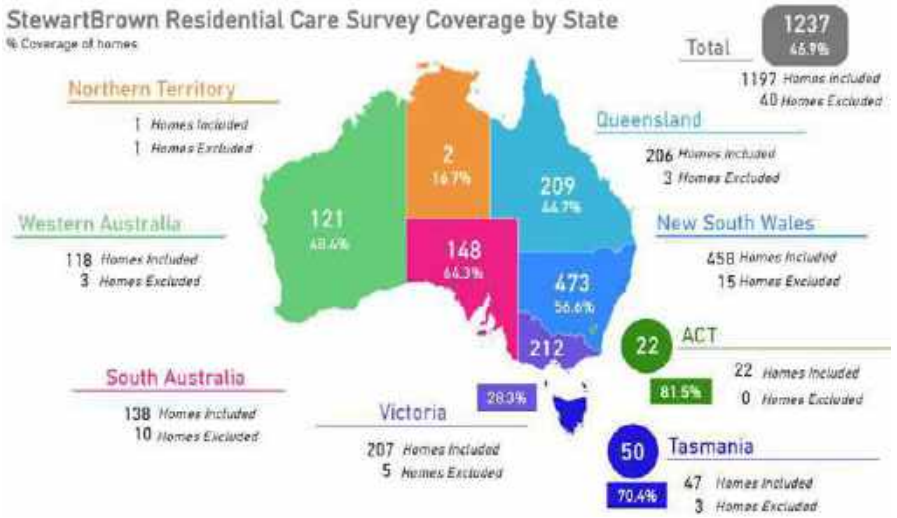
Table 3: Summary Equity (Balance Sheet) comparison

	Survey FY23 (223 Providers) (Average) $'000	Survey FY22 (223 Providers) (Average) $'000
Balance Sheet		
Assets		
Cash and cash equivalents	35,167	34,845
Operating assets	10,821	15,187
Property assets	152,873	142,845
Right-of-use Assets	3,054	2,125
Intangibles - other	2,323	1,805
Intangibles - Bed licenses	1,473	2,322
Total assets	**205,711**	**199,128**
Liabilities		
Refundable loans - residential	65,666	61,018
Refundable loans - retierment living	50,811	47,611
Home care unspent liability	1,685	1,819
Borrowings	10,369	10,989
Lease Liabilities	3,809	2,956
Other liabilities	16,162	17,086
Total liabilities	**148,501**	**141,479**
Net Assets	**57,210**	**57,649**
Net Tangible Assets (Liabilities)	**53,414**	**53,523**
Ratios		
Net assets proportion % total assets	*27.81%*	*28.95%*
Property assets proportion % total assets	*74.31%*	*71.74%*
Cash + financial assets % refundable loans	*30.19%*	*32.08%*
Cash + financial assets % debt	*27.36%*	*28.69%*

Residential Aged Care



Residential Key Points

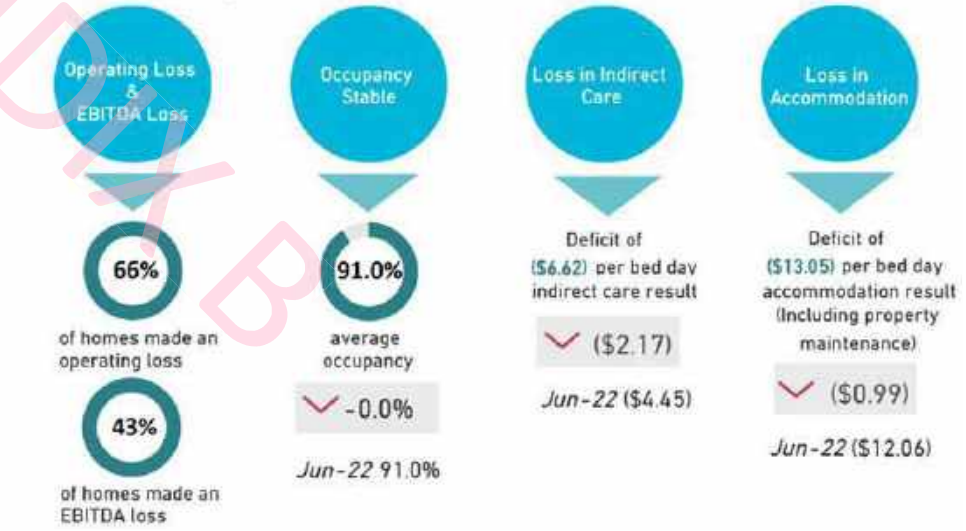


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Table 4: Summary Income & Expenditure Comparison ($ per bed day)

	Survey FY23 *1,197 Homes*	Survey FY22 *1,202 Homes*	Survey FY21 *1,163 Homes*
DIRECT CARE			
Revenue	$213.19	$194.77	$198.96
Expenditure			
Direct care labour costs	159.86	138.88	130.45
Other direct care labour costs	25.37	26.43	24.27
Other direct care costs	7.57	12.45	16.85
Administration	17.25	15.16	13.76
	$210.05	*$192.92*	*$185.33*
DIRECT CARE RESULT (A)	**$3.13**	**$1.85**	**$13.63**
INDIRECT CARE			
Revenue	$70.53	$66.33	$54.79
Expenditure			
Catering	37.55	34.51	32.90
Cleaning	10.47	9.88	9.25
Laundry	4.60	4.31	4.29
Other hotel services expense	0.12	0.08	0.06
Payroll tax	0.09	0.13	0.10
Overhead allocation (workcover & education)	0.91	0.80	0.75
Utilities	7.73	7.29	6.93
Administration	15.67	13.77	12.50
	$77.15	*$70.78*	*$66.78*
INDIRECT CARE RESULT (B)	**($6.62)**	**($4.45)**	**($11.99)**
CARE RESULT (C) *(A + B)*	**($3.49)**	**($2.60)**	**$1.64**
ACCOMMODATION			
Revenue			
Residents	15.01	13.03	13.03
Government	21.40	19.82	19.83
	$36.41	$32.84	$32.86
Expenditure			
Depreciation	21.03	19.54	19.59
Property maintenance	12.41	11.08	10.73
Property rental	0.94	1.00	0.53
Other	1.40	1.24	1.14
Administration	13.70	12.05	10.94
	$49.46	*$44.91*	*$42.93*
ACCOMMODATION RESULT (D)	**($13.05)**	**($12.06)**	**($10.07)**
OPERATING RESULT ($ per bed day) *(C + D)*	**($16.54)**	**($14.67)**	**($8.43)**
OPERATING RESULT ($ per bed per annum)	**($5,491)**	**($4,871)**	**($2,832)**
EBITDA ($ per bed per annum)	**$1,800**	**$1,949**	**$3,924**

Figure 2: Residential Operating Result Snapshot ($ per bed day)

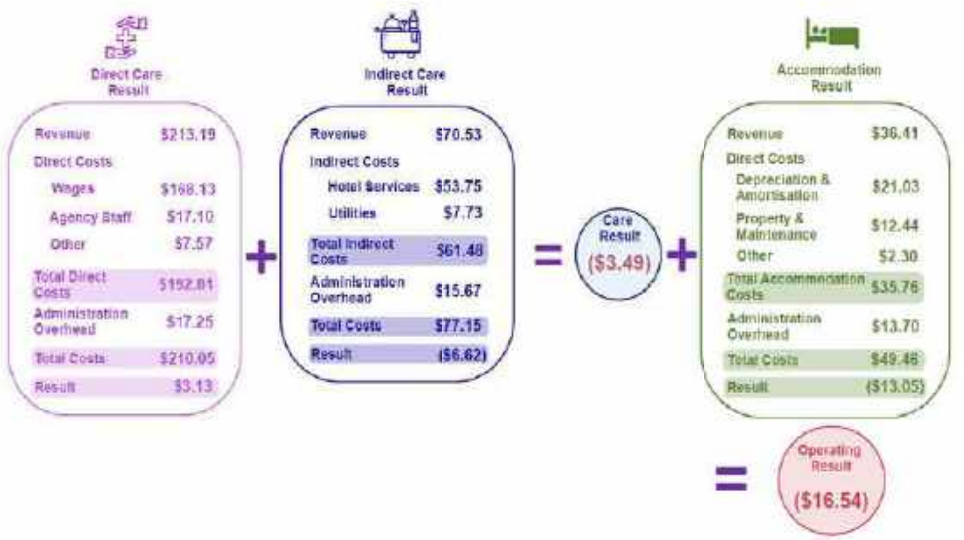

Table 5: Summary KPI Results Comparison

Summary KPI Results	FY23 *1,197 Homes*	FY22 *1,202 Homes*		Difference *(YoY)*	FY21 *1,163 Homes*
Operating Result ($pbd)	($16.54)	($14.67)	↓	($1.87)	($8.43)
Operating Result ($pbpa)	($5,491)	($4,871)	↓	($620)	($2,832)
EBITDA ($pbpa)	$1,800	$1,949	↓	($150)	$3,924
Average Occupancy *(all homes)*	*90.1%*	*89.7%*	↑	0.4%	*90.2%*
Average Occupancy *(mature homes)*	*91.0%*	*91.0%*	↓	(0.0%)	*92.0%*
Average direct care revenue ($pbd)	$213.19	$194.77	↑	$18.42	$198.96
Total direct care minutes per resident per day	189.62	176.91	↑	12.71	175.81
Direct care expenditure % of direct care revenue	*98.5%*	*99.1%*	↓	(0.5%)	*93.1%*
Supported Ratio %	*46.0%*	*45.3%*	↑	0.7%	*47.0%*
Average Full RAD/Bond held	$451,422	$425,852	↑	$25,570	$408,359
Average Full RAD taken during period	$472,803	$455,006	↑	$17,797	$448,532

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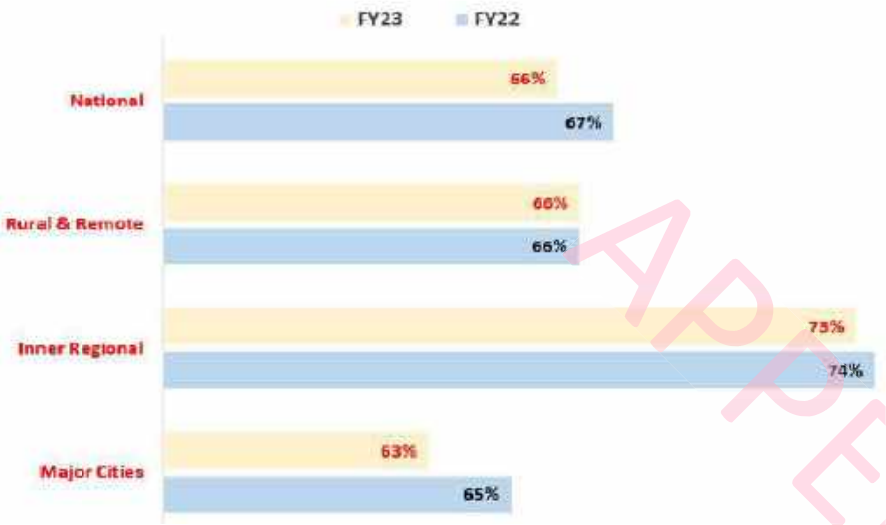
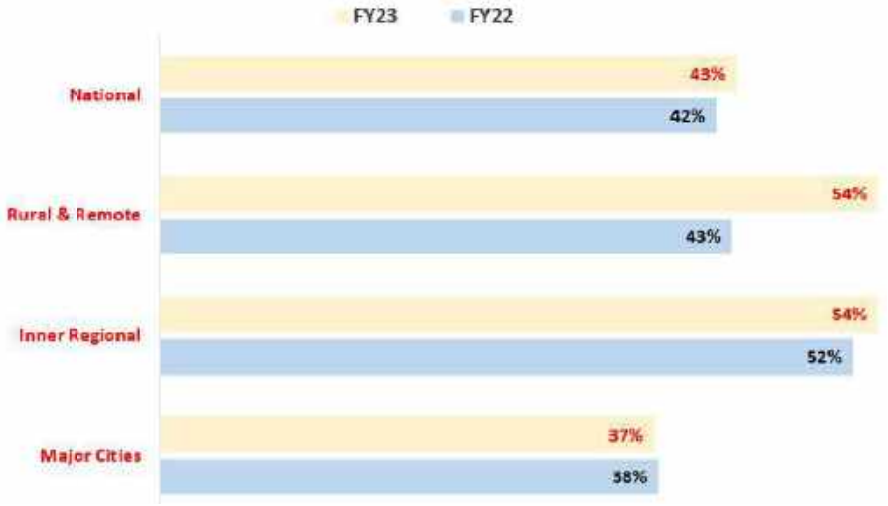
Number of Aged Care Homes making an Operating Loss

Figure 3: Aged care homes making an operating loss by remoteness



Number of Aged Care Homes making an EBITDA loss

Figure 4: Aged care homes making an EBITDA (cash) loss by remoteness



Results by Geographic Location

Table 6: Summary KPI Results by geographic location

	Major Cities	Inner Regional	Rural & Remote
	757 Aged Care Homes	318 Aged Care Homes	122 Aged Care Homes
Operating Result $ per bed per annum	($4,318)	($8,118)	($7,416)
Operating EBITDA per bed per annum	$3,225	($1,475)	($276)
Average Direct Care Revenue per bed day	$213.27	$210.69	$220.41
Direct care expenditure as % of direct care revenue	97.9%	100.6%	97.7%
Catering costs as % of indirect care revenue	51.7%	56.1%	59.1%
Direct care minutes per resident per day	190.28	187.73	189.77
Supported resident ratio	45.4%	45.5%	50.8%
Average occupancy	91.3%	90.4%	89.8%
Average full accommodation deposit held	$490,484	$360,998	$338,058
Average full RAD taken during the period	$512,102	$386,544	$362,968

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Direct Care Staffing Minutes (per resident per day)

Table 7: Direct Care staffing metrics

	Survey Average			Survey Average
Staffing Category	***FY23***	***FY22***		***FY21***
Registered nurses	31.89	27.11	↑	26.41
Enrolled & licensed nurses	12.30	13.16	↓	16.62
Other unlicensed nurses & personal care staff	145.39	135.85	↑	131.19
Imputed agency direct care minutes implied	0.05	0.79	↓	1.59
Total Direct Care Minutes	**189.62**	**176.91**	↑	**175.81**
Care management	5.55	7.52	↓	7.24
Allied health	5.60	5.07	↑	6.33
Diversional/Lifestyle/Activities	6.80	7.20	↓	6.63
Imputed agency other care minutes implied	0.08	n.a		n.a
Total Care Minutes	**207.65**	**196.70**	↑	**196.02**

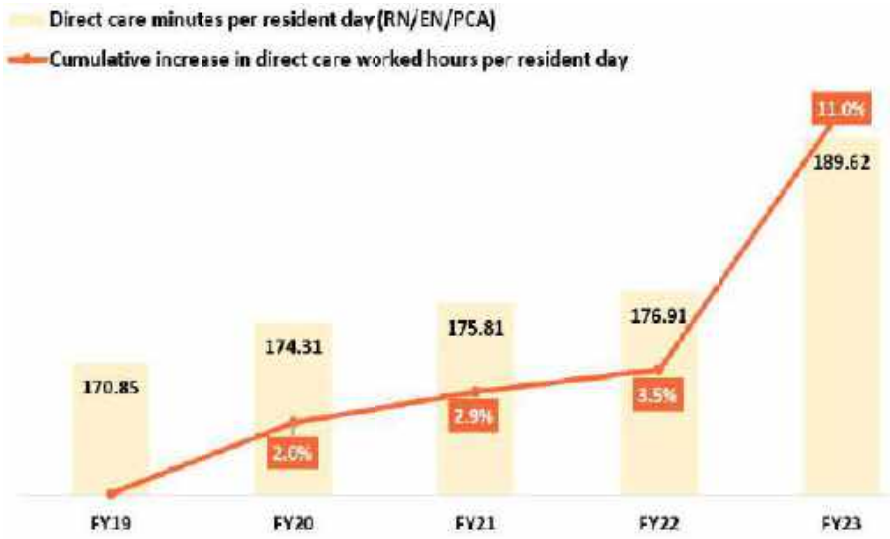
** Imputed agency is decreasing as actual agency is now included with direct staffing costs*

Table 8: Agency direct care staffing metrics

	Survey Average			Survey Average
Staffing Category	***FY23***	***FY22***		***FY21***
Agency - Registered nurses	3.17	1.36	↑	1.09
Agency - Enrolled & licensed nurses	0.81	0.81	↑	0.51
Agency - Other unlicensed nurses & personal care staff	10.60	5.39	↑	2.92
Imputed agency direct care minutes implied	0.05	0.79	↓	1.59
Total Direct Care Agency Minutes	**14.62**	**8.35**	↑	**6.11**

** Imputed agency is decreasing as actual agency is now included with direct staffing costs*

Figure 5: Direct Care staff (RN/EN/PCA) trend (minutes per resident per day)



Indirect Care (Everyday Living)

Table 9: Indirect Care (everyday living) revenue and expenses ($ pbd)

	FY23	FY22	YoY	FY21
	1,197 Homes	*1,202 Homes*	*Movement*	*1,163 Homes*
Basic daily fee supplement - government	$9.98	$9.94	↑	$0.00
Basic daily fee - resident	$57.16	$53.57	↑	$52.32
Other resident income	$3.38	$2.81	↑	$2.47
Indirect care revenue	**$70.53**	**$66.33**	↑	**$54.79**
Hotel services	$53.75	$49.72	↑	$47.35
Utilities	$7.73	$7.29	↑	$6.93
Indirect care expenses	**$61.48**	**$57.01**	↑	**$54.29**
Administration overhead	$15.67	$13.77	↑	$12.50
Indirect Care Result	**($6.62)**	**($4.45)**	↓	**($11.99)**

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Accommodation Analysis

Table 10: Accommodation revenue and expenses ($ pbd)

	FY23 1,197 Homes	FY22 1,202 Homes	YoY Movement	FY21 1,163 Homes
Accommodation revenue	**$36.41**	**$32.84**		**$32.86**
Accommodation expenses				
Depreciation	$21.03	$19.54		$19.59
Refurbishment	$0.24	$0.22		$0.32
Property maintenance	$12.41	$11.08		$10.74
Property rental	$0.94	$1.00		$0.53
Other accommodation costs	$1.16	$1.02		$0.82
Administration overhead	$13.70	$12.05		$10.94
Accommodation expenses	**$49.46**	**$44.91**		**$42.94**
Accommodation Result ($ per bed day)	**($13.05)**	**($12.06)**		**($10.08)**
Accommodation Result ($ per bed pa)	**($4,332)**	**($4,006)**		**($3,384)**
Depreciation charge ($ per bed pa)	**$6,980**	**$6,487**		**$6,578**

Accommodation Pricing

Figure 6: Effect of MPIR % on Accommodation result ($ per bed day)

Occupancy

Figure 7: Residential Occupancy by region (mature homes)

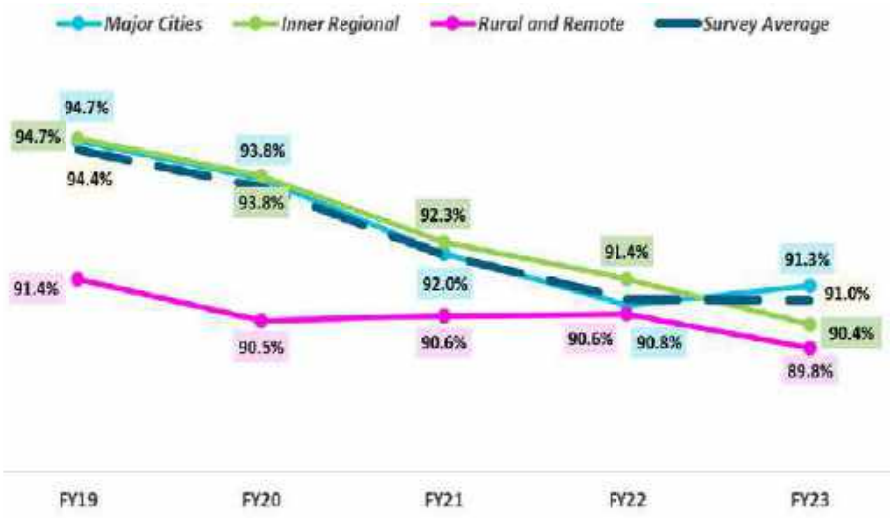
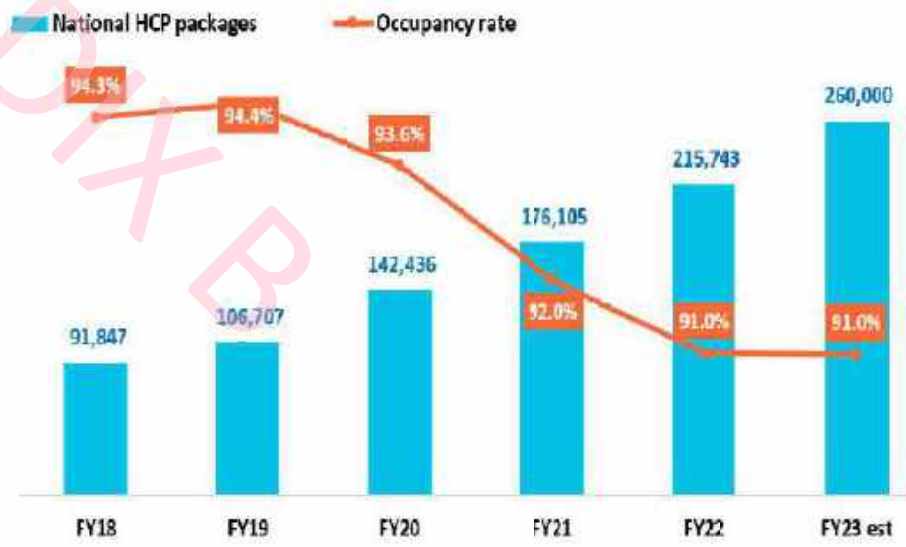


Figure 8: Residential Occupancy comparison to Home Care Packages



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Administration Costs

Table 11: Administration costs ($ pbd)

	FY23 1,197 Homes	FY22 1,202 Homes	YoY Movement	FY21 1,163 Homes
Administration (corporate) recharges	$27.33	$25.29	↑	$23.00
Labour costs - administration (facility)	$9.95	$7.79	↑	$7.03
Other administration costs	$7.34	$6.19	↑	$5.66
Workers compensation	$0.23	$0.17	↑	$0.16
Payroll tax - administration staff	$0.03	$0.04	↓	$0.03
Fringe Benefits Tax	$0.01	$0.02	↓	$0.02
Quality & education - labour costs	$0.07	$0.05	↑	$0.04
Quality and education - other	$0.03	$0.02	↑	$0.02
Insurances	$1.64	$1.41	↑	$1.24
Total Administration Costs	**$46.62**	**$40.98**	↑	**$37.20**

Modified Monash Model (MMM) Analysis

Figure 9: Operating result by MMM classification ($ per bed day)

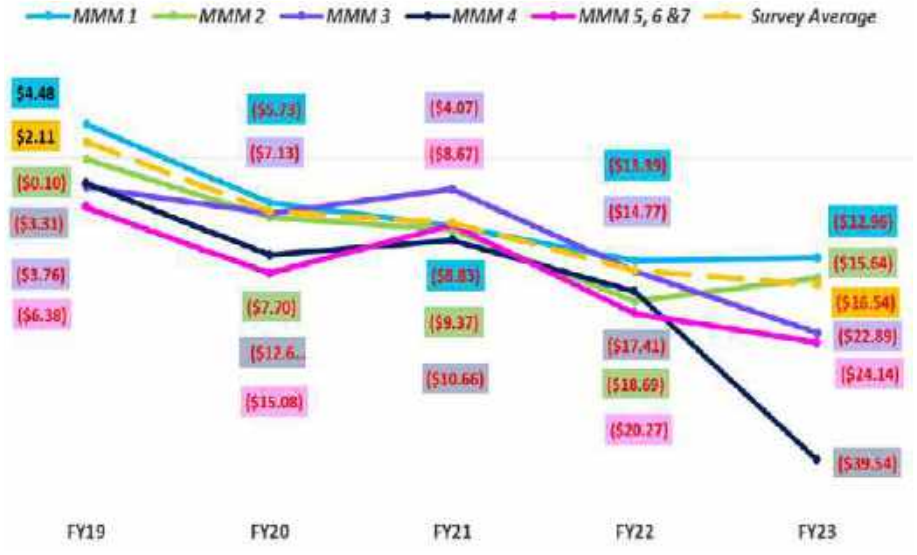


Figure 10: Operating EBITDA result by MMM classification ($ per bed per annum)

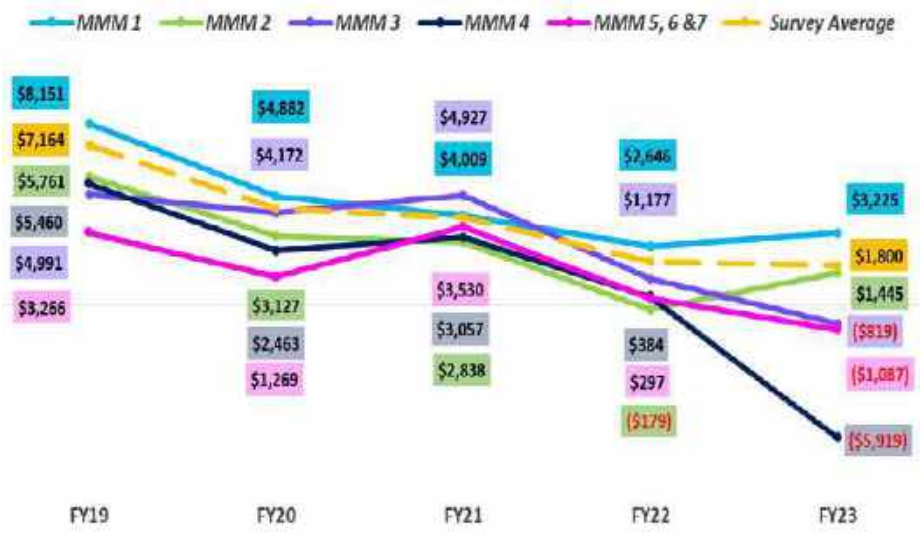
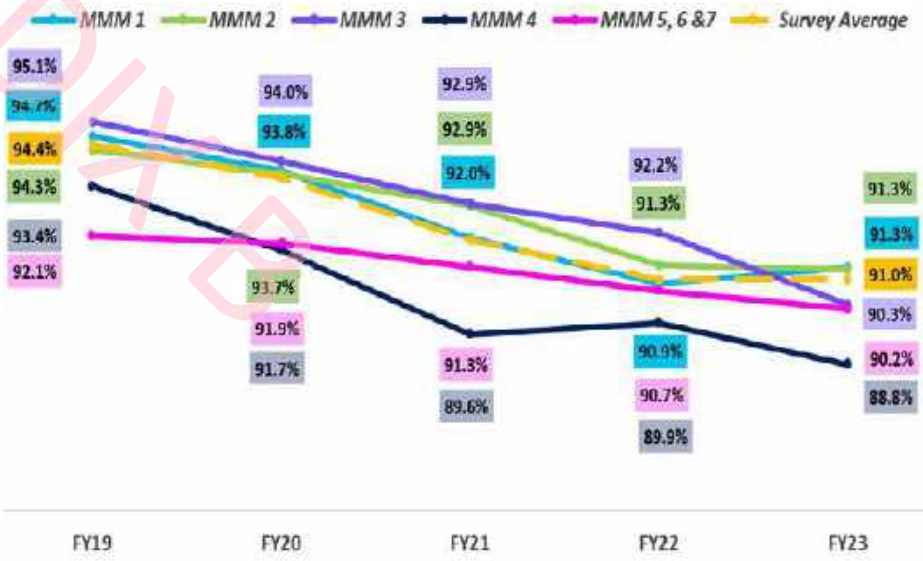


Figure 11: Occupancy percentage by MMM classification



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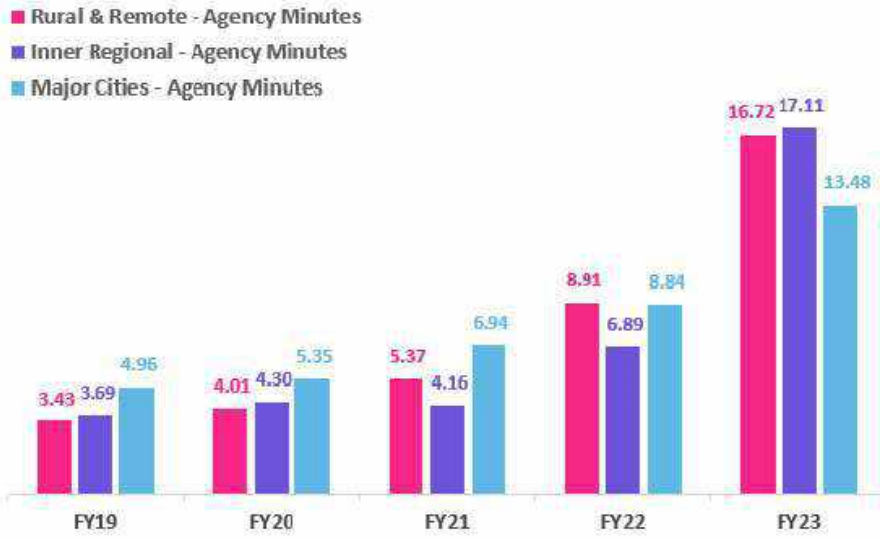
Agency Analysis

Figure 12: Agency Direct Care staff costs ($ per bed day)

Figure 13: Agency Direct Care staff minutes (per resident per day)



First 25% Trends

Figure 14: First 25% EBITDA result trend ($ per bed per annum)

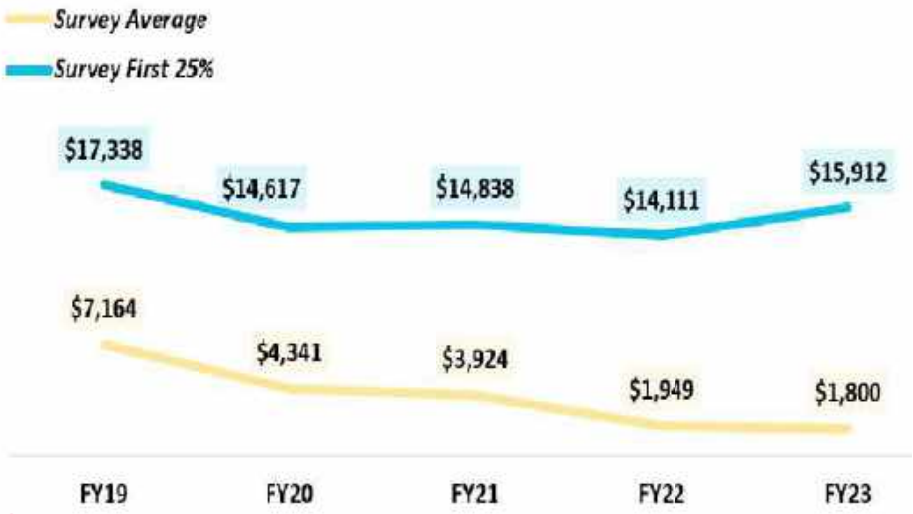


Figure 15: First 25% Direct Care result ($ pbd) and Direct Care minutes trend

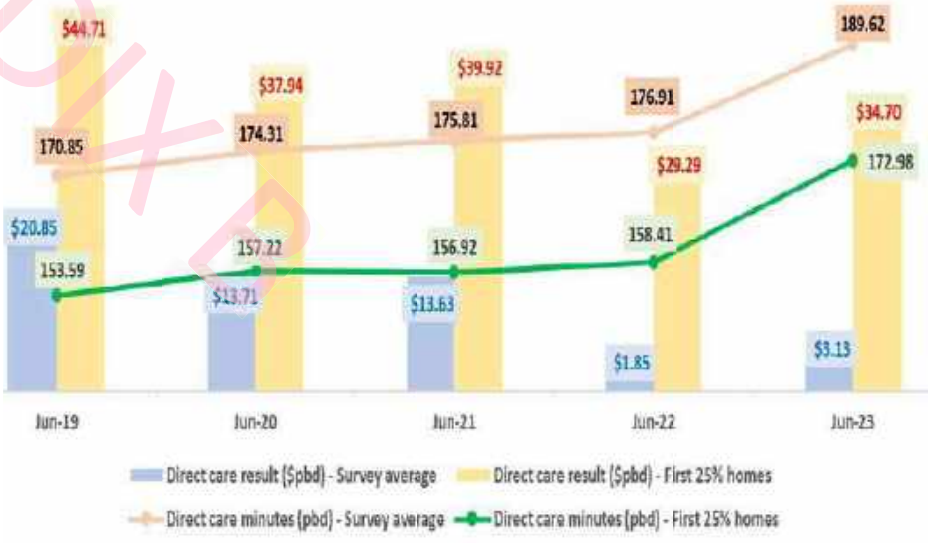


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Table 12: First 25% Direct Care staffing metrics

	Survey First 25%			Survey First 25%
Staffing Category	***FY23***	***FY22***		***FY21***
Registered nurses	29.12	24.38	↑	23.76
Enrolled & licensed nurses	9.79	9.67	↑	15.15
Other unlicensed nurses & personal care staff	134.03	123.75	↑	116.99
Imputed agency direct care minutes implied	0.04	0.61	↓	1.02
Total Direct Care Minutes	**172.98**	**158.41**	↑	**156.92**
Care management	5.99	7.35	↓	7.03
Allied health	4.90	3.89	↑	4.81
Diversional/Lifestyle/Activities	6.03	7.25	↓	6.16
Imputed agency other care minutes implied	0.05	n.a		n.a
Total Care Minutes	**189.94**	**176.90**	↑	**174.92**

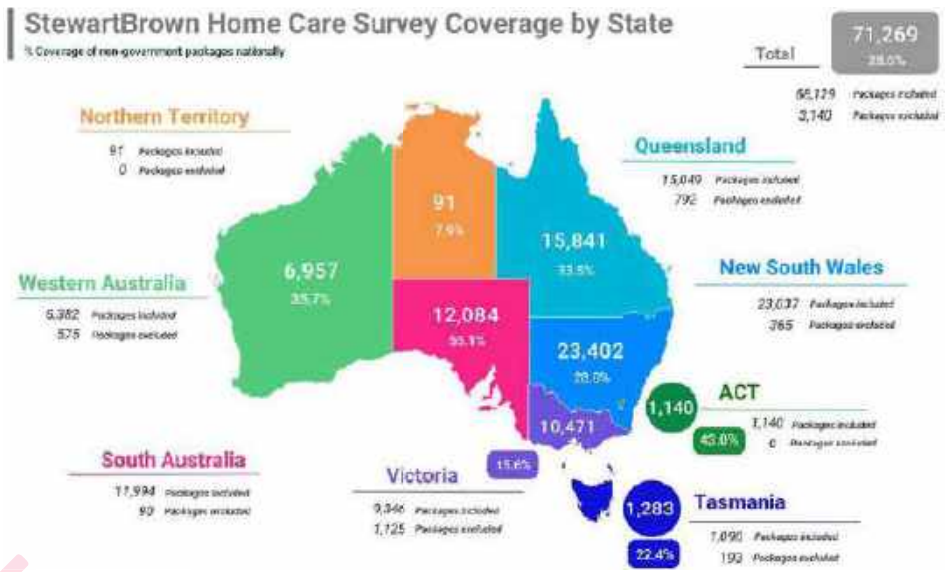
** Imputed agency is decreasing as actual agency is now included with direct staffing costs*

Table 13: First 25% Agency Direct Care staffing metrics

	Survey First 25%			Survey First 25%
Staffing Category	***FY23***	***FY22***		***FY21***
Agency - Registered nurses	1.99	0.93	↑	0.75
Agency - Enrolled & licensed nurses	0.47	0.39	↑	0.19
Agency - Other unlicensed nurses & personal care staff	7.00	3.97	↑	1.97
Imputed agency direct care minutes implied	0.04	0.61	↓	1.02
Total Direct Care Agency Minutes	**9.50**	**5.90**	↑	**3.93**

** Imputed agency is decreasing as actual agency is now included with direct staffing costs*

Home Care



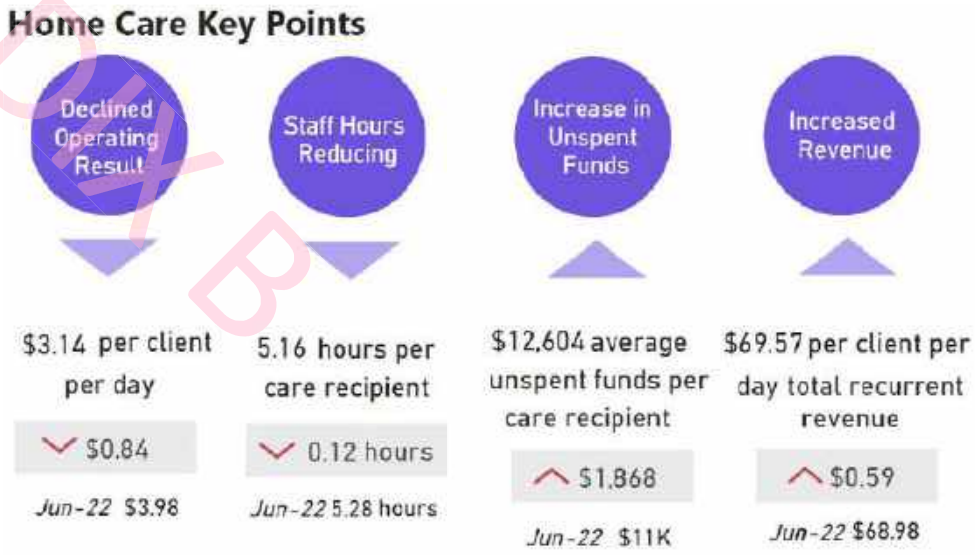


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Figure 16: Home Care key metrics summary

Figure 17: Operating Result by revenue band ($ per client per day)

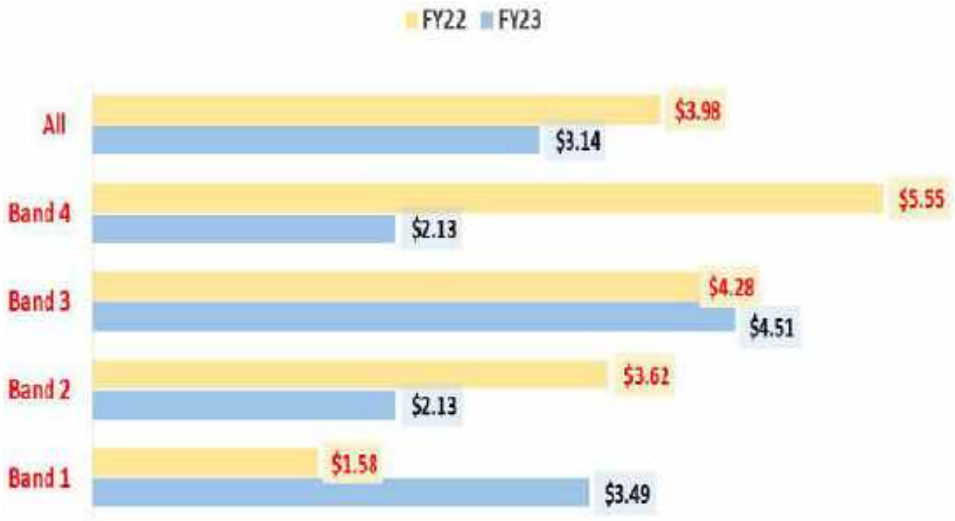

Table 14: Summary Home Care KPI results comparison

	FY23 *68,129 Packages*	FY22 *60,630 Packages*	Difference *(YoY)*	FY21 *50,567 Packages*
Total revenue $ per client per day	$69.57	$68.98	$0.59	$72.08
Operating result per client per day	$3.14	$3.98	($0.84)	$6.05
EBITDA per client per annum	$1,315	$1,632	($317)	$2,362
Average total Internal Staff hours per client per week	5.16	5.28	(0.12)	5.36
Median growth rate	*12.6%*	*14.3%*	*(1.7%)*	*13.8%*
Revenue utilisation rate for the period	*84.3%*	*85.0%*	*(0.7%)*	*87.3%*
Average unspent funds per client	$12,604	$10,736	$1,868	$9,855
Cost of direct care & brokered services as % of total revenue	*60.1%*	*58.6%*	*1.5%*	*58.4%*
Care management & coordination costs as % of total revenue	*10.5%*	*11.8%*	*(1.3%)*	*10.5%*
Administration & support costs as % of total revenue	*24.2%*	*23.1%*	*1.1%*	*22.0%*
Profit margin	*4.5%*	*5.8%*	*(1.3%)*	*8.4%*

Figure 18: EBITDA Result by revenue band ($ per client per annum)

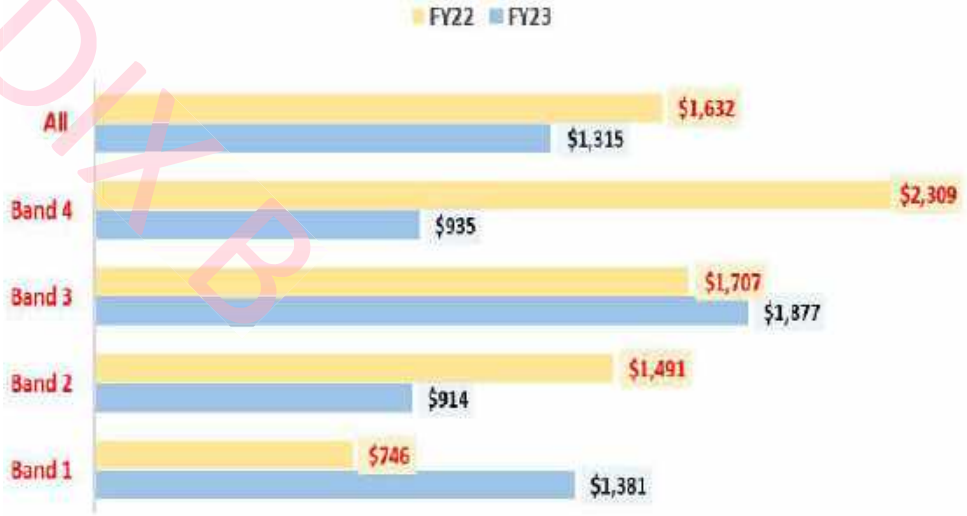

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Figure 19: Revenue Utilisation percentage by revenue band

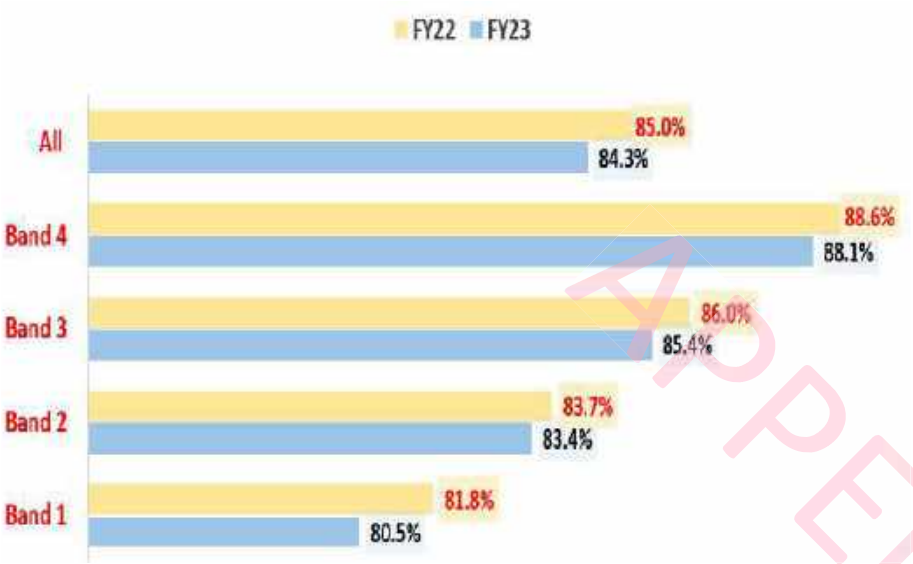
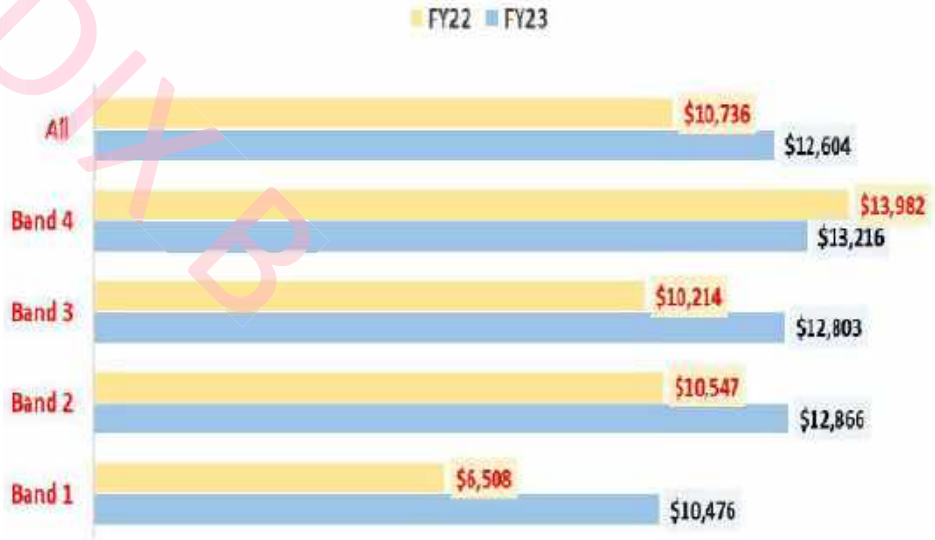


Figure 20: Operating Result and Revenue Utilisation revenue band

Unspent Funds

Figure 21: Unspent Funds trend analysis ($ per client)

Figure 22: Unspent Funds by revenue band ($ per client)



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Staff Hours Worked per Care Recipient

Table 15: Staff Hours and Minutes worked per care recipient per week

Internal staff hours worked per client week	FY23	FY22		Difference
Direct service provision	3.47	3.60	↓	(0.13)
Agency	0.09	0.08	↑	0.01
Care management & coordination	0.94	1.04	↓	(0.10)
Administration & support services	0.66	0.56	↑	0.10
Total Staff Hours	**5.16**	**5.28**	↓	**(0.12)**

Internal staff minutes worked per client week	FY23	FY22		Difference
Direct service provision	208.3	216.1	↓	(7.8)
Agency	5.6	4.9	↑	0.6
Care management & coordination	56.4	62.3	↓	(5.9)
Administration & support services	39.3	33.6	↑	5.7
Total Staff Minutes	**309.6**	**316.9**	↓	**(7.3)**

Figure 23: Staff Hours per care recipient week trend analysis

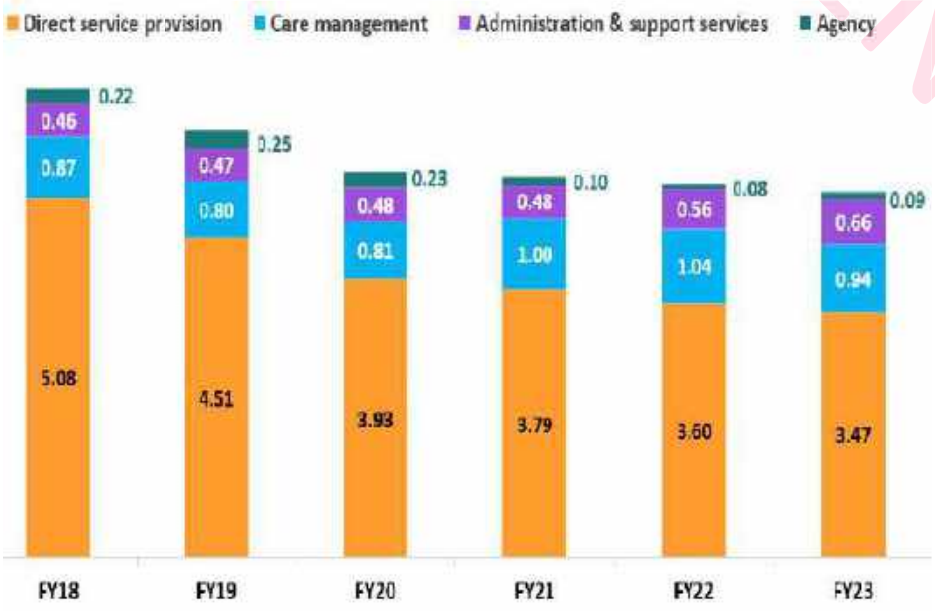


Figure 24: Internal and Brokered Services staff costs comparison

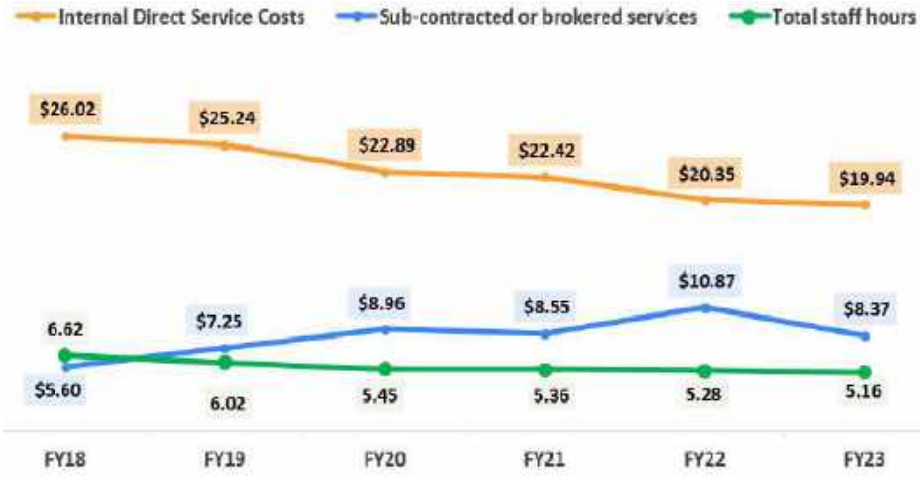
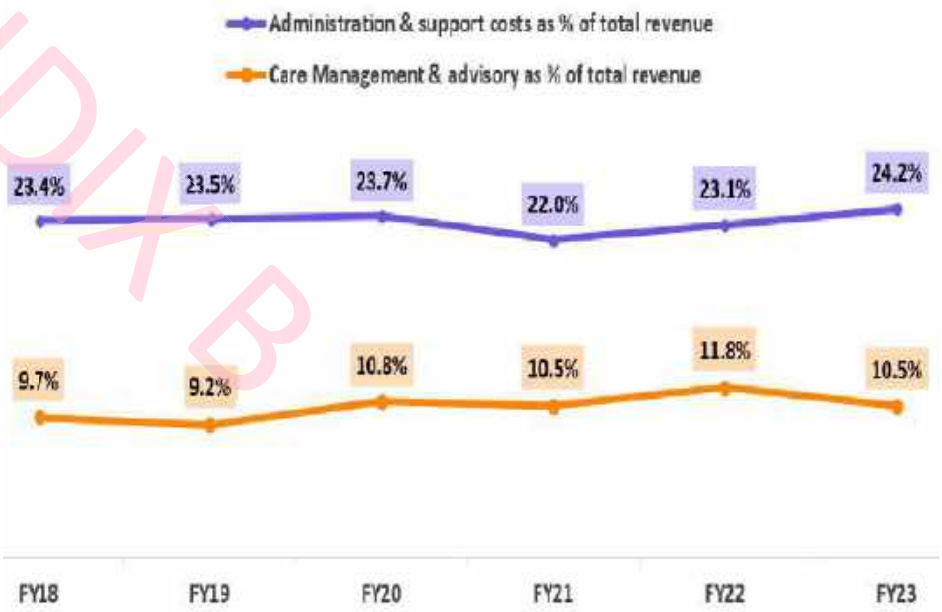


Figure 25: Case Management and Administration cost as % of revenue



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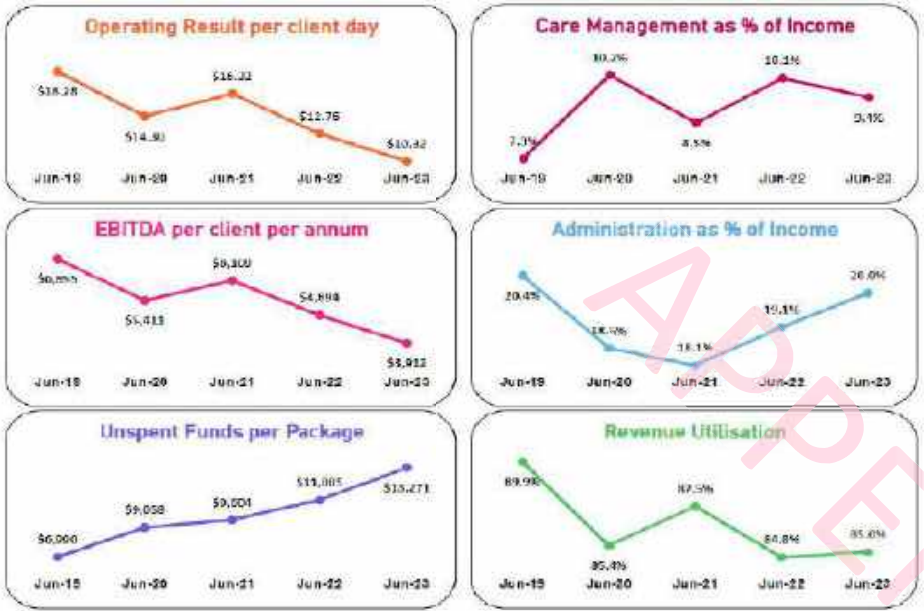
First 25% Trends



Home Care Key Points First 25%

Figure 26: EBITDA ($ per client pr annum) comparison First 25% and Average

Table 16: Summary Home Care First 25% KPI results comparison

	FY23 21,985 Packages	FY22 12,871 Packages	Difference (YoY)	FY21 11,586 Packages
Total revenue $ per client per day	$71.48	$77.68	($6.20)	$77.69
Operating result per client per day	$10.32	$12.76	($2.44)	$16.32
EBITDA per client per annum	$3,912	$4,894	($981)	$6,109
Average total internal Staff hours per client per week	4.92	5.20	(0.28)	5.35
Median growth rate	*16.6%*	*20.0%*	*(3.4%)*	*19.2%*
Revenue utilisation rate for the period	*85.0%*	*84.8%*	*0.3%*	*87.5%*
Average unspent funds per client	$13,271	$11,005	$2,265	$9,604
Cost of direct care & brokered services as % of total revenue	*55.6%*	*53.6%*	*2.0%*	*51.9%*
Care management & coordination costs as % of total revenue	*9.4%*	*10.1%*	*(0.7%)*	*8.5%*
Administration & support costs as % of total revenue	*20.0%*	*19.1%*	*0.9%*	*18.1%*
Profit margin	*14.4%*	*16.4%*	*(2.0%)*	*21.0%*

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Home Care Package Demographics

Figure 27: HCP Client exits

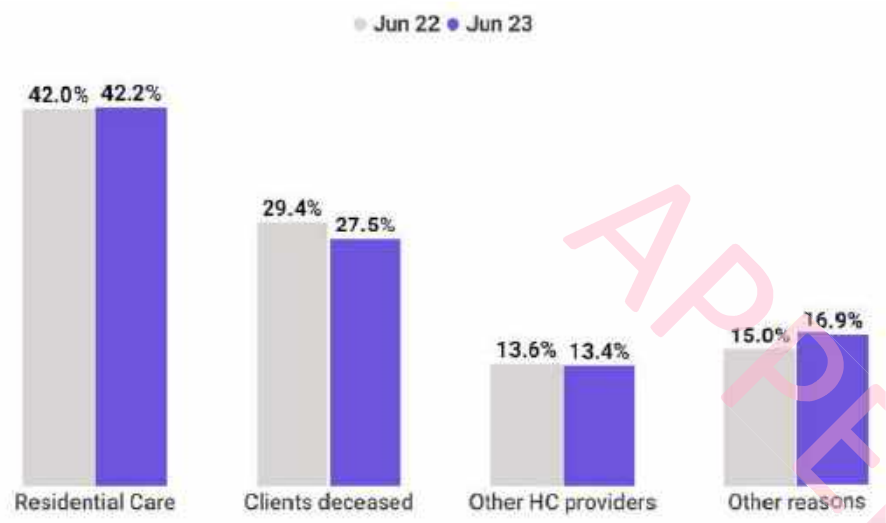
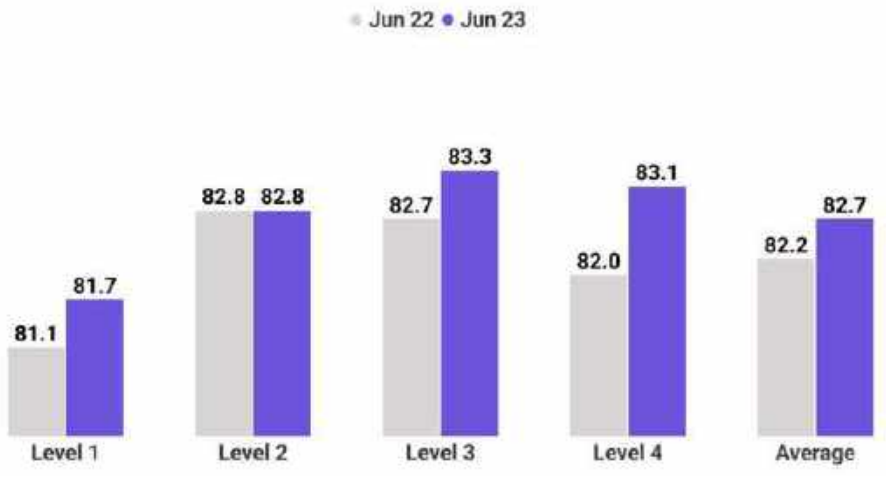


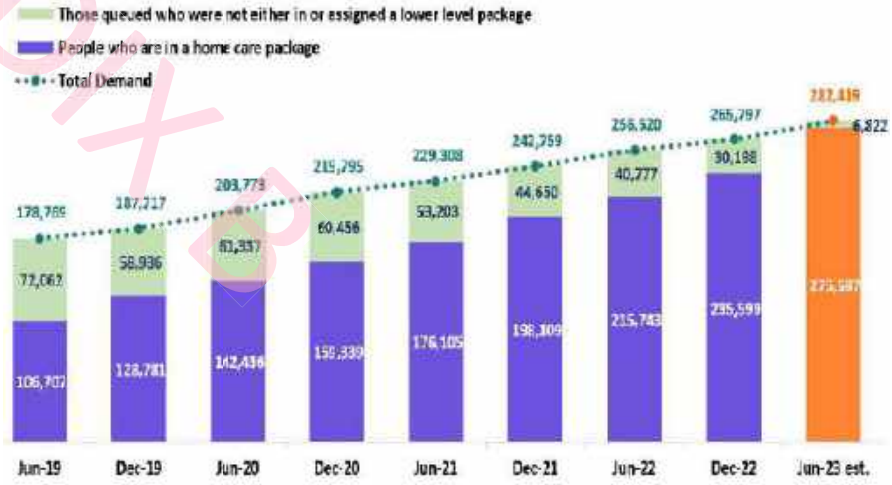
Figure 28: HCP Average Age of clients (participants)



Package Growth

Figure 29: Number of People in a Home Care Package

Figure 30: Demand for Home Care Packages



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3. APPENDIX

StewartBrown Survey

Survey Outline

The StewartBrown *Aged Care Financial Performance Survey* (Survey) commenced in 1995 and has grown exponentially since that date. The use of the term "Survey" is probably a misnomer, as unlike many public surveys which have a limited data set, the StewartBrown Survey is subscription based, quarterly and very granular in respect of data covered and depth.

The Survey is primarily for the benefit of aged care providers in reviewing their financial performance and considerations of strategic direction on an individual aged care home (facility) basis and home care package program basis.

Providers compare their performance of aged care facilities using a number of metrics through a range of data attributes, including resident mix and acuity, staffing levels (cost and hours/minutes), geographic region, age of building, type of building, number of places (beds), accommodation pricing and administration costs. Home care has a similar range of metrics. The Survey participants utilise an interactive website with high level dashboards, business intelligence tools and the ability to drill down on all data fields as required.

A secondary benefit is that the aggregate of the data provides a significant level of trend data and detailed analysis as included in our Survey reports and now through independent analysis undertaken by the University of Technology (UTS Ageing Research Collaborative) which provides an additional level of academic rigour.

Each participant completes detailed data input sheets for each quarter. Once received, the data undergoes a substantial cleansing and checking process (refer Glossary) which identifies all material variances, by comparison to previous quarters for each facility and comparison to equivalent benchmark facilities. In this context, all variances identified through this automated cleansing process are followed up with the respective provider for comment and further amendment if required.

To join the Survey please email benchmark@stewartbrown.com.au

StewartBrown has also commenced a disability services benchmark incorporating the same granular analysis as the aged care Survey (Disability Services Survey (stewartbrown.com.au))

Survey Results Matrix

As noted above, the primary purpose of the Survey is for participating providers to benchmark individual aged care facility and home care programs against similar de-identified comparators using a range of metrics. To ensure accurate and relevant benchmark comparisons, all outlier aged care facilities and home care programs are excluded from the Survey results. Examples of outliers include:

- Facilities/programs under sanction
- Facilities with significant infectious disease outbreaks (such as covid-19)
- Facilities undergoing major refurbishment
- Newly built facilities still in the ramping up stage
- Recently acquired facilities/programs undergoing structural operation changes
- Facilities/programs closed during the financial year (and reporting period)
- Facilities with occupancy less than 80%

For the purpose of the Survey analysis, all facilities/programs included are referred to as being **mature**.

Financial Reform Considerations

A number of potential reforms to the financing of aged care have been considered over many years and during countless reviews. Unfortunately, the lack of a consistent strategy and agreement from all sector stakeholders has inhibited some of the significant reform that is required.

The Department of Health and Aged Care has been very active in considering, implementing reforms where required and supporting regulatory changes but the sector, including all stakeholders, needs to embrace reform and provide solutions and not just focus on Government funding issues.

Ultimately, this will come down to requiring a greater level of consumer co-contribution in funding aged care. Clearly, where the consumer does not have the financial means to further contribute to the costs of services this must not in any respect disadvantage them. A safety net must be enshrined within aged care, as with other areas of health care and social services.

A brief overview of some financial reforms to be considered is as follows.

APPENDIX

Staff Remuneration and Benefits

One of the biggest challenges facing aged care is workforce, with considerable shortages in staff numbers being felt in all regions of Australia. The ability to attract and retain staff has reached a critical stage.

The recent Fair Work Commission wage ruling effective from 30 June 2023 of 15% increase (for Direct Care, recreation and head chef staff only) is a positive step. Whether this increase is sufficient on its own to attract additional staff is questionable, and the Governments has a number of programs to assist.

Other incentives and benefits may be required and several possible considerations could include:-

- Increase the Fringe Benefits Tax exemption for aged care employees to a cap of $40,000 (current cap of $30,000 has been in place since 1 April 2001)
- Expand the exemption criteria to include all aged care workers, not just those employed by a public benevolent institution
- Allow travel to work cost to be tax deductible for aged care workers (many of whom travel quite a distance to their place of employment)
- Provide a payroll tax supplement where applicable

A characteristic of the Fringe Benefit Tax exemption is that this amount must be consumed (as a fringe benefit) and not saved, and accordingly will have a lower economic cost and impact than a straight wage increase.

Subsidy Funding

A major and appropriate reform is for IHACPA to be responsible for the review of the various cost components in providing aged care services for residential and community care. IHACPA will provide recommendations to the Government as to the appropriate subsidy required to fund these costs which will provide greater transparency.

AN-ACC Subsidy

From 1 October 2022, residential aged care subsidy for the provision of direct care services has changed from the Aged Care Funding Instrument (ACFI) to the Australian National Aged Care Model (AN-ACC).

AN-ACC has been designed to more accurately reflect the funding required for each resident to align with their acuity and care needs and is welcomed by the sector.

The AN-ACC subsidy has been expanded to include funding for providing additional direct care minutes (Registered Nurses/Enrolled Nurses/Personal Care Workers) to be in line with the mandated levels as recommended by the Royal Commission. In this sense, it has morphed into a hybrid funding model.

As with any new funding model in such a complex and diverse area as aged care there will need to be refinements over time. In this regard, the role of IHACPA is paramount to ensure that the funding matches the input costs, and that inflation and wage increases are appropriately covered, unlike the recent experience of COPE not being adequate in this regard.

Regulated Consumer Contribution for Home Care

Home care providers (HCP and Commonwealth Home Support Program (CHSP)) are entitled to receive a consumer contribution of up to 17.5% of the single aged pension amount. Due to the less than optimal revenue utilisation in home care packages (refer earlier commentary) there has been little incentive for providers to seek a consumer contribution as it merely adds to the unspent funds and a portion is ultimately returned to the care recipient when they leave the home care program.

This has distorted the overall funding, and, importantly, has created a climate whereby consumers do not regard co-contribution as being a necessary component of aged care.

Recommendation 12 of the "Legislated Review of Aged Care 2017" (Tune Review) included requiring providers to charge the basic daily fee (consumer contribution) for home care packages.

Recommendation 16 recommended that mandatory consumer contributions be levied for CHSP services.

Implementation of these recommendations together with a new funding model designed to ensure that approved funding for each care recipient is appropriately aligned to the care needs of the care recipient and is fully utilised (services provided), should significantly improve the home care financial performance, and importantly, enable care recipients to receive a more inclusive care service delivery.

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Amendments to the Means-Tested Care Fee Criteria

Recommendation 13 of the Tune Review stated "include the full value of the owner's home in the means test for residential care when there is no protected person in that home".

Recommendation 15 sought the abolishment of the annual and lifetime caps on income-tested fees in home care and means-tested care fees in residential care.

These recommendations in full or at the very least in part, are fundamental to ensuring that aged care funding is appropriate and also being contributed to by the consumer.

In residential aged care, the means-tested care fee represents only 3.8% of the direct care subsidy. If this was lifted to (say) 9% and the means-tested care fee added to the funding envelope (rather than being deducted from the subsidy paid by the government), this would add in excess of $1.25 billion pa in the overall direct care funding envelope based on the FY23 direct care subsidy levels.

Deregulation of the Basic Daily Fee

The Basic Daily Fee is levied to reimburse for the costs associated with everyday living services. The costs are currently greater than the revenue received.

The Tune Review *Recommendation 14* effectively sought to deregulate the BDF by proposing that providers be allowed to charge a higher basic daily fee to non-low means residents up to a $100 per day cap before requiring pricing commissioner approval.

This proposal would eliminate the current unwieldy additional services and extra services regime and provide consumers with a greater choice and clarity.

Structural Reform of the Accommodation Pricing Model

This represents possibly the least understood aspect of residential aged care funding. The current Refundable Accommodation Deposit (RAD)/Daily Accommodation Payment (DAP) model infused with a prescriptive Maximum Permitted Interest Rate (MPIR) is cumbersome and confusing. It is also inequitable for consumers and providers as paying a RAD where possible is far less costly to the resident than paying a daily fee (DAP).

StewartBrown has advocated for changing the model to be more focussed on a "rental" payment for accommodation whereby the rent amount is determined by the actual upfront contribution paid. The underlying principle is that a rental portion is paid irrespective of whether a full contribution (currently a RAD) is paid.

As the name suggests, a Refundable Accommodation Deposit has no rental component included, and accordingly when paying a RAD the loss of alternate revenue from the RAD (such as interest) is the only actual cost to the resident for the accommodation in an aged care home. If the RAD amount still resides in the residential home, it is likely that the increase in the value of the home will be greater than the amount of lost interest income.

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4. GLOSSARY

Accommodation Result
Accommodation Result is the net result of accommodation revenue (DAPs/DACs/Accommodation supplements) and expenses related to capital items such as depreciation, property rental and refurbishment costs.

AN-ACC Direct Care Subsidy
From 1 October 2022 the Australian National Aged Care Classification (AN-ACC) replaced the previous Aged Care Funding Instrument (ACFI) funding model. Direct care revenue includes the subsidy received from the Commonwealth and the means-tested care fee component levied to the resident. Direct Care revenue includes the additional care supplement subsidies and some specific grant (not capital) funding.

AN-ACC Direct Care Result
The Direct Care (AN-ACC and formerly ACFI) Result represents the net result from revenue and expenses directly associated with direct care. It includes AN-ACC (formerly ACFI) and Supplements (including means-tested care fee) revenue less total direct care expenditure, and this includes an allocation of workers compensation and quality and education costs.

ACH (Facility) Result
This refers to the Operating Result may also be referred to as the net result or the NPBT Result.

ACH EBITDA
The same as Facility EBITDA. The starting point for this calculation is the Aged Care Home (Facility) Result which is the combination of the Care and Accommodation results. It excludes all "provider revenue and expenditure" including fundraising revenue, revaluations, donations, capital grants and sundry revenue. It also excludes those items excluded from the EBITDA calculation above.

This measure is more consistent across the aged care homes (facilities) because it excludes all those items which are generally allocated at the aged care home (facility) level on an inconsistent and arbitrary basis depending on the policies of the individual provider.

Administration Costs
Administration Costs includes the direct costs related to administration and support services and excludes the allocation of workers compensation and quality and education costs to Direct Care (ACFI) and Indirect Care (everyday living).

Aged Care Home
Individual discrete premises that an approved provider uses for residential aged care. "Aged Care Home" is the term approved at the Department of Health and Aged Care; in some contexts, "facility" is used, with an identical meaning.

Averages
For residential care all *averages* are calculated using the total of the raw data submitted for any one-line item and then dividing that total by the total occupied bed days for the aged care homes in the group. For example, the average for contract catering across all homes would be the total amount submitted for that line item divided by the total occupied bed days for all aged care homes in the Survey.

For home care all *averages* are calculated using the total of the raw data submitted for any one-line item and then dividing that total by the total client days for the programs in the group. For example, the average for sub-contracted and brokerage costs across all programs would be the total amount submitted for that line item divided by the total client days for all programs in the Survey.

***Average* by line item**
This measure is *averaged* across only those aged care homes that provide data for that line item. All other measures are *averaged* across all the homes in the particular group. The *average* by line item is particularly useful for line items such as contract catering, cleaning and laundry, property rental, extra service revenue and administration fees as these items are not included by everyone.

Bed Day
The number of days that a residential care place is occupied in the Survey period. Usually represents the days for which a Direct Care subsidy or equivalent respite subsidy has been received.

APPENDIXES

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Benchmark
We consider the benchmark to be the average of the *First 25%* in the group of programs being examined. For example, if we are examining the results for aged care homes (facilities) / programs in Band 4, then the benchmark would be the average of the *First 25%* of the aged care homes (facilities) / programs in Band 4.

Benchmark Bands
Residential Care
Based on Average Direct Care + Supplements (including respite) ($ per bed day):

Band 1 - Over $217
Band 2 - Between $207 and $217
Band 3 - Between $197 and $207
Band 4 - Under $197

Home Care
Based on Total Revenue (Direct Care Services + Sub-contracted and Brokered Services + Care Management + Package Management) ($ per client day):

Band 1 - Under $58
Band 2 - Between $58 and $68
Band 3 - Between $68 and $78
Band 4 - Over $78

Care Result
This is the element of the aged care home (facility) result that includes the Direct Care expenses and Indirect Care (everyday living) costs and administration and support costs. It is calculated as Direct Care Result *plus* Indirect Care Result *minus* Administration Costs.

Dollars per bed day
This is the common measure used to compare items across aged care homes (facilities). The denominator used in this measure is the number of occupied bed days for any home (facility) or group of homes (facilities).

Dollars per client day
This is the common measure used to compare items across programs. The denominator used in this measure is the number of client days for any programs or group of programs.

EBITDA
This measure represents earnings before interest (including investment revenue), taxation, depreciation and amortisation. The calculation excludes interest (and investment) revenue as well as interest expense on borrowings.

The main reason for this is to achieve some consistency in the calculation. Different organisations allocate interest and investment revenue differently at the "aged care home (facility) level". To ensure that the measure is consistent across all organisations we exclude these revenue and expense items.

EBITDA per bed per annum
Calculation of the overall aged care home (facility) EBITDA for the financial year-to-date divided by the number of operational beds in the aged care home (facility).

NPBT
Net Profit Before Tax. For the context of the Survey reports, NPBT is referred to as Operating Result or net result or, in the aged care home (facility) analysis, as the ACH Result (Aged Care Home, or Facility) Result.

Facility
An aged care home is sometimes called a "facility" for convenience. The Facility Result is the result for each aged care home being considered. Often called Aged Care Home and abbreviated to ACH.

Indirect Care (Everyday Living) Result
Revenue from Basic Daily Fee plus Extra or Optional Service fees less Hotel Services (catering, cleaning, laundry) and Utilities (includes allocation of workers compensation premium and quality and education costs to hotel services staff).

Home Care Packages (HCP)
Home Care results (NPBT) are distributed for the Survey period from highest to lowest by $ per client per day ($pcd). This is then divided into quartiles - the *First 25%* is the first quartile, second 25%, third 25%, fourth 25% and the average of each quartile is reported. The *First 25%* represents the quartile of programs with the highest NPBT result.

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Residential Care

The Residential Care results are distributed for the Survey period from highest to lowest by Care Result. This is then divided into quartiles - the *First 25%* (the first quartile), second 25%, third 25%, fourth 25% and the average of each quartile is reported. The *First 25%* represents the quartile of homes with the highest Care Result.

Location - City

Aged care homes have been designated as being city based according to the designation by the Department of Health and Aged Care in their listing of aged care services. Those that were designated as being a "Major City of Australia" have been designated City.

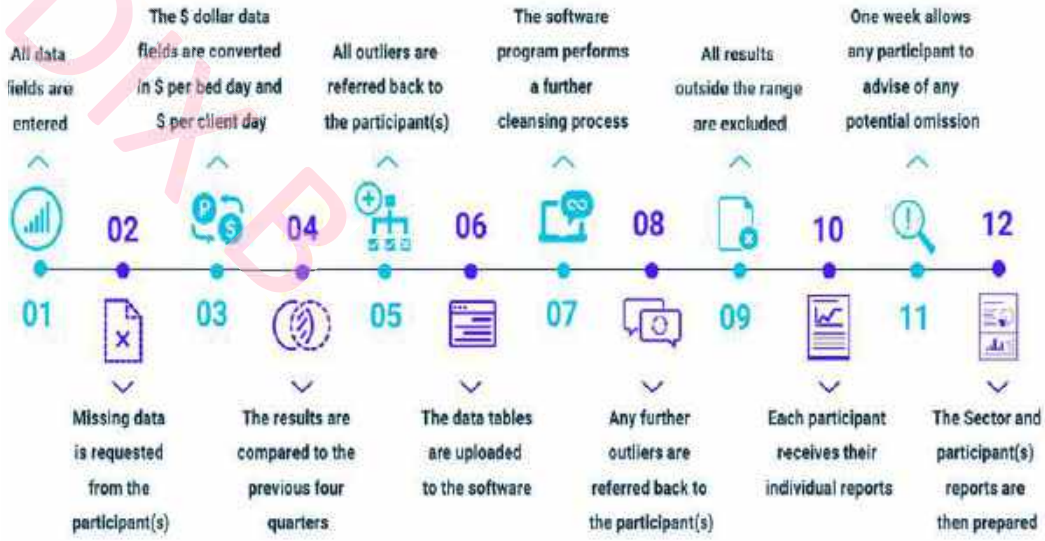
Location - Regional

Aged care homes have been designated as being regionally based according to the designation by the Department of Health and Aged Care in their listing of aged care services. Those that were designated as being an "Inner Regional", "Outer Regional" or "Remote" have been designated as Regional.

Survey is the abbreviation used in relation to the *Aged Care Financial Performance Survey*.

Data Collection Process

Data Cleansing Process



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