From: Jordan Lombardelli <Jordan.Lombardelli@ablawyers.com.au>
Sent: Monday, 23 May 2022 11:28 AM
To: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Cc: Chambers - O'Neill C <Chambers.ONeill.C@fwc.gov.au>
Subject: RE: AM2020/99, AM2021/63, AM2021/66 - Aged Care Work Value - Amended Witness Statement

Dear Associate,

Please see attached.

We also note that Mr Smith amended his statement during his cross-examination (see PN 13293 of Transcript dated 12 May 2022) and have included this as well (if required).

Sincerely

Jordan

Jordan Lombardelli
Associate
Australian Business Lawyers & Advisors

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From: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Sent: 19/05/2022 2:48 PM
To: Jordan Lombardelli <Jordan.Lombardelli@ablawyers.com.au>
Cc: Chambers - O'Neill C <Chambers.ONeill.C@fwc.gov.au>
Subject: AM2020/99, AM2021/63, AM2021/66 - Aged Care Work Value - Amended Witness Statement

Dear Ms Lombardelli,

I refer to the Statement [2022] FWCFB 71 published on 12 May 2022. Paragraph [7] requires parties to do the following:

- Provide copies of any documents already filed in word format; and
- Provide copies of any amended witness statements, in both word and pdf format

I note that the witness statement of Anna-Marie Wade requires amendment. Please provide the amended witness statement as soon as possible.

Kind regards,

Madeleine Castles (she/her)

Associate to the Hon. Justice IJK Ross, President

Fair Work Commission

Australia's national workplace relations tribunal

T 03 8656 4645

E madeleine.castles@fwc.gov.au

Level 4, 11 Exhibition Street, Melbourne, VIC, 3000
PO Box 1994, Melbourne, Vic, 3001

The Fair Work Commission acknowledges that our business is conducted on the traditional lands of Aboriginal and Torres Strait Islander people. We acknowledge their continuing connection to country and pay our respects to their Elders past, present and emerging.

This email was sent from Wurundjeri Woi Wurrung Country.

IN THE FAIR WORK COMMISSION

Matter(s): AM2020/99; AM2021/63 & AM2021/65

Re Applications by: Health Services Union (HSU) and Australian Nursing and Midwifery Federation (ANMF)

STATEMENT OF CRAIG SMITH

I, Craig Smith of 2 Pine Street, Albion Park Rail, in the state of New South Wales state as follows:

Background

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 currently employed by Warrigal in the position of Executive Leader Service Integrated Communities. I have held this position since December 2015.

3. Prior to this, I was employed as General Manager - Lifestyle & Care North NSW for the Illawarra Retirement Trust from April 2007 through to November 2015.

4. I hold a Bachelor's Degree in Commerce from the University of Wollongong.

Warrigal

5. Warrigal is a provider of aged care services to the Illawarra, Southern Highlands and Queanbeyan regions of NSW and the ACT and has been for over 50 years.

6. Warrigal operates 11 Residential Aged Care Facilities (**RACF**), community villages, provides home care services to around 3706 elderly persons and social services to the general community.

7. Warrigal is a not-for-profit and is passionate about its community and giving back.

8. Warrigal employs roughly:

   (a) 1246 Staff in Residential Care; and

   (b) 128 Staff in Home Services.

9. Warrigal operates under the *Warrigal and NSW Nurses and Midwives' Association, Australian Nursing and Midwifery Federation NSW Branch, and Health Services Union NSW/ACT Branch Enterprise Agreement 2017*. Annexed and marked **CS1** is this Enterprise Agreement.

My Position

10. As part of my role, I am responsible for the overall operations of Warrigals RACF, villages and home care services.

11. I lead and manage a multi-disciplinary team involved in the direct provision of Residential and Community services across a range of functional areas.

12. I am responsible and accountable for the effective planning and efficient delivery of a range of seamless care services across Warrigal.

13. A part of my roles is to lead the operational and compliance team as well as the wellness and lifestyle services of Warrigal.

14. This involves:

   (a) ensuring Warrigal Residential and Community services and Villages are compliant and offer a seamless service system for all our customers;

   (b) shaping the strategic improvements, along with the CEO, of our Residential and Community based services across the organisation; and

(c) providing high level executive leadership across the Management Team in our integrated and holistic care services.

15. I also have spent time working 'on the floor' of some of our RACF's to appreciate and understand the work that is being undertaken by Warrigal's employees.

Regulation of Warrigal

16. I set out below the changes to the regulation of the industry and the impacts this has had on Warrigal's operations.

17. It is the responsibility of me and my compliance team to ensure that Warrigal understands, applies and complies with the regulations.

The Standards

18. When I commenced with Warrigal around 6 years ago, the RACF operations of Warrigal was going through its fourth round of accreditation under the *Quality of Care Principles 1997* (**1997 Principles**)*.* Annexed and marked **CS 2** is this Quality Care Principles 1997.

19. Under the 1997 Principles, there was four general areas with 44 outcomes, being:

(a) management systems, staffing and organisational development – 9 expected outcomes;

(b) health and personal care – 17 expected outcomes;

(c) resident lifestyle – 10 expected outcomes; and

(d) physical environment and safe systems – 8 expected outcomes.

20. In 2014, the 1997 Principles were updated to the *Quality of Care Principles 2014* (**2014 Principles**)*.* However, the four general areas and expected outcomes remained the same.

21. Home Care Common Standards were also detailed in the 2014 Principles and consisted of 18 expected outcomes across three standards, being:

(a) Effective management (8 expected outcomes)

(b) Appropriate access and service delivery (5 expected outcomes); and

(c) Service user rights and responsibilities (5 expected outcomes).

Annexed and marked **CS 3** is this home care standards.

22. RACF's and home care were audited by the Accreditation Agency on Warrigals compliance with the 1997 Principles and 2014 Principles in order to maintain our accreditation.

23. The Aged Care Standards and Accreditation Agency would let the provider know they were coming out to do an inspection and which sections of the 2014 Principles they would be auditing the provider against.

24. The accreditation process at the time was more about validating the information Warrigal had previously supplied to the regulator, rather than undertaken an audit of the operations or reviewing the RACF against each of the expected outcomes.

25. From my experience being involved in this process, I would consider that the focus of the accreditation process under the 1997 Principles and 2014 Principles was on ensuring the clinical care provided to the consumer met the standards.

26. In 2019, the Aged Care Quality Standards (**ACQS**) were introduced and replaced the 2014 Principles. Annexed and marked **CS4** is the ACQS.

27. The ACQS introduced a new set of standards which would apply across all aged care services, including RACF, home care and Commonwealth Home Support Programme (**CHSP**). There are now eight standards, being:

(a) Consumer dignity and choice;

(b) Ongoing assessment and planning with consumers;

(c) Personal care and clinical care;

(d) Services and supports for daily living;

(e) Organisation's service environment;

(f) Feedback and complaints;

(g) Human resources; and

(h) Organisational governance.

28. The ACQS is now more consumer focused than the 2014 Principles, given that consumer dignity and choice is now the first standard and is now the foundation to all the other standards. In order to meet the ACQS, this requires aged care providers to consult and involve the consumer (a change in language from 'resident' which was also adopted during this time) and their family/responsible person in all decisions regarding the consumer. This was not required under the 2014 Principles or its predecessor (however was best business practice).

29. For example, when developing a care plan for a consumer, they are now involved and have a say in their care. the 2014 Principles did not require consultation with the consumer in order to develop their care plan. This meant that Warrigal had to refocus our approach to the consumer and ensure the consumers were involved in the delivery of their care.

30. The impact of the ACQS started with the governance processes of Warrigal and the compliance team who had to understand how the ACQS would impact the way Warrigal operates and to ensure compliance.

31. For RACF's, the main impact for personal care workers (**PCW**) and nurses (**RN**) was that their roles moved from task based and regimented, to consumer having a greater involvement. Examples of this include:

(a) when setting care plans, the consumer and registered nurse (normally) now set the consumers goals together;

(b) PCW and RN's now need to have improved communication skills to determine the needs and goals of the consumer; and

(c) the care being provided is then in accordance with the care plan, this might involve the consumer wanting to shower at night time as that is their preferred time, rather than in the morning when the PCW might have done their shower rounds.

32. The fundamental role that these employees undertake hasn't changed, they are still providing the same daily care and clinical care in accordance with a care plan.

33. The impact is to when and how the work is being perform going from task based to a more varied process, on basis of the consumer needs. There is need for greater communication and to work flexibly. For example, the work being performed is still largely routine, however, a consumer may advise a worker that they would like to eat in their room instead of the dining room.

Living Longer, Living Better

34. Living Longer, Living Better (**LLLB**) was introduced in 2013 and with it, brought reform across the whole industry. It was LLLB that introduced consumer directed care to the industry.

35. Aged care funding was previously based on high care and low care needs resident and the funding was linked to a 'bed'. For example, a low care needs resident could reside in a hostel, and if the resident was deemed to need more support and thus be a high care needs resident, they could be moved to a nursing home/RACF as this was where the care was funded.

36. However, with the introduction of LLLB changed the way that funding was provided to providers and in turn how providers operated. LLLB removed the concept of high and

low care in residential aged care facilities and the funding was now no longer connected to a bed.

37. The concept of 'aging in place' was also introduced. This meant that a consumer would have more say and, using the example above, if they were in a hostel, could choose to stay there, rather than being moved to the nursing home and still receive the level of care required.

38. With regards to home care, it brought about more home care packages and fairer means testing arrangements for elderly persons looking to access in home support through the government.

39. The introduced of LLLB was recognition of the changing needs of elderly persons (More elderly persons were coming in with more frailty, higher care needs, either palliative or with dementia) and how this was effecting the industry.

40. From a Warrigal perspective this meant that the consumer had more say in whether they stayed at home/in one of our villages rather than going into a RACF.

National Aged Care Mandatory Quality Indicator Program (*NACMQIP*)

41. NACMQIP was introduced on 1 July 2019 and implemented on 1 July 2021. Annexed and marked **CS5** is the NACMQIP

42. NACMQIP is essentially a new reporting program for residential aged care facilities to provide data that will be used to improve the quality of care and services.

43. The NACMQIP requires that RACF providers collect and report on indicators, being:

    (a) Pressure injuries:

    (b) Physical restraints;

    (c) Unplanned weight loss;

    (d) Falls and major injury; and

    (e) Medication management

44. Some of the abovementioned indicators were required to be reported upon every 6 months prior to the introduction of the NACMQIP.

45. Further, from my experience, most providers would have already collected the information required through a providers own reporting/incident management system, but just weren't required to be reported upon. Indeed, from experience at Warrigal, this information and more are already captured.

46. The practical impact of NACMQIP is that there is an additional reporting requirement for Warrigal's compliance team.

47. Having to report to regulatory bodies is not a new concept for providers. The industry has always had to undertake reporting on certain matters. This was just expanded the coverage of what providers need to report upon.

48. For providers, the major impact is that the clinical care team need to document and follow through with actions to address reportable incidents, and be able to provide evidence of this. This requires more reviewing of the actions about the improvement.

49. Another impact arising from the introduction of NACMQIP, is that residents must now have a diagnosis that justifies the use of chemical restraints (such as Schedule 8 medications) not just a symptom.

Serious Incident Response Scheme **(SIRS)**

50. SIRS was introduced in RACFs October 2021.Annexed and marked **CS 6** is the SIRS.

51. SIRS is an initiative to help prevent and reduce incidents of abuse and neglect in residential aged care services subsidised by the Federal Government by requiring residential aged care providers report, reportable incidents and take reasonable action to prevent incidents from happening.

52. The reportable incidents under SIRS :

(a) unreasonable use of force;

(b) unlawful sexual contact or inappropriate sexual conduct;

(c) neglect of a consumer;

(d) psychological or emotional abuse;

(e) unexpected death;

(f) stealing or financial coercion by a staff member;

(g) inappropriate use of restrictive practices;

(h) unexplained absence from care.

53. Prior to the introduction of SIRS, there have been incidents in which providers had to report upon and would keep a register of these incidents. An example of this includes falls and unexpected deaths. The SIRS process now requires providers to report on a broader range of incidents through to the regulatory body's portal.

54. I would estimate that across the 11 RACFs there is roughly between 25 to 30 reportable incidents per month or 1 per reportable incident at each RACF per week.

55. The process for making a report involves:

(a) A PCW is spending time with a resident, noticing a concern and then they will document their observation or depending on the seriousness directly report it the RN on shift;

(b) the RN or deputy manager then collates the information into the clinical care system; and

(c) the centralised reporting team reviewing the information in the clinical care system then logging a report with SIRS.

56. With regards to the PCW, if there was an incident or if the care worker had a concern or observed an incident, they always had to report this to an RN. There is now an increased number of incidents that need to be documented.

57. In order to deal with regulatory requirements which have been introduced over the last two decades and to assist our direct care employees, not just due to SIRS, Warrigal has introduced a centralised reporting team.

58. With regards to RN's, the new reporting requirements are not new clinical skills, rather an increase in what is required to be documented.

59. That being said, and as discussed above, the average for Warrigal is one report per home, per week. This has not significantly increased the work of PCW's or RN's.

The Elderly

60. In my experience since being in the industry there has been a change in the elderly persons accessing aged care.

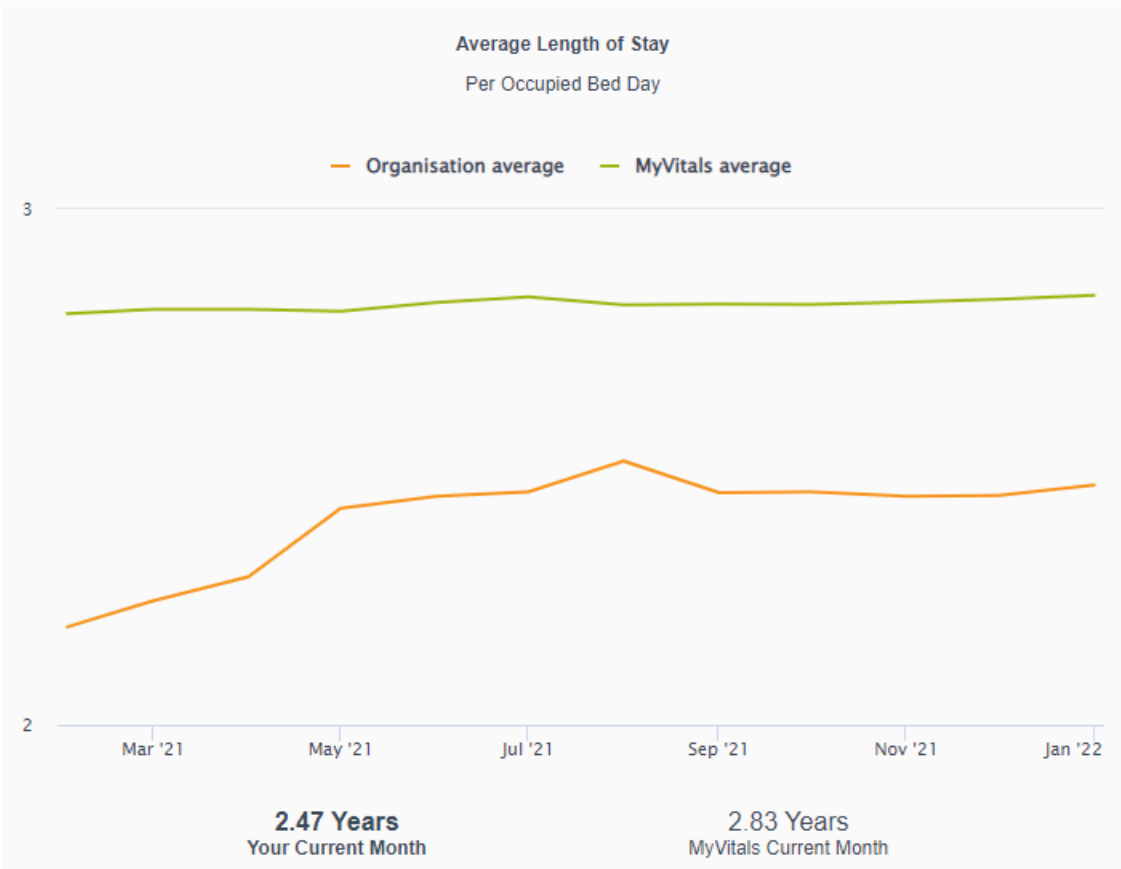
61. The persons coming in RACF are generally coming in with higher needs and are frailer than they were previously.

62. Warrigal's average Aged Care Funding Instrument (**ACFI**) is currently sitting at $192.00 per day, per resident. 2 years ago, our ACFI was $170.00 per day, per resident. This demonstrates that the consumers are now being assessed as requiring higher levels of care.

63. In line with his change in the type of consumers in RACF, Consumers are more likely to require two person assists or the use of mechanical aids as the consumers are less mobile.

64. Consumers are also staying for shorter periods in RACF. When I first entered the industry, the length of stay could be up to 10 years or so. Now the general length of stay is less than 2 years for consumers with higher care needs such as dementia.

65. The length of stay for consumers has remained fairly steady over the last 10 years. Warrigal's turnover of consumers ~~has increased by~~is 30%.



66. From my observations having consumers with higher ACFI demonstrates that the consumers have higher needs and can make the work more involved for the PCW as they provide the care.

The Work Environment

67. During my time in the industry there has been a gradual shift in the RACF environment.

68. There used to be multi-bed rooms and hostel style accommodation for consumer with lower needs to the majority being single rooms with ensuites.

69. Two of Warrigals older homes have 2 or 4 person rooms. However, there is a single room for palliative care.

Funding

70. Warrigal has been operating at a loss for the last 3 years. A recent and temporary subsidy has allowed for Warrigal to just start operating not a deficit.

Residential

71. When I entered the industry, funding for RACF was based on the Resident Classification Scale (**RCS**).

72. Consumers were classified on the RCS between level 1 (low) to level 8 (high) depending on the care needs. The classification of the consumer would determine the funding given to the provider.

73. Around 8 years ago, the Aged Care Funding Instrument (**ACFI**) replaced the RCS as the funding model. The ACFI is the tool that is provided to the Federal Government to allocate funding to a provider based upon the care needs of consumers. The ACFI provides information on the consumers needs across three care domains being:

    (a) activities of daily living;

    (b) cognition and behaviour; and

    (c) complex health care.

74. A downfall to the ACFI is that it assigns funding on the consumers assessed care needs, which may not be their current needs. An auditor can also come and assess the consumer and change the level of funding provided.

75. There was also a dementia supplement for RACF providers, however, it was removed within months of it being implemented due to the high cost.

76. Funding greatly impacts the operation of Warrigal.

77. Warrigal relies upon funding to fund roughly 90% of our total costs

As such, Warrigal uses the StewartBrown Benchmarking Report (**SB Report**) to determine the number of staff we can have on and what we can pay them. Annexed at ***CS 7*** *is the SB Report.*

78. Our RACF's are benchmarked according to other Homes based on the average ACFI/resident/day. One RACF falls into the highest band according to this report of over $197 per resident per day.

79. We then use the benchmarking to set out rosters and the rates of pay we can afford for our employees (above and beyond any minimum payments under an industrial instrument).

80. What we can afford to pay our employees is irrevocably linked to the funding we receive.

81. The funding we restricts the number of employees we can have on per shift. For example, if a Manager of an RACF would like to have 2 RN's on shift, then there would need to be less PCW's as a RN rates of pay are higher.

82. Without taking into account these considerations, Warrigal could not continue its operations as we would not be able to afford our operational and direct care costs.

83. The funding provided has not increased in line with the wage increases under the Agreement nor the general cost of living (CPI increases). This means that wages continue to eat into funding we receive, and the bottom line is getting closer and closer. Without a significant funding boost, wages will completely consume the funding we are provided.

84. This would mean that we would have to increase the additional service fees that we charge to consumers. Warrigal currently charges its consumers at all but three RACF's additional service fees between $2.10 - $38.00 per day depending on the services.

85. Any increase to these service fees is not an attractive option as consumers accessing our services are vulnerable and may not be able to afford this increase.

Home Care

86. Warrigal currently offers around 250 home care places.

87. In 2017 the way that home care is funded changed to be Consumer Directed Care that is that the funding allocated to the Consumer goes to the Consumer, rather than straight to the provider.

88. This means that consumers can now choose their provider.

89. Consumers are still assessed on the care needs which determines the funding allocated to them. This can be between level 1 to level 4.

90. The government subsidy for each Home Care Package (**HCP**) level is as follows:

Home Care Package level	Daily government subsidy rate	Yearly government contribution
Level 1	$24.73	$9,026.45
Level 2	$43.50	$15,877.50
Level 3	$94.66	$34,550.90
Level 4	$143.50	$52,377.50

91. There was no noticeable impact on the way Warrigal operates from this change.

92. The funding we receive determines what we can afford to pay our employees. Warrigal considers the hourly rate of pay for direct care employees, add on the oncosts and check this against benchmarking. This then determines what we "charge" a consumer for the services we offer.

93. Direct staffing costs take up roughly 80% of the funding we receive to provide these services for these consumers. There is also a cost of the coordinator who arranges the services for the consumers which is also factored into this figure.

94. If minimum rates were increased, we would have to factor this in and increase the cost of our services to the consumer.

95. Generally, consumers are not using their full amount of home care funding. As at 31st January 2022 there were 321 HCP customers with an unspent funds balance, overall total unspent funds were $3,036,282 averaging $9,459 per customer.

96. HCP consumers are not using their full amount of home care funding due to consumers are unsure of what to use the funds for, they don't necessarily need the amount of services that the funds cover but mostly they are saving the funds for a rainy day.

97. Warrigal currently has around 600 CSHP customers.

98. Warrigal receives funding from the Government which allows us to provide subsidised aged care services to recipients of CHSP. Our current subsided rate is $14.60/hour.

Qualifications and Training

99. In the past Warrigal did not require its PCW and home care workers to have a certificate III qualification in order to be employed as a PCW.

100. From my experience, there is less and less employees coming in at the non-qualified entrant level under the Enterprise Agreement.

101. This is due to Warrigal wanting PCW's to come in with some understanding of the industry and the eldery. Whilst we would prefer a CIII qualification from TAFE, due to the limitations in the talent pool we will accept a CIII from anywhere.

102. Due to changes in the medication administration process, we are also seeking a CIII with an assist clients with medication competency unit. Those who hold this competency and undertake medication assistance are paid an allowance under the Agreement.

103. If an applicant doesn't have the CIII we would train them internally and support them to achieve a CIII.

104. With regards to internal training offered, Warrigal has always offered internal training. The shift over the last 5 to 10 years is that the training provided is now offered online, rather than in face to face settings. Some internal training such as infection control and manual handling still require a face to face assessment in order to be deemed competent.

_____

Date:

IN THE FAIR WORK COMMISSION

Matter(s): AM2020/99; AM2021/63 & AM2021/65

Re Applications by: Health Services Union (HSU) and Australian Nursing and Midwifery Federation (ANMF)

STATEMENT OF ANNA-MARIA WADE

I, Anna-Maria Wade of Level 4, 320 Pitt Street Sydney in the state of New South Wales state as follows:

Background

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 currently employed by Aged & Community Services Australia (**ACSA**) in the following positions:

   (a) National Manager - Employee Relations, September 2017 - now;

   (b) State Manager - NSW & ACT, September 2018 - now;

   (c) Acting Executive Director – Membership & Services December 2021 – now

3. Prior to this, I worked as an Employee Relations Advisor for Aged & Community Services NSW/ACT from May 2014 to April 2017.

4. Prior to my employment ACSA, I also held the following relevant positions:

(a) Manager - People, Culture & Engagement at Sterling Process from 2013 - 2014;

(b) Human Resource Manager at Cooinda Coonabarabran Limited from 2010 to 2013; and

(c) TVET Coordinator, Teacher (HR & Food Safety) at TAFE NSW from 2007 to 2010.

5. I hold the following qualifications:

(a) Graduate Certificate, Employment Relations, Distinction 2018;

(b) Diploma of Business, Human Resource Management and Services, Distinction 2001; and

(c) Bachelor of Applied Science, Biotechnology (Microbiology), First Class Honours 1995.

ACSA

6. ACSA is an employer organisation that advocates for and supports not-for-profit, church and charitable aged care employers across Australia.

7. ACSA currently has around 500 member organisations across retirement living, community, home and residential care supporting more than 450,000 older Australians. Each member organisation may have multiple facilities or sites and can operate across residential and home care.

My Positions

8. My role as National Manager, Employee Relations, involves management of ACSA's Employee Relations service offering including the provision of day to day advice on the employee lifecycle, interpretation of Enterprise Agreements and Awards, personal injury and work-related injuries, workers compensation, managing employees, training and education on workplace issues.

9. In my role as State Manager for NSW/ACT, I am the point of contact into the organisation for members in these jurisdictions. I interface with the members, ACSA and other stakeholders such as NSW Ministry of Health, the Commonwealth Department of Health and the Aged Care Quality and Safety Commission on matters such as aged care related projects and programs, policy and public health matters. I act as a conduit between those levels of government, ACSA and the members. I also inform the Commonwealth Department of Health on the issues that providers are experiencing, including financial viability of their operations.

10. As part of my roles with ACSA, and prior to COVID-19, I would visit with members at their facilities around once a month to conduct training and attend meetings.

Regulation of the industry

The Aged Care Act

11. The *Aged Care Act 1997* (**the Act**) prescribes what can and cannot be done in the Aged Care Services (**ACS**) by a provider to ultimately protect those most vulnerable.

12. The Act also safeguards providers in the ACS by setting out a clear prescription for the ACS to follow. For example, section 96(1) of the Act, sets out the principles which the ACS must comply with including the accountability principles and user rights principles. Approved providers of aged care must comply with these requirements.

Industrial Instruments

13. From my experience with ACSA, depending on the service offered by the provider, they are generally governed by one or more of the following industrial instruments:

    (a) *Aged Care Award 2010* (**Aged Care Award**)*;*

    (b) *Nurses Award 2020* (**Nurses Award**)*;*

    (c) *Social, Community, home care and disability industry award 2010 (***SCHADS Award**); or

    (d) *Health Professional and Support Services Award* 2020*.*

14. ACSA assists its members in negotiating Enterprise Agreements (**EA**) terms and conditions. There are two main EA's in the ACS, these are:

    (a) the NSWNMA and HSU NSW Enterprise Agreement 2017 - 2020 (**ACSA Agreement**)

    (b) the NSWNMA, ANMF NSW Branch and HSU New South Wales Branch Enterprise Agreement 2020 (**LASA Agreement**)

    Set out in Annexure **AM-01** is a version of the ACSA Agreement

15. The EA generally include above award minimum wages. The rates in the ACSA Agreement for nurses are anywhere between 1.9 and 56% above the minimum award rates.

16. Outside of nurses rates, the rates set out in the ACSA Agreement are minimally above the relevant minimum award rates as the Government provides the majority of funding, and approved providers under the Act (which are the majority) are unable to afford wage increases within the current funding framework.

17. From experience in discussing the ACSA Agreement with our members, most employees covered by the ACSA Agreement are employed between CSE 1 and CSE 4 of the ACSA Agreement which is roughly between a 0.4% to 178% above the minimum award rates.

18. The Industrial Instruments make operation of the ACS difficult. The classifications and operational clauses in the Aged Care Award and SCHADS Award do not currently suit the needs of provider in the ACS. The Enterprise Agreements attempt to make the classifications, progression throughout the classification clearer and operational clauses suit the needs of the providers, however, this is an imperfect science.

19. I would estimate that roughly 70% of ACSA members operate under an Enterprise Agreement.

Aged Care Quality Standards

20. In July 2019, the Aged Care Quality Standards (**ACQS**) were updated. Set out in Annexure **AM-02** is the new standards.

21. Prior to this update the ACQS consisted of 44 standards that are categorised into four key areas being:

    (a) Management systems, staffing and organisational development

    (b) Health and personal care;

    (c) Care recipient lifestyle; and

    (d) Physical environment and safe systems.

    Set out in Annexure **AM-03** are the 2014 standards.

22. Once the 2019 standards were implemented, ACSA reviewed the 2019 standards, developed and implemented training programs to help providers understand the new standards and how these impacted their services. From this process, I understand the new standards to be a different way of looking at care.

23. The standards as they were, focused on the collective “consumers’” needs rather than the individual consumer. That is, the way the standards were drafted focused on the majority of consumers being better off, rather than focusing on each individual consumer.

24. The new standards are about tailored and individualised consumer needs.

25. The new standards do not explicitly require more of providers. The new standards require providers to shift their focus on their governance, including clinical governance. As a result, members have reported that there may be an increase in documentation and processes to ensure they meet the standards.

How the Industry Operates

26. Providers in the ACS must be approved as a provider under the Act.

27. ACS is made up of:

    (a) residential care;

    (b) home care;

    (c) Commonwealth Home Support Package (**CHSP**); and

    (d) respite care.

28. Retirement villages are not regulated under the Act, however, residents of the villages may access Home Care Packages or CHSP.

29. Over the last 10 years, admissions into the ACS has increased by around 40%. Set out in Annexure **AM-04** is an AIHW fact sheet on admissions into aged care.

30. Providers in the ACS conduct their operations in a number of ways. Examples of general operational structures from our membership include:

    (a) Warrigal that offers residential care, home care, CHSP, respite care;

    (b) Three Tree Lodge that only offers residential care; and

(c) ADSSI that offers home care, CHSP, short term restorative care and respite.

31. Providers are responsible and accountable for the quality of care of consumers according to the Act.

32. The majority of providers in the ACS are not for profit, community or charity run.

Set out in Annexure **AM-05** at page 39 is the Aged Care Royal Report is a table that identifies that 1006 providers out of 1458 are not for profit.

33. The Federal Government is the main funder of aged care with the ACS largely relying on the funding provided in order to operate.

Annexure **AM-05** at page 41 confirms that the Australian Government subsidies the majority of care services.

34. Outside of retirement village operators, no ACSA member operates without receiving funding.

35. Providers receive funding from the government depending on the service being offered. A potential consumer is assessed by either a Regional Assessment Service (**RAS**) or the Aged Care Assessment Team (**ACAT**).

36. The ACAT or RAS will ask the consumer questions about their needs, their lifestyle, their goals and will also speak to their doctor and other health professionals (as needed).

37. If the consumer is assessed as needed entry level support in their home with everyday tasks, they will then be referred for a RAS assessment and their support needs subsequently determined and approved through the CHSP. These services are subsidised by the Australian Government and consumers may be asked to contribute to the cost of these services.

38. If the consumer is assessed as needing more care, they will then be assessed as needing either a home care package or residential aged care. Some consumers pay additional fees above and beyond the government funding.

39. Residential care is funded through Aged Care Funding Instrument (**ACFI**) with home care funded through the Home Care Package and CHSP.

40. An ACS may choose to charge consumers fees called 'additional service fees' in some circumstances, which are in addition to the ACFI funding received. The fees that can be charged are mandated under the *Quality of Care Principles 2014.* These include basic daily fees, accommodation costs, means testing fees.

41. In order to be able to charge these fee's the provider must show that:

    (a) the services being offered are better than those set out in Schedule 1 of the *Quality of Care Principles 2014;*

    (b) are not specified care and services in Schedule 1 of the Principles;

    (c) are not covered by the payment of an extra service fee or an accommodation payment; and

    (d) are not services you're required to deliver under your responsibilities as a provider.

42. There are also restrictions on the monetary amount of additional service fees that can be charged.

    Set out in Annexure **AM-06** and **AM-07** is the schedule of fees and charges for residential and home care as well as the understanding fees for aged care homes fact sheet.

43. The StewartBrown Report identifies how funding is spent and the current economic state in the ACS:

(a) direct care (employee) costs make up 88.9% of the ACFI funding provided for residential care;

(b) direct care cost exceeded revenue received per bed;

(c) 56% of residential aged care providers are operating at a loss; and

(d) home care providers operating results have slightly improved although there has been an increase in unspent funds per home care client.

Annexed and marked **AM-08** is the StewartBrown Report.

44. As evidenced above, there continues to be declining levels of financial stability in the industry, specifically in residential aged care.

45. Providers have reported to me that they are struggling to continue operating in the current funding climate. When this happens, I offer to assist by providing advice on staff structures.

Qualifications and training

46. From my observations during my time in the industry, over the last decade there has been an increasing prevalence of providers requiring their personal care workers to hold a certificate III in Individual Support (or its predecessor qualifications). With regards to nurses the requirement to either hold their enrolled nurse qualification or degree in nursing has not changed.

47. From my experience with members and working in a facility, having a certificate III does not make a worker competent to perform the role. It gives the worker a base line understanding of care principles. What is more important is experience, as they develop the skills required to deliver the care needed. I would state that personal care workers continue to develop their skills up to 3 years.

48. The qualification itself can be achieved quicker too. For example, two decades ago, the main provider of the Certificate III was undertaken at TAFE. The qualification took between 6 to 12 months onsite. Now, from my understanding and my own research, there are more registered training organisations offering a Certificate III which can be undertaken in as little 6 to 8 weeks full time (plus around 120 placement hours) and ranging up to 6 to 12 months.

Set out in Annexure **AM-09** at page is an extract from a registered training organisation demonstrating that the qualification can be achieved within 7 weeks full time.

49. Anecdotally, through conversations with members, the quality of the content of a Certificate III has decreased over time. There has been concern in the industry that the courses offered by some RTOs are too short.

50. Although mandatory training is not prescribed by the regulations, when a provider is audited by the Quality and Safety Commission, they will check to ensure that the workforce has been trained. In my experience, there has always been internal training required such as, privacy, confidentiality, elder abuse, fire safety, infection control including handwashing and manual handling. The main shift over the last several years regarding internal training has been the introduction of COVID-19 specific infection controls and the training moving from in person to online training.

Medications

51. In some states and territories personal care workers/assistants in nursing are able to assist with medications, where this task has been delegated by the registered nurse. There is no uniform national approach to the regulation of this practice.

52. The states and territories that do allow personal care workers to assist with medications require appropriate training in medication administration.

53. The Guiding principles for medication management in residential aged care facilities developed by the Department of Health and Aging further support the guiding principles for medication management is that staff are appropriately qualified and authorised to administer medicines, and that administration practices are monitored for safety and quality.

Set out in Annexure **AM-10** is the Guiding principles

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Date: