Pulse Check of the Aged Care Sector: The Real Impact of Reforms

A national aged care survey

August 2026

Australian Nursing & Midwifery Federation

About the Australian Nursing and Midwifery Federation (ANMF)
The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial and political interests of more than 356,000 nurses, midwives and care-workers across the country.

Our members work in the public and private health, aged care and disability sectors across a wide variety of urban, rural and remote locations. We work with them to improve their ability to deliver safe and best practice care in each and every one of these settings, fulfil their professional goals and achieve a healthy work/life balance.

Our strong and growing membership and integrated role as both a trade union and professional organisation provides us with a complete understanding of all aspects of the nursing and midwifery professions and sees us uniquely placed to defend and advance our professions.

Through our work with members, we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities.

Acknowledgement of Country
We acknowledge the Traditional Custodians of the lands on which we work and live, and recognise their continuing connection to land, water, and community. We pay our respects to Elders past, present, and emerging. We acknowledge the stories, traditions, and living cultures of Aboriginal and Torres Strait Islander peoples on this land and commit to building a brighter future together.

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Table of Contents

List of tables

List of figures

Abbreviations

Abbreviation	Full name
AiN	Assistant in nursing
ACQSC	Aged Care Quality and Safety Commission
AN-ACC	Australian National Aged Care Classification
ANMF	Australian Nursing and Midwifery Federation
CHSP	Commonwealth Home Support Programme
COVID-19	Coronavirus disease 2019
CSE	Care service employee
EN	Enrolled nurse
HCP	Home Care Packages
NP	Nurse practitioner
OHS	Occupational health and safety
PCA	Personal care assistant
PCW	Personal care worker
RAC	Residential aged care
RACF	Residential Aged Care Facility
RN	Registered nurse
Royal Commission	Royal Commission into Aged Care Quality and Safety
WVA	Workplace violence and aggression

Executive summary

Background

The Australian Nursing and Midwifery Federation (ANMF) has been a leading advocate for aged care reform both before and following the Royal Commission into Aged Care Quality and Safety. These reforms, including mandatory care minutes, 24/7 registered nurse coverage, stronger workforce standards, and greater financial accountability, aim to improve care quality and strengthen the aged care workforce.

While important progress has been made, the ANMF believes a significant gap remains between policy intent and the realities experienced by nurses and care workers. Members continue to report workforce shortages, excessive workloads, workplace violence and aggression, and ongoing concerns about how public funding is translated into better care.

To assess the implementation of these reforms, the ANMF undertook a national 'pulse check' survey of aged care nurses and care workers. This report presents frontline perspectives on three priority areas critical to achieving sustainable reform:

1. Staffing levels and skills mix.
2. Workplace violence and aggression.
3. Financial transparency.

This report aims to provide an assessment of whether current reforms are delivering meaningful improvements for aged care workers and the older Australians they support.

Methods

An online cross-sectional survey was open for 6 weeks from 16 October 2025 to 09 December 2025. The survey consisted of demographic, multiple-choice, and open-ended questions. The survey covered topics such as staffing, skill mix, funding, consumer safety, worker safety, and clinical safety.

Eligible participants were individuals aged 18 years or older who were currently employed in any role within the aged care sector in Australia. The survey was open to both ANMF members and non-members.

Results

- A total of 3,552 eligible participants commenced the survey and answered at least one question.
- Most respondents were from Victoria (54.71%), registered nurses (42.59%), and working in residential aged care (89.40%) for a private not-for-profit provider (44.13%).
- This survey captures the perspectives of approximately 3.58% of registered nurses, 4.74% of enrolled nurses, and 0.74% of all aged care workers working in the aged care sector across Australia.

Staffing and skills mix

- Workforce perceptions of staffing adequacy were divided, with nearly two in five respondents (39.71%) rating the overall level of staffing at their workplace as inadequate ("poor" or "very poor") and around one-third (34.73%) considering levels as adequate ("good" or "very good").
- Respondents who worked for private for-profit providers were more likely to rate the overall number of staff at their workplace as inadequate (43.47%) compared to respondents who worked for not-for-profit or public providers. This trend remained stable across almost all staffing factor ratings.
- While the number of registered nurses at respondents' workplaces was viewed relatively favourably (with 46.06% of respondents rating this "good" or "very good"), 44.07% and 41.35% of respondents rated the number of enrolled nurses and personal care workers as inadequate, respectively.
- Nearly half (47.52%) of all respondents reported that the ratio of nursing staff to care staff was inadequate. This increased to over half (52.09%) among respondents from for-profit providers.
- Almost half (49.03%) of the workforce reported having insufficient time to deliver care. This increased to over half (55.75%) among respondents from for-profit providers.
- Respondent comments described poor staffing ratios and caring for large numbers of residents with minimal staffing and support, impacting their ability to deliver high-quality care and resulting in moral distress, chronic fatigue, and burnout.
- Respondents also described substantial changes to staff roles. These included registered nurses being shifted from direct clinical care toward administrative responsibilities; personal care workers being moved away

from providing direct care to undertake hotel services, food service, and laundry duties under 'universal' care worker models; and a significant erosion of the enrolled nurse role, characterised by reduced clinical responsibilities, reclassification from nursing to care staff positions, and, in some cases, redundancy.

Workplace violence and aggression (WVA)

- Almost all respondents (96.43%) reported having experienced and/or observed one or more instances of WVA at their workplace in the past 12 months.
    - Just over three-quarters (76.69%) reported that they had experienced verbal abuse,
    - Over two-thirds (69.68%) reported experiencing physical abuse,
    - Just under half (n=1,209, 49.01%) reported property damage or thrown objects,
    - Over one-third (36.44%) reported experiencing racism, and
    - Over one-third (35.55%) reported sexual harassment.
- Those who rated the overall level of staffing at their workplace as "very poor" were more likely to report experiencing WVA, suggesting that inadequate staffing levels contribute to the likelihood of experiencing WVA.
- Most respondents identified residents/clients as the perpetrators in one or more of their experiences of verbal abuse (95.08%), physical aggression (97.73%), property damage (96.28%), and sexual harassment (93.84%). Respondents also identified that visitors and/or family members of residents were perpetrators of verbal abuse towards staff (54.44%) and racist behaviours (48.39%).
- Respondents indicated that they experienced WVA on a frequent or semi-frequent basis. For example, among those who reported experiencing verbal abuse, 32.12% indicated that it occurred multiple times per day and 32.12% reported that this occurred daily.
- Respondent comments highlighted risks attributed to organisational factors, such as the lack of behavioural planning, preventative, and follow-up actions. Further, respondents described how insufficient staffing levels resulted in residents being left unsupervised or receiving rushed care, increasing the likelihood of aggressive incidents.
- Respondent comments also described a poor reporting culture, where resident aggression was framed as inevitable and unmodifiable, with

managers perceived as being dismissive of staff concerns and blaming staff for incidents, rather than addressing root causes or the impact on staff wellbeing. This lack of support contributed to significant under-reporting, as staff lost confidence that anything would be done or feared negative repercussions.

Financial transparency

- Throughout the survey, respondents from for-profit providers demonstrated higher levels of dissatisfaction with staffing factors and were more likely to report experiences of WVA compared to respondents from other provider categories, highlighting how providers driven by profitability are more likely to neglect their workforce.
- Respondents perceived that providers misallocated funding, linking concerns such as chronic understaffing to providers prioritising profit over resident well-being.
- Respondents also reported that management frequently failed to cover for sick staff or hire agency workers, which was perceived as a measure to control costs. Other cost-saving measures included rationing essential supplies such as wound dressings or updating equipment.

Conclusions

The findings of the ANMF 'pulse check' survey provide a timely assessment of the impact of recent aged care reforms from the perspective of one of the groups most affected, the aged care workforce. While recent reforms have driven some improvements in the aged care sector, the ANMF contests that in many cases they have not gone far enough and serious systemic concerns persist, including unsafe staffing levels and skills mix, unacceptably high levels of WVA, and a lack of transparency in how providers use government-provided funding. These concerns continue to compromise both the quality of care provided to older Australians and the wellbeing of the workforce.

To address these concerns, structural change that places workforce capacity, clinical expertise, and accountability at the centre of policy is required. This includes mandating staffing ratios and evidence-based skill mix, strengthening protections against WVA, enhanced financial transparency, and stronger regulatory oversight. These reforms are essential to achieving the intent behind the Royal Commission's recommendations.

The ANMF recommends that the Australian Government:

1. Improve staffing levels and skills mix in the aged care sector by:
    1.1. Replacement of care minutes with mandated staffing ratios that increase the presence of nursing staff and align with evidence-based benchmarks and the complexity of care to create a clearer and more enforceable staffing standard to ensure safe staffing levels across all shifts.
    1.2. Implementing a national workforce strategy focused on attraction, retention, and training which will support staffing and skills mix reforms and development of the aged care workforce.
    1.3. Attracting enrolled nurses back to the sector through dedicated staffing targets and a range of workforce incentives that recognise and strengthen the role of enrolled nurses.
    1.4. Establishing a national AHPRA-consistent registration scheme and minimum training standards to professionalise the personal care worker workforce.
    1.5. Prohibiting "universal" worker models that dilute clinical roles and divert staff from direct care.

2. Eliminate workplace violence and aggression (WVA) by:
    2.1. Implementing mandatory, standardised risk assessments and person-centred care planning to prevent and manage WVA as part of standard care with regular review and auditing of compliance, including the number of WVA instances.
    2.2. Incorporating consideration of environmental WVA risk factors into the design, refurbishment, and accreditation of aged care facilities.
    2.3. The development and delivery of Government-funded, nationally consistent, competency-based workforce training on WVA prevention and management in aged care.
    2.4. Ensuring that restrictive practices involving physical or chemical restraint must not be used except as a last resort and that providers must demonstrate that all reasonable, least restrictive, evidence-based alternatives have been explored and implemented before restraint is considered.

2.5. Strengthening WVA incident reporting systems, including mandatory reporting and systems that ensure transparency and accountability in how providers respond to incidents.

2.6. Ensuring the Department of Health, Disability and Ageing implement a 'zero tolerance' approach to preventing and managing violence in all health, disability, and ageing sectors.

2.7. Establishing national WVA incident data collection, monitoring, and continuous improvement frameworks to track outcomes and inform policy.

3. Increase transparency in how public funding is utilised by:

3.1. Requiring stronger and more transparent, standardised public reporting of provider financial performance and use of funds.

3.2. Strengthening the role, resourcing, and enforcement powers of the aged care regulator to ensure compliance and accountability.

3.3. Developing and implementing a staged de-privatisation strategy to reduce for-profit ownership of aged care services and expand public and not-for-profit care.

Ultimately, the quality of Australia's aged care system depends on the strength of the workforce that sustains it. By implementing the recommendations outlined in this report, governments can build a sustainable, accountable, and high-performing aged care system that delivers safe, person-centred care, supports and retains its workforce, and restores public confidence in the care provided to our older generations.

Introduction

The Australian Nursing and Midwifery Federation (ANMF) has a long and established history of advocating for a safe, high-quality, accessible and sustainable aged care system that upholds the dignity, rights, and wellbeing of older Australians and provides a safe and rewarding workplace for aged care staff.

As the largest professional and industrial organisation representing nurses, midwives, and care workers, the ANMF brings together the voices and lived experiences of those working at the frontline of aged care delivery across residential, home, and community settings. This experience has consistently informed the ANMF's evidence-based advocacy with governments, regulators, and industry aimed at strengthening care quality while ensuring the workforce is properly protected, supported, and valued.

In the wake of the Royal Commission into Aged Care Quality and Safety (hereafter referred to as the Royal Commission), the ANMF has been a leading national advocate for comprehensive and enduring reform to address long-standing systemic failures in the aged care system. This advocacy has focused on the critical link between workforce conditions and the care outcomes and experiences of older people. Key areas where the ANMF have driven reform include mandated staffing levels and skills mix through direct care time standards, 24 hour/ seven day a week registered nurse coverage, improved wages and conditions, registration for personal care workers (PCWs), stronger sector regulation and oversight, and greater transparency and accountability in the use of public funding and aged care fees. While many of these reforms have now been introduced or are in train, their success ultimately depends on how they are implemented at the service level and whether they are adequately resourced to support both workers and older people.

It is the view of the ANMF and the workforce it represents that despite progress there remains a significant gap between legislative intent and sector realities. Our members continue to report ongoing challenges such as workforce shortages, workplace violence and aggression (WVA), high workloads, fatigue, moral distress, and limited access to education, training and career progression. These challenges continue to shape daily working lives and directly affect the quality and continuity of care that can be provided.

As the aged care sector continues to undergo significant changes, there is a pressing need to understand how these reforms, including the new Aged Care Act, are being experienced by those delivering care on the ground. To explore this gap, the ANMF has undertaken a 'pulse check' survey of aged care workers to capture a timely and comprehensive snapshot of the state of the aged care sector from the perspective of nurses and care workers.

Informed by the voices of the ANMF members, this report focuses on three critical areas of reform: 1) insufficient staffing levels and skills mix; 2) continued and unacceptable levels of WVA; and 3) a lack of financial transparency in how providers utilise government funding intended for care delivery.

Background

Staffing and skills mix

The Royal Commission identified inadequate staffing levels and poor skills mix as longstanding systemic issues in Australian residential aged care, contributing to substandard care and workforce pressures. Under the Aged Care Act 1997, providers were not required to meet defined staffing ratios, skills mix standards, or minimum care time requirements, leaving these decisions to provider discretion. To address these gaps, Recommendation 86 proposed a minimum direct care time standard of 200 minutes of direct care per resident per day, including 40 minutes of registered nurse (RN) time. The Commission stressed this was a minimum threshold for safe care, noting evidence that higher nurse staffing levels improve clinical outcomes and quality of life.

In response, the Australian Government implemented mandatory care minutes linked to the Australian National Aged Care Classification (AN-ACC) funding model. From October 2022, a sector-wide target of 200 minutes (including 40 RN minutes) was introduced, becoming mandatory in October 2023. From October 2024, this increased to 215 total minutes, including 44 RN minutes, with up to 10% of RN time able to be delivered by enrolled nurses (ENs). Recommendation 86 also mandated continuous RN presence. From July 2023, residential aged care facilities are required to have at least one RN on-site at all times (24/7 RN), supported by targeted government funding.

Despite mandated direct care minute targets, concerns remain that some aged care providers adopt compliance-focused staffing practices that enable them to meet regulatory requirements without necessarily improving residents' access to

high-quality care. The existing care minute framework can be "gamed" by maximising the recording of activities that qualify as direct care while minimising indirect but essential tasks. There is also persistent confusion over what is counted as direct care, resulting in lack of consistency and transparency in reporting. In addition, providers may rely heavily on lower-paid personal care workers to meet care minute targets while limiting the availability of registered nurses and other highly qualified staff whose clinical expertise is essential for managing increasingly complex resident needs. Consequently, compliance with mandated care minutes may not accurately reflect the quality, continuity, or appropriateness of care delivered.

Workplace violence and aggression

Workplace violence and aggression has long been a significant workplace health and safety issue in Australian residential aged care, affecting nurses and personal care workers (PCWs).[1] It is often linked to challenging resident behaviours associated with dementia, mental illness, pain, distress or unmet care needs,[2] however, WVA may also be perpetrated by residents' family members, visitors, and other staff, including managers. Violence and aggression are harder to prevent and manage where there are too few staff or staff are not provided sufficient education, training, and support to safely and effectively manage and prevent it.

Despite being widely recognised as a systemic risk, WVA has historically been normalised as an unavoidable aspect of care work.[3] ANMF members have often told us of providers' inaction on their responsibilities to identify, prevent, and manage violence and aggression through staffing, training, reporting systems, workplace design and strong management action. Evidence from sector research has shown that many aged care workers have lost faith that incidents can be managed and prevented appropriately,[4-8] highlighting the extent of WVA experience and inadequate management.

While the Royal Commission did not make an independent WVA recommendation, it recognised the behavioural and care risks that can contribute to aggression in residential aged care and supported broader reforms aimed at safer, better-staffed care. This included broader reforms such as adequate staffing and skills mix, which are essential to reducing the frequency and impact of WVA in aged care.

Financial transparency

The Royal Commission identified financial transparency as a major weakness in Australia's aged care system, finding that governments, regulators, and the public lacked clear, consistent information about how providers used public funding. At the time, reporting requirements under the Aged Care Act 1997 did not sufficiently show whether subsidies were being directed to core care needs such as staffing, clinical care, and food, limiting accountability for care outcomes.

This is of particular concern given the scale of public investment in the aged care sector. The lack of detailed financial data on how funding accrued through public taxation is utilised has reduced public confidence in whether the system was delivering the best possible care for older people.

In response, the Royal Commission made several recommendations to strengthen financial oversight, transparency, and accountability. This included the introduction of the Australian National Aged Care Classification (AN-ACC), which linked funding more directly to residents' assessed care needs. Further recommendations included the implementation of enhanced financial and prudential reporting requirements, including more detailed reporting on care, staffing, and food expenditure, and public release of provider-level financial data to improve transparency through the introduction of the Quarterly Financial Report and expansion of the Aged Care Financial Report. More recently, accountability measures linking government funding to meeting of mandatory care minute targets aim to strengthen accountability in the use of funding.

Methods

Design

An online cross-sectional survey was open for six weeks from 16 October 2025 to 9 December 2025. The ANMF Federal Office developed the survey, and the ANMF state and territory branches provided input into its design and content to ensure applicability to their local members' concerns.

The survey consisted of demographic, multiple-choice, and open-ended questions. The survey covered topics such as staffing, skill mix, funding, consumer safety, worker safety, and clinical safety.

Participants and recruitment

Participants for this survey were recruited through ANMF state/territory branch communication channels, including email distribution lists, newsletters, and social media platforms. Snowball sampling, such as sharing of the survey link with colleagues, was encouraged. Participation was voluntary, and no incentives for participation were offered.

Eligible participants were individuals aged 18 years or older who were currently employed in any role within the aged care sector in Australia. The survey was open to both ANMF members and non-members.

The survey was hosted on the secure survey platform, SurveyMonkey. Consent was obtained electronically, and participants were presented with an electronic participant information statement outlining the study purpose, the voluntary nature of participation, confidentiality measures, and contact details for support services prior to commencing the survey.

Data analysis

Data collected were exported from SurveyMonkey and securely stored electronically. Only members of the research team had access to survey data. All data were de-identified prior to analysis, and no identifying variables have been included in this report. Quantitative data were summarised using descriptive statistics, and qualitative open-text responses will be presented narratively.

All eligible responses were included in the analysis regardless of total survey completion rate. For each survey item, the denominator was defined as the number of participants who submitted a response to that specific item.

For ‘select all that apply’ items that did not include a ‘not applicable’ response option, denominators were calculated to approximate the number of participants who viewed the item. In these cases, the denominator comprised all participants who selected at least one response option, as well as participants who did not select any option but were inferred to have viewed the item, based on whether they provided responses to adjacent survey items while leaving the item in question blank. Because this does not allow definitive differentiation between intentional non-selection (i.e., ‘none of the options apply’) and item non-response, percentages derived using this approach should be interpreted as estimates only. This has been clearly marked where this applies in the results.

Results

The results section is divided into four sections: (1) demographics, (2) staffing levels and skills mix, (3) workplace violence and aggression, and (4) financial transparency.

1. Demographics

A total of 3,644 nurses, midwives, and care workers accessed the survey. Of these, 70 respondents (1.92%) did not provide consent, and 25 (0.69%) were under 18 years of age and therefore ineligible to participate. A total of 3,552 eligible participants commenced the survey and answered at least one question. No single-registration midwives participated, however some participants were dual registered nurses and midwives.

1.1. State and territory distribution

Respondents (n=3,418) were asked in which state/territory they worked in aged care. While the survey was open to participants from all states and territories, over half of the respondents (n=1,870, 54.71%) were from Victoria. A smaller proportion of respondents were from New South Wales (n=566, 16.56%), Western Australia (n=301, 8.81%), Queensland (n=292, 8.54%), South Australia (n=261, 7.64%), and other states/territories [see Figure 1]. This distribution of respondents across the states and territories should be considered when interpreting the results regarding the representativeness of the national sample [see Table 1]. Most respondents (n=3,260, 93.60%) were current ANMF/QNMU/NSWNMA members.

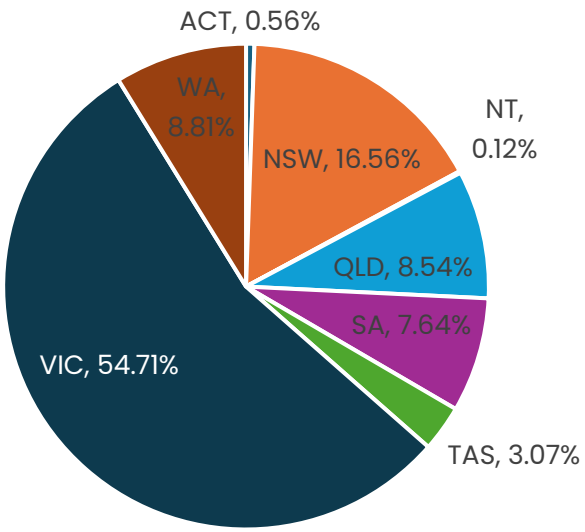

Figure 1. Distribution of respondents by state and territory

Table 1. Estimated response rate by state and territory

State/ Territory	Number of survey respondents	Estimated number of ANMF aged care members*	Estimated response rate (%)
VIC	1870	19000	9.84%
NSW	566	13100	4.32%
WA	301	3238	9.30%
QLD	292	9500	3.07%
SA	261	4800	5.44%
TAS	105	1220	8.61%
ACT	19	276	6.88%
NT	4	124	3.23%
Total	3418	51258	6.67%

1.2. Primary role in aged care

Respondents (n=3,494) were asked what their main role (where they worked the most hours in the last 12 months) was in aged care. The largest proportion of responses were registered nurses (RNs) (n=1,488, 42.59%), followed by aged care workers (PCWs†) (n=915, 26.19%) and enrolled nurses (ENs) (n=829, 23.73%). Only a few respondents were dual registered nurses/midwives (n=17, 0.49%) or nurse practitioners (NPs) (n=12, 0.34%). Of respondents reporting that their main role was something other than those above (n=233, 6.67%), these included managerial, administrative, or non-clinical roles such as care managers, lifestyle assistants, or administrative officers [see Table 2].

Based on workforce data, this sample represents approximately 3.58% of registered nurses, 4.74% of enrolled nurses, and 0.74% of aged care workers working in the aged care sector.‡

* Note that figures are estimates provided by ANMF state/territory branches and may not fully capture the extent of the aged care workforce represented by the ANMF.
† In this report, the term 'personal care workers' (PCWs) is used to refer to members of a diverse staff group including assistants in nursing (AIN), personal care assistants (PCA), and care services employees (CSE), etc.
‡ According to the Department of Health, Disability and Ageing Health Workforce Data Set, in 2024 there were 41,542 registered nurses and 17,473 enrolled nurses working in aged care. While data on the exact number of personal care workers in aged care is limited, the 2021 ABS Census indicates a total of 123,257 personal care workers working in aged care Australia-wide.

Table 2. Respondents' primary role in aged care

Main Role	n	%
Registered nurse (RN)	1488	42.59%
Aged care worker (e.g. AIN, PCW, PCA, etc)	915	26.19%
Enrolled nurse (EN)	829	23.73%
Registered nurse & midwife	17	0.49%
Nurse practitioner (NP)	12	0.34%
Other	233	6.67%
Total	3494	

1.3. Primary aged care employment sector

Respondents (n=3,415) were asked in which aged care sector they worked the most hours in the past 12 months. Most respondents worked in residential aged care (RAC) (n=3,053, 89.40%). Fewer were employed under the Support at Home program (n=137, 4.01%) or in a hospital (n=81, 2.37%). Of respondents who reported working in areas other than those provided (n=82, 2.40%), these included community nursing, aged care assessment, NDIS, veteran affairs, education, and palliative care [see Table 3].

Respondents (n=3,408) were asked what provider category their primary employer is. Respondents reported working for private not-for-profit providers (n=1,504, 44.13%), followed by private for-profit (n=1,050, 30.81%), and public/government providers (n=523, 15.35%) [see Table 4].

Table 3. Sector of respondents' primary role in aged care

Aged Care Sector	n	%
RACF	3053	89.40%
Support at Home Program	137	4.01%
Hospital	81	2.37%
MPSP	27	0.79%
Primary Health Care Clinic	14	0.41%
NATIFACP	5	0.15%
General Practice	8	0.23%
Other	82	2.40%
Not sure	8	0.23%
Total	3415	

Table 4. Provider category of respondents' primary employer

Provider Category	n	%
Private not-for-profit	1504	44.13%
Private for-profit	1050	30.81%
Public/government	523	15.35%
Not sure	269	7.89%
Other	62	1.82%
Total	3408	

1.4. Years of experience in aged care

Respondents (n=3,422) were asked how long they've worked in the aged care sector. Over half of the respondents (n=1,768, 51.67%) had been working in aged care for over ten years [see Table 5].

Table 5. Years of experience in the aged care sector

Years of Experience	n	%
Less than 6 months	67	1.96%
6 months – less than 1 year	122	3.57%
1-3 years	578	16.89%
4-6 years	525	15.34%
7-9 years	362	10.58%
10 years or more	1768	51.67%
Total	3422	

2. Staffing and skills mix

While the ANMF Pulse Check Survey did not ask respondents to provide or estimate their workplace's performance on direct care minute targets, as this data is reported elsewhere,[9] the impact of this reform was examined in the context of participant-reported staffing factors.

As staffing and skills mix requirements within the other sectors are variable and not mandated, this section only reports on staffing factors reported by respondents working in residential aged care facilities (n=3,053).

2.1. Staffing factors

2.1.1. Overall number of staff

When asked to rate the overall number of staff at their workplace over the past 12 months, respondents (n=2,594) were mixed. Almost two in five respondents

(n=1,030, 39.71%) rated the overall number of staff as inadequate, describing staffing levels as "poor" (n=740, 28.53%) or "very poor" (n=290, 11.18%), while around one-third (34.73%, n=901) reported that staffing levels were adequate, describing staffing levels as "good" (n=665, 25.64%) or "very good" (n=236, 9.10%) [see Figure 2].

When examined by provider type (not-for-profit, for-profit, or public/government), some differences between respondents were observable. More than two in five respondents in for-profit facilities (n=356, 43.47%) rated overall staffing levels as "poor" or "very poor", compared with 42.77% (n=136) in public/government facilities and 36.83% (n=449) in not-for-profit facilities. For-profit facilities also had the smallest percentage of participants who rated their facilities as "very good" in terms of overall staffing [see Figure 3].

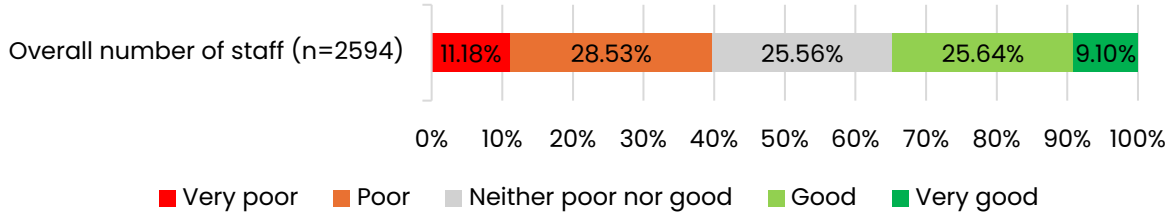

Figure 2. Rating of overall staffing levels at respondents' primary workplace over the past 12 months

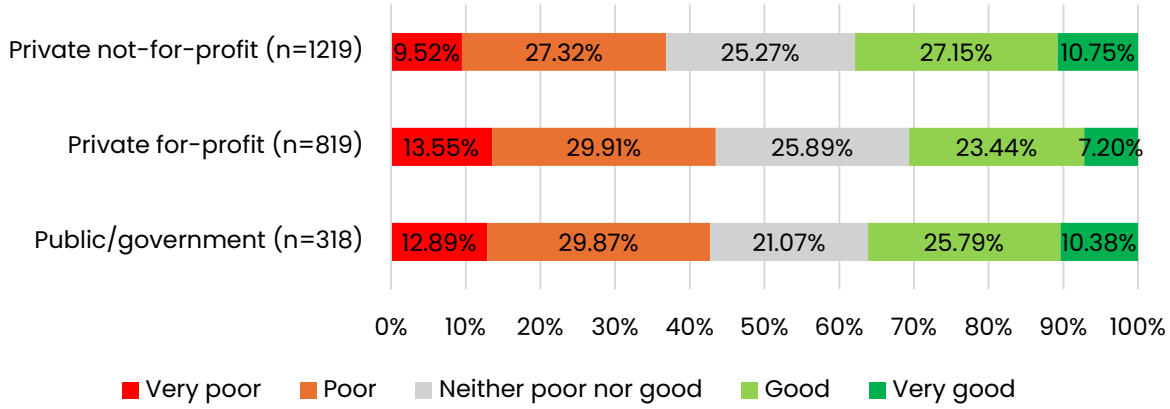

Figure 3. Rating of overall staffing levels at respondents' primary workplace over the past 12 months, by provider category

2.1.2. Number of registered nurses, enrolled nurses, and personal care workers

Respondents were asked to rate the number of RNs (n=2,575), ENs (n=2,351), and PCWs (n=2,527) at their workplace in the past 12 months. While the number of RNs

was viewed relatively favourably, with just under half of respondents (n=1,186, 46.06%) rating the number of RNs as "good" or "very good", staffing shortfalls were pronounced for ENs and PCWs. Of respondents, 44.07% (n=1,036) rated the number of ENs as "poor" (n=603, 25.65%) or "very poor" (n=433, 18.42%), and 41.35% (n=1,045) rated the number of PCWs as "poor" (n=780, 30.87%) or "very poor" (n=265, 10.49%) [see Figure 4].

When respondent ratings of the number of RN, ENs, and PCWs are examined by the provider type, respondents who worked at for-profit facilities were more likely to rate the numbers of these workers as "poor" or "very poor" compared to respondents who worked for other provider types. More than one-third of respondents from the for-profit sector (n=312, 38.38%) rated the number of RNs as "poor" or "very poor", while almost half rated the number of ENs (n=362, 48.20%) and PCWs (n=359, 44.54%) as "poor" or "very poor" [see Figure 5, Figure 6, and Figure 7].

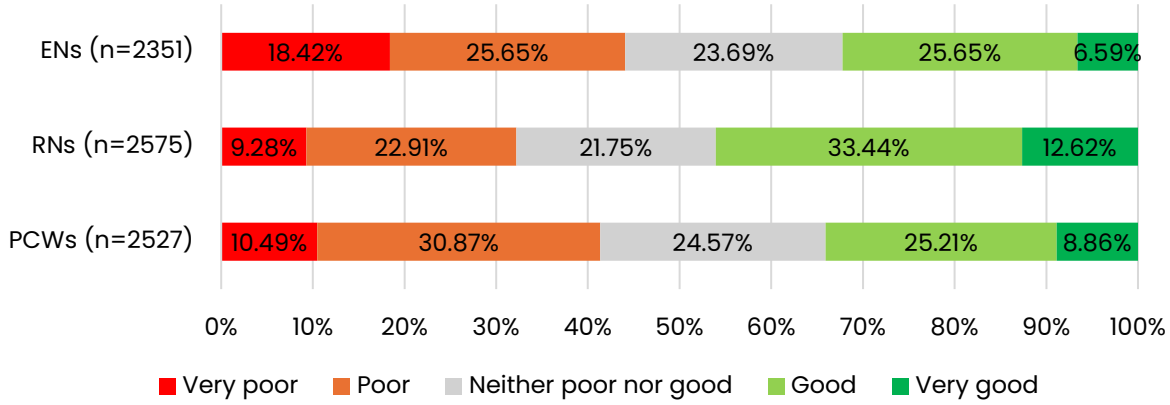

Figure 4. Rating of staffing levels for registered nurses (RNs), enrolled nurses (ENs), and personal care workers (PCWs) over the past 12 months

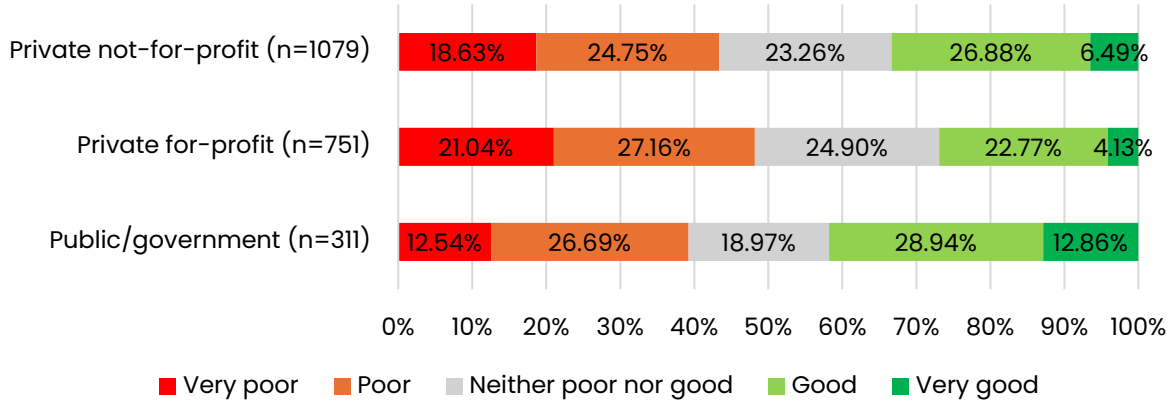

Figure 5. Rating of enrolled nurse staffing levels over the past 12 months, by provider category

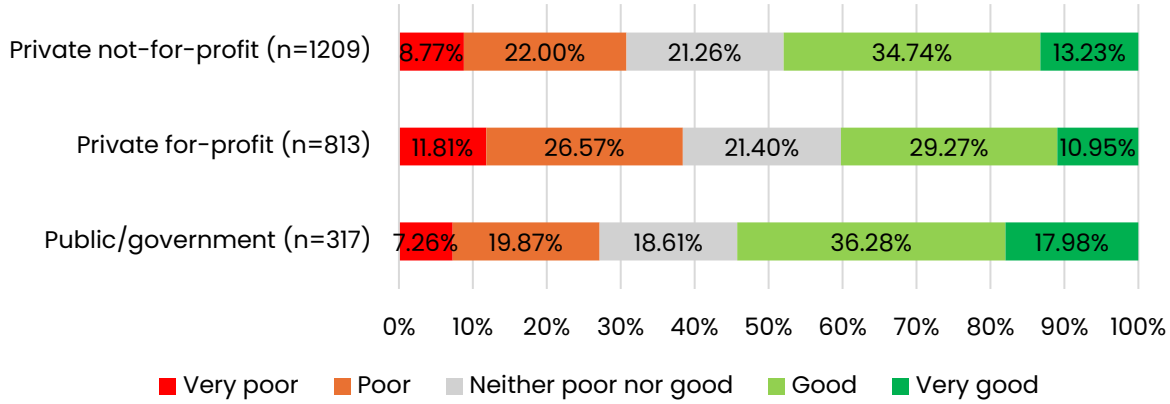

Figure 6. Rating of registered nurse staffing levels over the past 12 months, by provider category

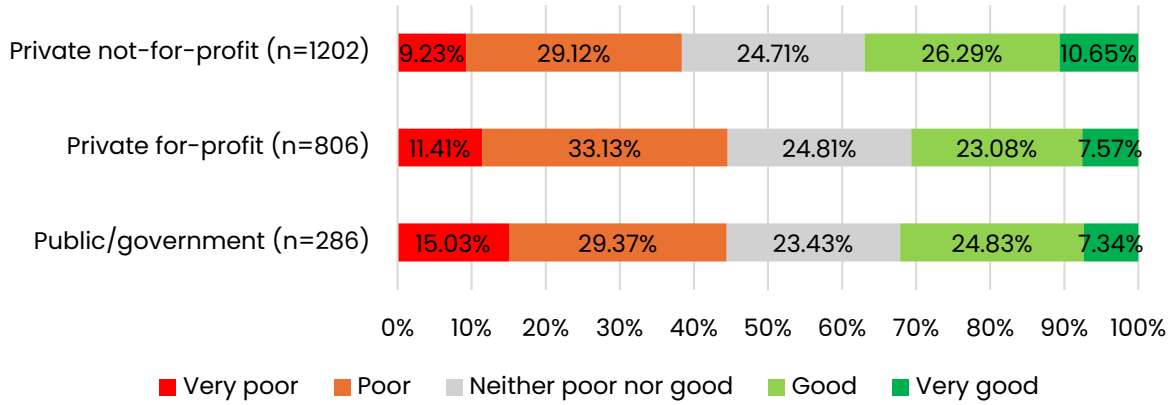

Figure 7. Rating of personal care worker staffing levels over the past 12 months, by provider category

2.1.3. Ratio of care to nursing staff

Respondents (n=2,557) were asked to rate the ratio of nursing to care staff at their workplace over the past 12 months. Nearly half of the respondents (n=1,215, 47.52%) reported that the ratio of nursing to care staff at their workplace was not appropriate, rating this as "poor" (n=762, 29.80%) or "very poor" (n=453, 17.72%) [see Figure 8]

When examined by provider type, over half of respondents from for-profit facilities (n=423, 52.09%) reported that the ratio of nursing to care staff was inadequate ("poor" or "very poor"), exceeding the proportions reported by respondents from public/government (n=140, 46.20%) and not-for-profit (n=545, 45.19%) facilities [see Figure 9].

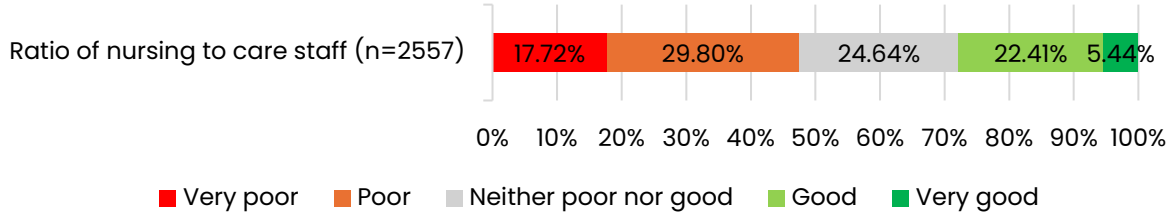

Figure 8. Rating of the ratio of nursing to care staff over the past 12 months

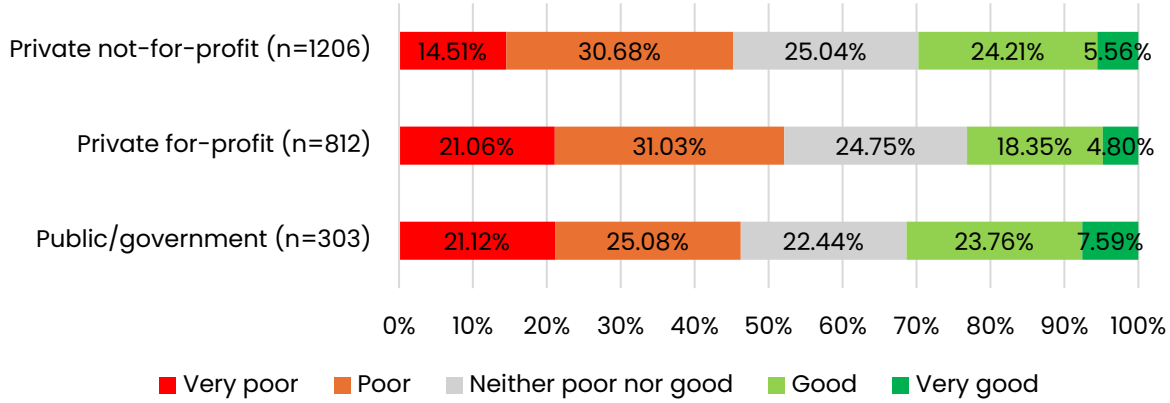

Figure 9. Rating of the ratio of nursing to care staff over the past 12 months, by provider category

2.1.4. Access to multidisciplinary support

Respondents were asked to rate the access to nurse practitioners (NPs) (n=2,094), medical doctors (n=2,498), and allied health professionals (n=2,518) at their workplace in the past 12 months. While access to allied health and doctors was rated relatively favourably (as "good" or "very good") by 54.85% (n=1,381) and

48.56% (n=1,213) respectively, ratings of access to nurse practitioners was more mixed, with 45.32% (n=949) rating this as "poor" or "very poor" and 30.42% (n=637) rating this as "good" or "very good" [see Figure 10].

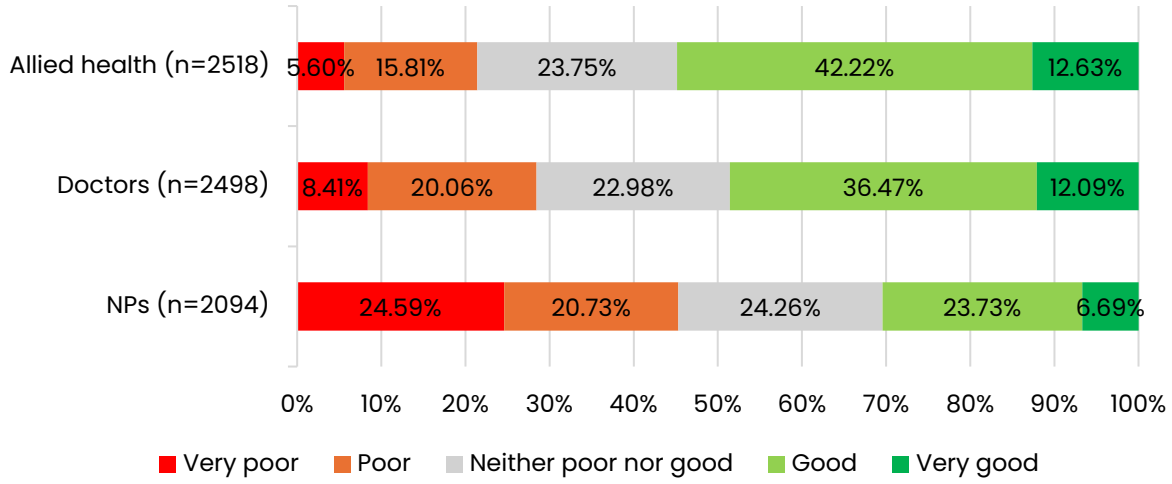

Figure 10. Rating of access to nurse practitioners, doctors, and allied health staff over the past 12 months

2.1.5. Time spent providing care to residents

Respondents (n=2,588) were asked to rate the time they spent providing care to residents over the past 12 months. Reported staffing shortfalls appear to be directly impacting the time workers have to provide care, as almost half of respondents (n=1,269, 49.03%) reported having insufficient time to deliver care to residents, rating this as "poor" (n=839, 32.42%) or "very poor" (n=430, 16.62%) [see Figure 11]. Of those who rated the overall number of staff as "very poor", 60.42% (n=174) also rated the time spent providing care to residents as "very poor".

When examined by provider type, more than half of respondents working in for-profit facilities (n=456, 55.75%) reported having insufficient time to provide care, compared with 47.53% (n=577) of respondents in not-for-profit facilities, and 40.13% (n=128) in public/government facilities [see Figure 12].

When examined by worker type (RN, EN, and PCW), it can be viewed that concerns regarding time spent providing care are universally expressed by workers. Over half of aged care workers (n=360, 51.95%) rated this as either "poor" or "very poor", closely followed by 49.61% (n=321) of ENs, and 48.21% (n=525) of RNs [see Figure 13].

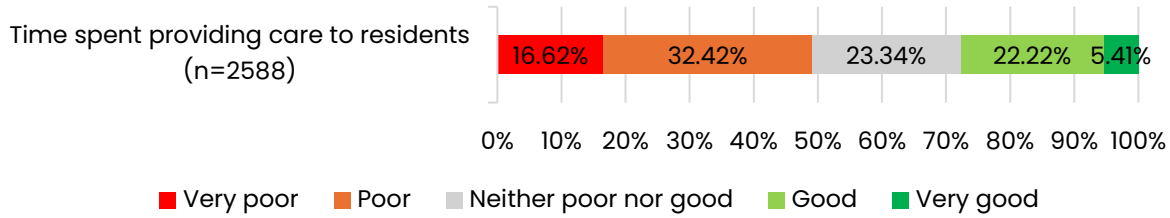

Figure 11. Rating of time spent providing care to residents over the past 12 months

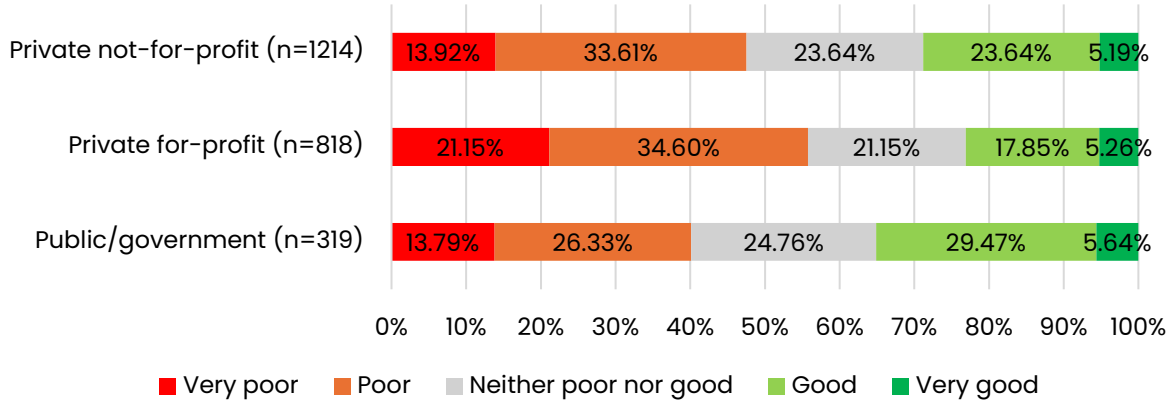

Figure 12. Rating of time spent providing care to residents over the past 12 months, by provider category

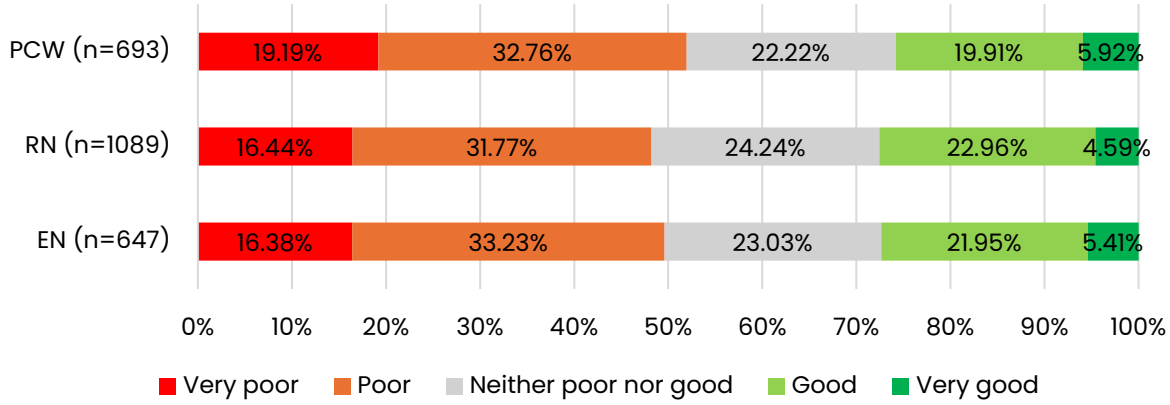

Figure 13. Rating of time spent providing care to residents over the past 12 months, by primary role

2.1.6. Time spent on paperwork and administrative duties

Respondents (n=2,558) were asked to rate the amount of time they spent completing paperwork or administrative tasks in the past 12 months. Overall, close

to half (n=1,193, 46.64%) rated this as either "poor" (n=725, 28.34%) or "very poor" (n=468, 18.30%) [see Figure 14].

When examined by provider type, over half of the respondents from for-profit facilities (n=421, 52.10%) rated this as "poor" or "very poor" compared to 46.52% (n=147) of respondents from public/government facilities and 44.76% (n=538) of respondents from not-for-profit facilities [see Figure 15].

When examined by worker type, it can be viewed that this concern was most pronounced among RNs, with over half (n=549, 50.88%) rating this as "poor" or "very poor", compared to 45.85% (n=293) of ENs and 42.48% (n=288) of PCWs [see Figure 16].

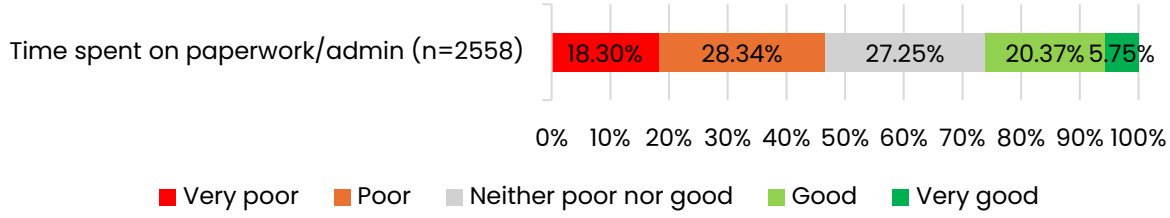

Figure 14. Rating of time spent on paperwork and administration over the past 12 months

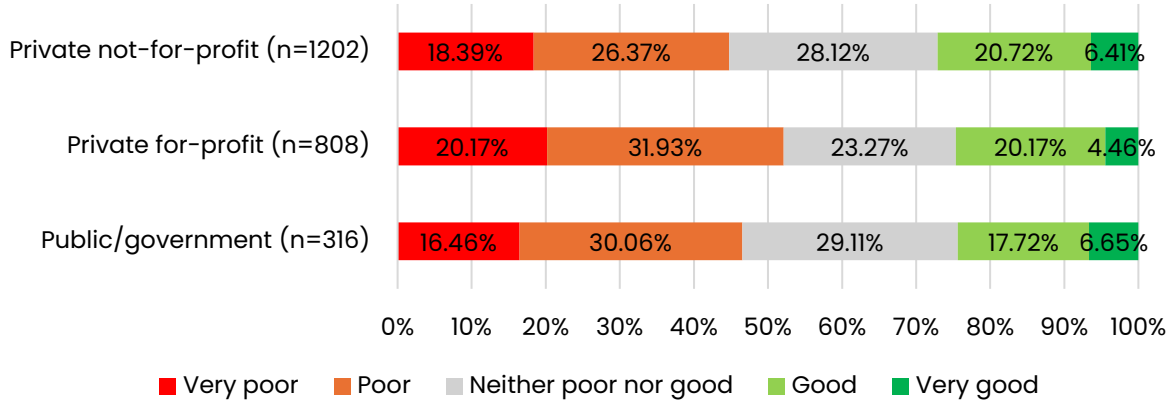

Figure 15. Rating of time spent on paperwork and administration over the past 12 months, by provider category

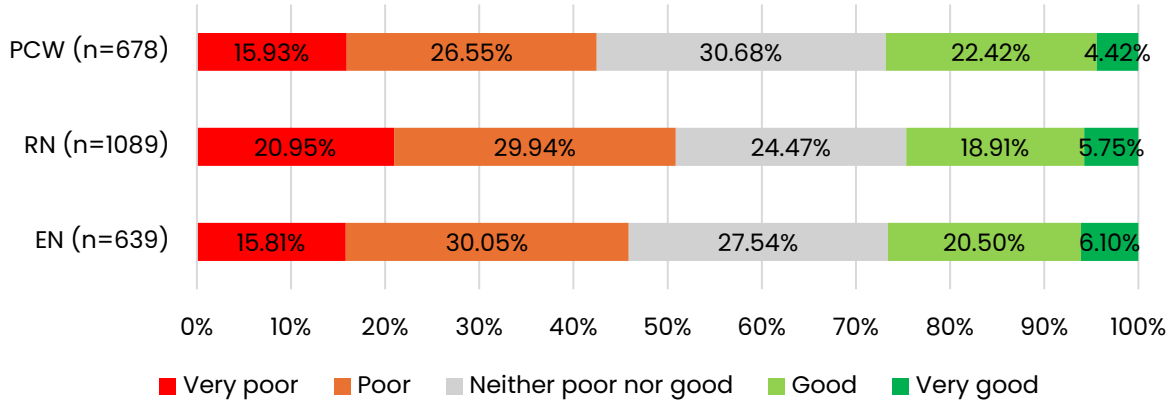

Figure 16. Rating of time spent on paperwork and administration over the past 12 months, by primary role

2.1.7. Respondent comments regarding staffing levels

Respondents (n=1,438) were asked to provide comments or examples related to staffing factors. Respondents reported poor staffing ratios and caring for large numbers of residents with minimal staffing and support. They described how this impacted their ability to deliver high-quality and safe care.

> *"...there would often be 1 RN with occasionally 1-2 EN's for 110 residents... This is a recipe for disaster and has direct impacts, known and predicted, on care of these residents."* – RN, WA, RACF

> *"Our ratio to workload and care needs are nowhere to what they should be to provide high-quality, person-centred care."* – RN, VIC, Public RACF

> *"...How is a nurse supposed to deliver safe and inclusive care when the ratio is 1:34? Residents constantly complain that they feel rushed and are less likely to ask for help because they feel a burden... Our older generation love to connect, but how is this supposed to happen when nurses constantly have to tell them, sorry, but I really need to get to the next person..."*- EN, VIC, Private (for-profit) RACF

Respondents highlighted that staffing levels were being affected by issues such as providers' reluctance to backfill unplanned leave.

> *"Staffing levels are adequate until there's a sick call. Management has hierarchy orders that nurses are to be replaced with care workers instead of another nurse especially during morning shifts."* – RN, WA, Private (not-for-profit) RACF

Increasing demands on RNs and PCWs were, at least in part, described as a result of the erosion of the EN role in aged care. With ENs being made redundant, other workers are being required to 'pick up the slack' and complete roles that ENs otherwise perform.

> *"EN are being utilised as care staff and not being able to contribute to clinical* (care)*…"* – EN, WA, Private (not-for-profit) RACF

> *"Care staff are picking up the slack from all ENs being made redundant…"* – PCW, VIC, RACF

> *"RAC no longer employing ENs to contribute to clinical care is putting strain on RNs"* – EN, QLD, Private (not-for-profit) RACF

Further burdens placed on RNs included increased administrative duties and paperwork requirements introduced by new reporting and compliance measures resulting from Royal Commission reforms.

> *"For RNs the reforms have us attending more paperwork than providing invaluable clinical care. We struggle to follow up with our care teams to ensure they are attending cares or addressing clinical concerns. Many RNs are staying back beyond rostered hours or skipping breaks to catch up on paperwork."* – RN, NSW, Private (not-for-profit) RACF

> *"We have seen an increase in registered nurses but they are in management roles or primarily focused on documentation, not providing direct clinical care…"* – PCW, NSW, Private (not-for-profit) RACF

> *"Estimate spend at least 80% of shift completing computer work documentation to fulfil expectations of commission/ level of recording care, incidents, care planning and behaviours to justify funding and prove compliance.*" – RN, NSW, Private (not-for-profit) RACF

Respondents point towards an increasing demand, which has not been supported by increased staffing capacity or capability.

> *"As resident acuity increases, staffing levels do not. Wounds are becoming more complex, vital sign monitoring is increasing, and tasks are being generated for everything… These duties are compounded by falls, hospital transfers, and frequent family concerns, creating an overwhelming workload."* – EN, WA, Private (not-for-profit) RACF

Respondents acknowledged the importance of quality improvement and accountability but reported that current requirements were disconnected from operational realities, particularly in the context of inadequate staffing.

> *"(The) New Act has caused nurses to now spend an excessive amount of our time at the computer doing admin work instead of bed side care… Quality improvement is needed however people in quality do not understand the realities of the day to day need of residents in comparison to the low staffing ratios…"* – EN, WA, Private (not-for-profit) RACF

Several respondents described the cumulative effect of increasing resident acuity, limited resources, and expanding legal and documentation requirements as placing the sector under unprecedented strain.

> *"It's getting harder every day to deliver the care our residents need. They come with higher acuity, more complexity and less support or resources. The documentation and legal parameters are exceeding our capacity no matter how exceptional our time management and prioritisation is…"* – RN, NSW, Private (not-for-profit) RACF

> *"Not enough staff to implement changes. We struggle to get basic toileting and showering accomplished."* – PCW, QLD, Private (not-for-profit) RACF

Respondents described how increasing workloads and inadequate staff were impacting their well-being.

> *"Registered Staff are very overwhelmed with the workload and most of the time forgo their breaks to complete allocated work."* – RN, VC, Public RACF

> *"Work overload is causing sick calls, injuries, rushed work, and staff conflicts"* – RN, NSW, Private (not-for-profit) RACF

> *"We are working short staffed again leading to increased stress levels and higher risk of burn out"* – EN, VIC, Public RACF

2.2. Role change

Respondents (n=2,567[§]) working in RACFs were asked to indicate if they had observed staff (PCWs, ENs, and RNs) experiencing any of the following role changes at their workplace in the last 12 months. Across most role change categories described in the survey, approximately one-third or more of respondents indicated observing a change, suggesting that role redesign is a common feature of current workforce practice [see Figure 17].

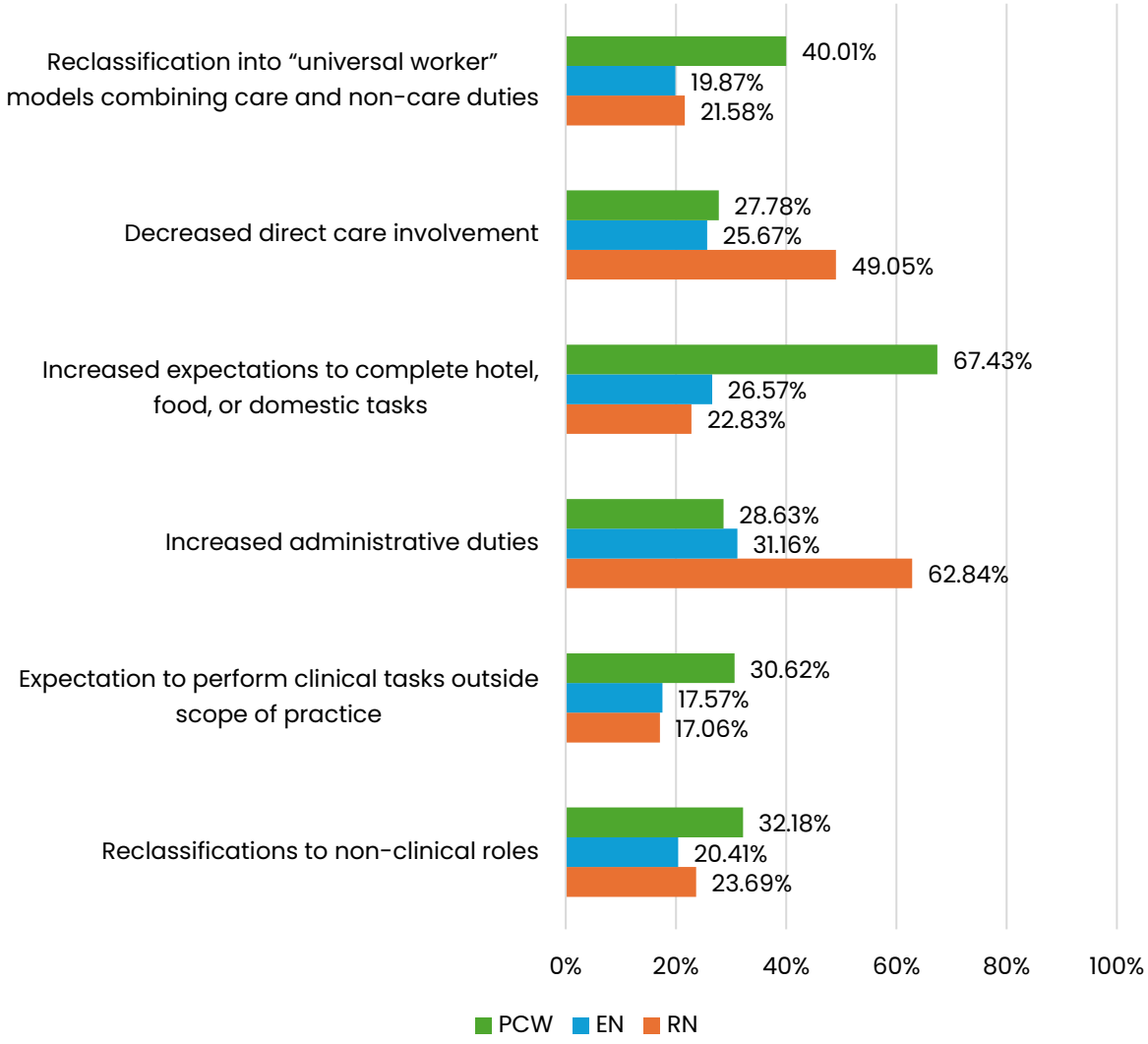

Figure 17. Reported role changes at respondents' workplace over the past 12 months

[§] Note that as this is a "select all that apply" item that did not include a "not applicable" response option, the denominator was calculated based on all participants who selected at least one response option, as well as participants who did not select any option but were inferred to have viewed the item, based on whether they responded to adjacent survey items while leaving the item in question blank.

2.2.1. Registered nurses

For RNs, the most frequently observed change was an increase in administrative duties (n=1,613, 62.84%). This corresponded with a reported decrease in direct care involvement (n=1,259, 49.05%). Across provider types, differences were minimal [see Figure 18].

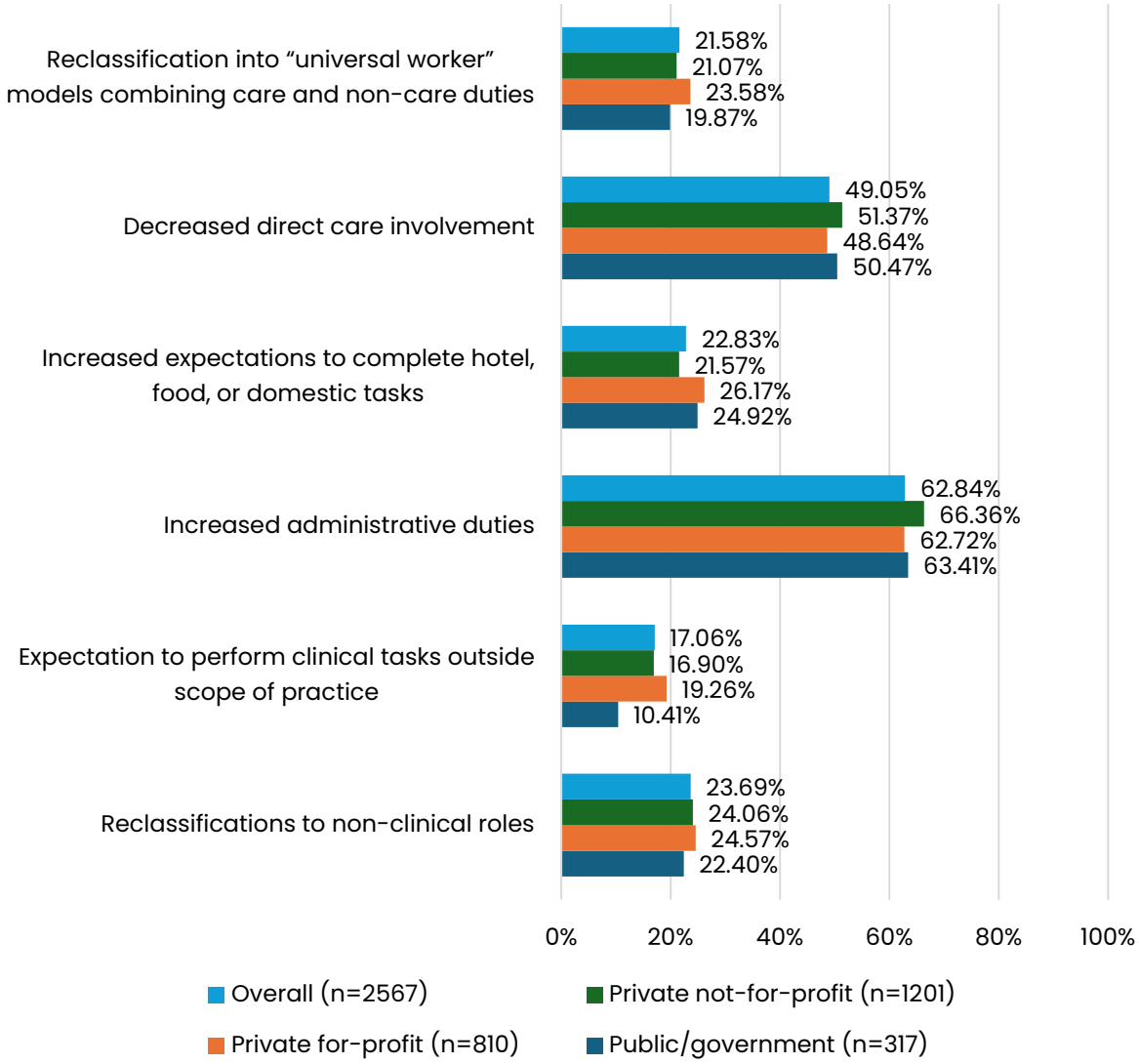

Figure 18. Reported changes in registered nurse roles over the past 12 months, by provider category

2.2.2. Enrolled nurses

Observed role changes among ENs were reported less frequently across most categories compared to RNs and PCWs. When examined by provider type, ENs working in public/government services were more likely to report role changes

than those in either for-profit or not-for-profit facilities. Public/government ENs were particularly affected by increased expectations to complete hotel/food/domestic tasks (n=155, 48.90%), and increased administrative duties (n=135, 42.95%) [see Figure 19].

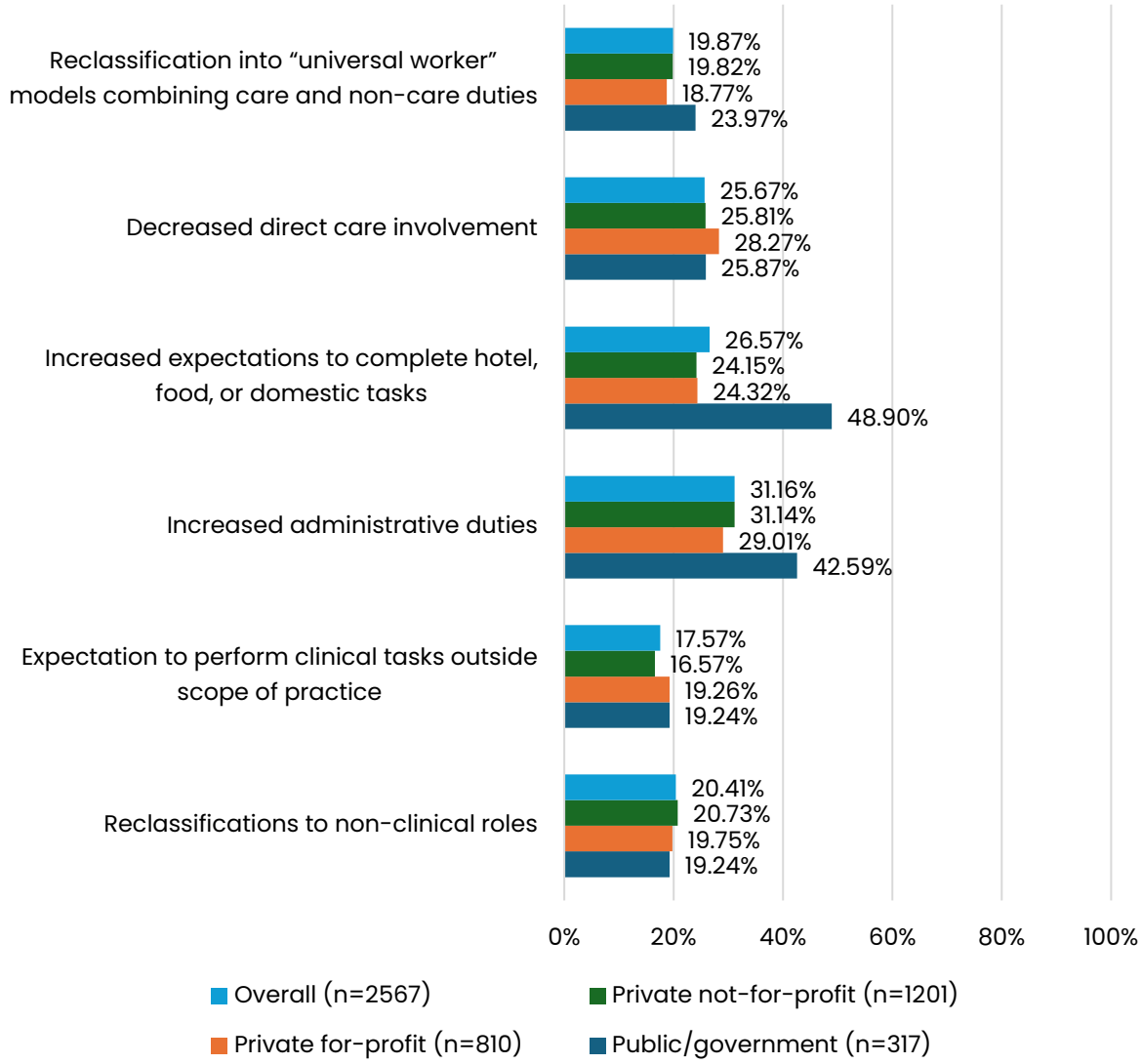

Figure 19. Reported changes in enrolled nurse roles over the past 12 months, by provider category

2.2.3. Aged care workers

For PCWs, the majority of respondents reported increased expectations to complete hotel, food, or domestic duties (n=1,731, 67.43%), alongside reclassification into "universal worker" models combining care and non-care responsibilities (n=1,027, 40.01%).

Role changes were reported most frequently by respondents from for-profit facilities across most domains, for example, 71.98% (n=583) reported "increased expectations to complete hotel, food, or domestic tasks" compared to 50.16% (n=159) from public/government facilities and 69.78% (n=838) from not-for-profit facilities. However, these between-sector differences were generally modest [see Figure 20].

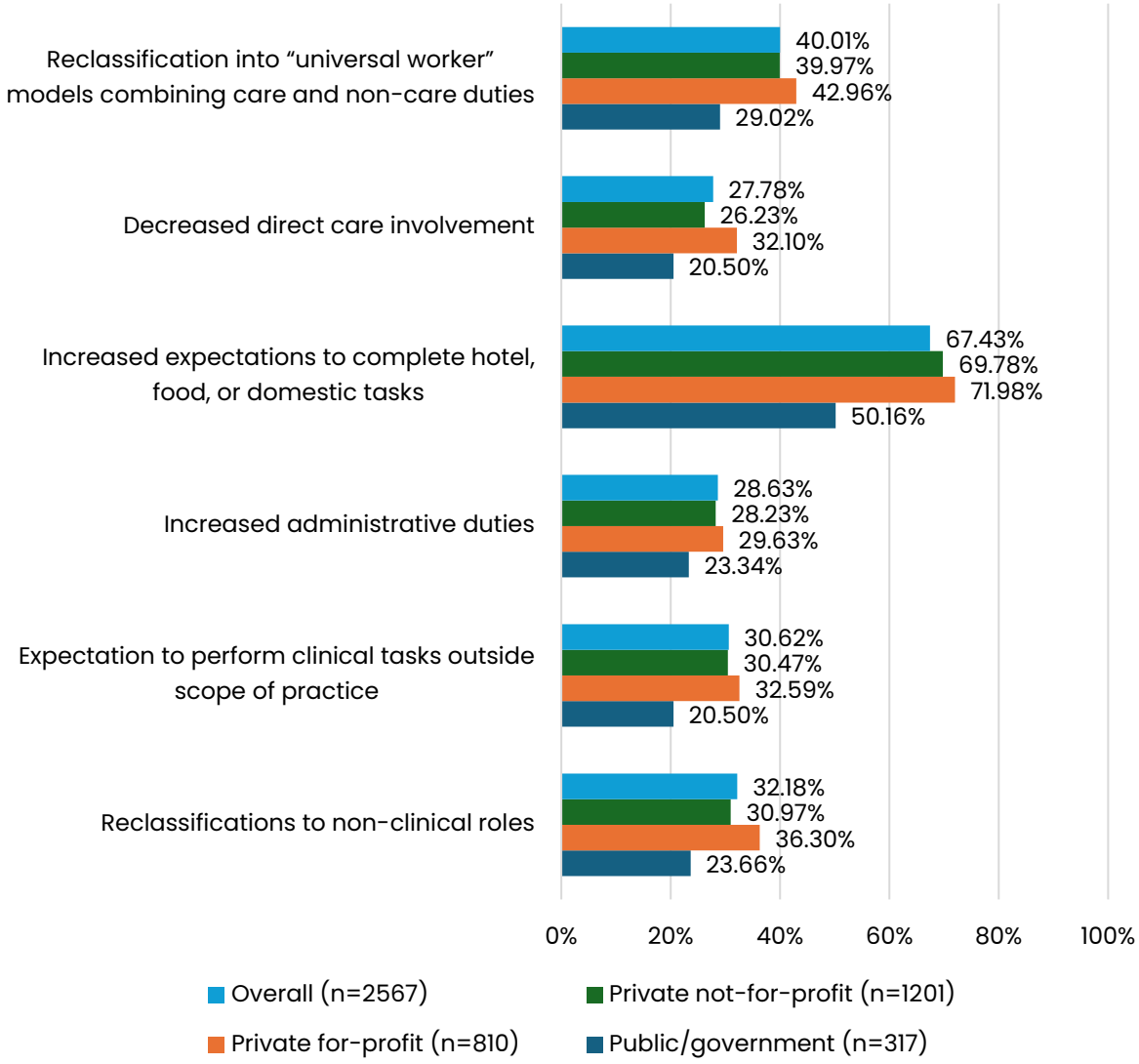

Figure 20. Reported changes in personal care worker roles over the past 12 months, by provider category

2.2.4. Respondent comments regarding role changes

Respondents (n=762) provided comments regarding the role changes they had observed or experienced at their workplace in the past 12 months.

2.2.4.1. Registered nurses

Respondents reported observing/experiencing RN role changes away from clinical care delivery and towards more managerial positions, with the bulk of their time taken up by new documentation requirements.

> *"Due to increased administrative duties to RN less client direct care given. Due to EN nurses reduced to 10% of clinical care counted minutes in RAC this creates a gap of clinical criteria that needs to attended in which increases more workload and stress and potentially a poor outcome to the client as ENs work in collaboration with the RN to achieve these outcomes."* – EN, QLD, Private (not-for-profit) RACF

> *"RNs are busy just doing paperwork which is a lot and hence reducing time of direct patient care."* – RN, VIC, Private (for-profit) RACF

> *"There are more RN in aged care but they are also expected to complete ridiculous amounts of admin/paperwork to stay compliant. This reduces one on one direct care contact with residents. Enrolled nurse whom were able to assist as this was within their scope of practice are made redundant…"* – EN, VIC, Private (not-for-profit) RACF

2.2.4.2. Personal care workers

Regarding personal care workers, respondents described role changes that moved them away from the delivery of direct care and towards hoteling, food, and laundry duties. This increasing responsibility was thought to be as a result of staffing shortages among hospitality and housekeeping staff, requiring care workers to cover these duties.

> *"Us AIN's are doing less care work, and more non nursing duties, which include kitchen work… all of which is not in the AIN job description…"* – PCW, NSW, Private (for-profit) RACF

> *"…aged care workers taking on greater domestic and servery duties without decreasing already existing expectations within our role…"* – PCW, NSW, Private (not-for-profit) RACF

> *"Our staff are expected to serve meals and wash dishes because there is not enough service staff to fullfill there role and our residents can not get the care from nursing staff."* – EN, SA, Public RACF

Some respondents also noted increasing clinical responsibilities, such as the delivery of medications. This shift was thought to be a result of reduced nursing staff availability and the introduction of medication competent carers to deliver medications when nursing staff were not available.

> *"RN's are becoming administrators… We rely on med comp care staff to attend to medication do our vital sign checks and in some instances to do basic wound care…"* – RN, NSW, Private (not-for-profit) RACF

> *"…Carers are used to give medications and are not clinically experienced enough for this role. Enrolled nurses are expected to take on more carer roles and less clinical roles…"* – EN, SA, Private (not-for-profit) RACF

> *"Care workers administering complex medications to very high care clients who are unable to give consent."* – RN, WA, Private (not-for-profit) RACF

> *"AIN med comps administering medications-not safe. ENs made to work as AIN while med comps giving meds. ENs have to pay their yearly registrar what do AINs have pay for while AIN take our jobs."* – EN, QLD, Private (for-profit) RACF

2.2.4.3. Enrolled nurses

Enrolled nurses were reported as experiencing reduced clinical responsibilities and reclassifications from nursing to care staff. These reclassifications were thought to be a result of a lack of specific EN funding under the AN-ACC and care minute funding model.

> *"Most enrolled nurses have left the facility as they were mainly working in direct care roles due the ANACC funding model which does not really have hrs for EN so they are included in care minutes. This is really unfortunate as they were highly skilled workers for aged care."* – Manager, VIC, Private (for-profit) RACF

> *"Enrolled nurses position has become expendable due to RN hours only required."* – EN, QLD, Private (not-for-profit) RACF

3. Workplace violence and aggression

Respondents (n=2,467**) were asked if they had experienced and/or observed instances of WVA in their workplace within the previous 12 months. Questions pertained to the following categories of WVA:

- **Verbal abuse:** Use of aggressive or intimidating language, yelling, swearing, name-calling, or threatening.
- **Physical aggression:** Use of physical force, such as hitting, kicking, pushing, spitting, slapping, or other acts causing bodily harm or discomfort.
- **Property damage or throwing objects:** Deliberate destruction, defacement, or throwing of objects or property.
- **Sexual harassment or inappropriate behaviour**: Unwanted sexual advances, comments, touching, exposure, or any coercive sexual conduct violating personal boundaries.
- **Racism:** Discriminatory treatment, slurs, or actions based on race, ethnicity, or cultural background, including verbal or nonverbal actions.

3.1. Prevalence of workplace violence and aggression

Overall, almost all respondents (n=2,379, 96.43%) reported having experienced and/or observed one or more instances of WVA at their workplace in the past 12 months. For the most part, respondents were more likely to report experiencing WVA than observing it. This may reflect difficulties in identifying WVA and/or that a majority of WVA incidents occur when other staff are not present. The only exceptions to this were sexual harassment, which was observed by 38.63% (n=953) and experienced by 35.55% (n=877), and racism, which was observed by 46.17% (n=1,139) and experienced by 36.44% (n=899) [see Figure 21].

Regarding experiences of WVA, 76.69% (n=1,892) reported that they had experienced verbal abuse (such as yelling, swearing, and threats), and 69.68% (n=1,719) reported experiencing physical abuse (including hitting, kicking, pushing, and spitting) in the past 12 months. Just under half (n=1,209, 49.01%) reported property damage or thrown objects. Over one-third reported experiencing racism (n=899, 36.44%) and/or sexual harassment (n=877, 35.55%) [see Figure 21].

**Respondent number (n=2,467) was calculated as those who answered any question in this question block (reporting experiencing and/or observing) and/or answered questions around this one, to approximate the number of participants who did not answer due to the options being "not applicable".

When those who reported experiencing WVA in the past 12 months were subdivided by their main role in aged care, some differences between groups were observable. ENs and PCWs were more likely to report experiencing verbal abuse (n=499, 79.08% and n=479, 78.91%, respectively) compared to RNs (n=782, 74.69%). ENs and PCWs were also more likely to report experiencing physical aggression (n=475, 75.28% and n=461, 75.95%, respectively) compared to RNs (n=681, 65.04%). RNs were more likely to report experiencing racism (n=433, 41.36%) than ENs (n=184, 29.16%) and PCWs (n=255, 37.07%) [see Figure 22].

When examined by respondents' ratings of the overall number of staff in their workplace, it can be viewed that those who rated staffing as "poor" or "very poor" were more likely to indicate that they had experienced WVA in the past 12 months, compared to those who rated staffing as "good" or "very good". For example, among those who rated staffing as "very poor" (n=277), 88.09% (n=244) indicated that they had experienced verbal abuse in the past 12 months, compared to only 66.18% (n=150) of those who rated staffing as "very good" (n=220). This trend is observable across reported WVA categories [see Figure 23]. This trend suggests that inadequate staffing levels contribute to the likelihood of experiencing WVA.

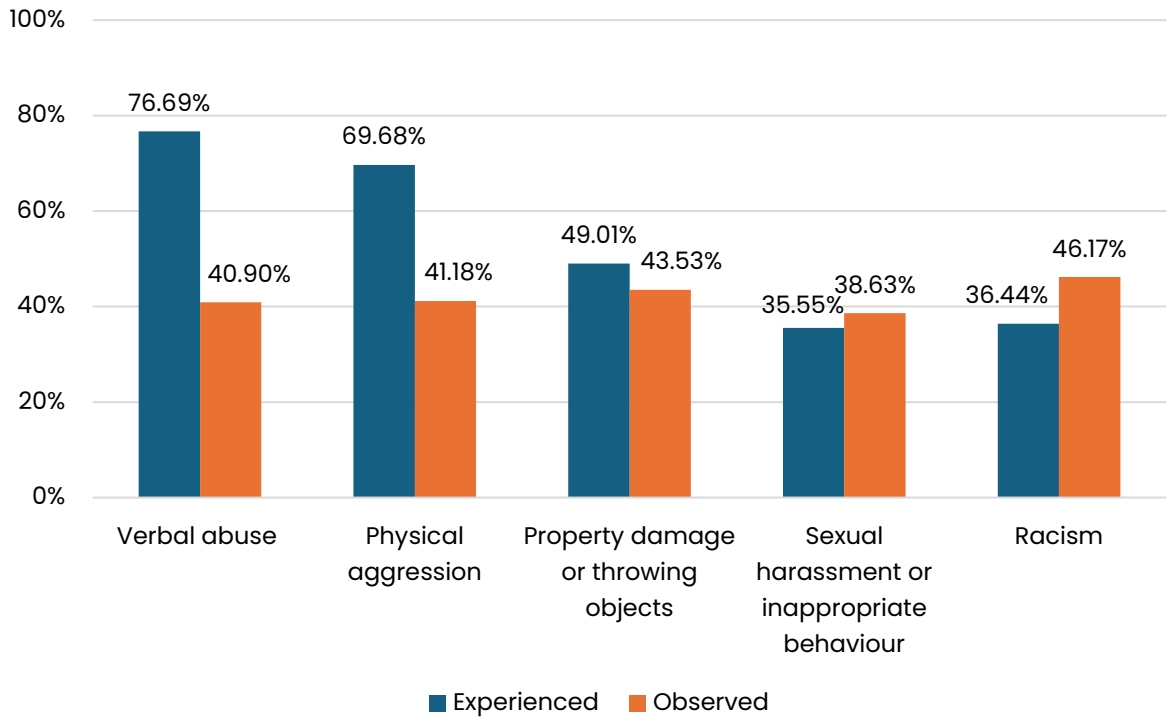

Figure 21. Percentage of respondents reporting workplace violence and aggression in the workplace within the past 12 months

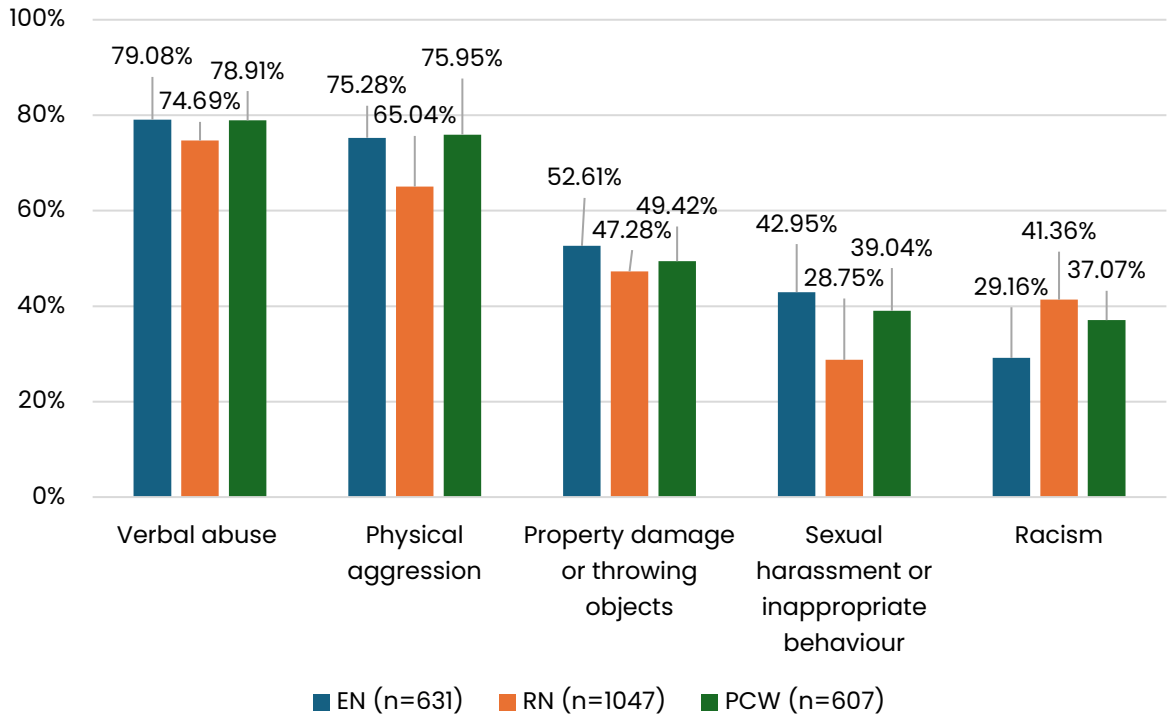

Figure 22. Percentage of respondents reporting Workplace violence and aggression within the past 12 months, by primary role

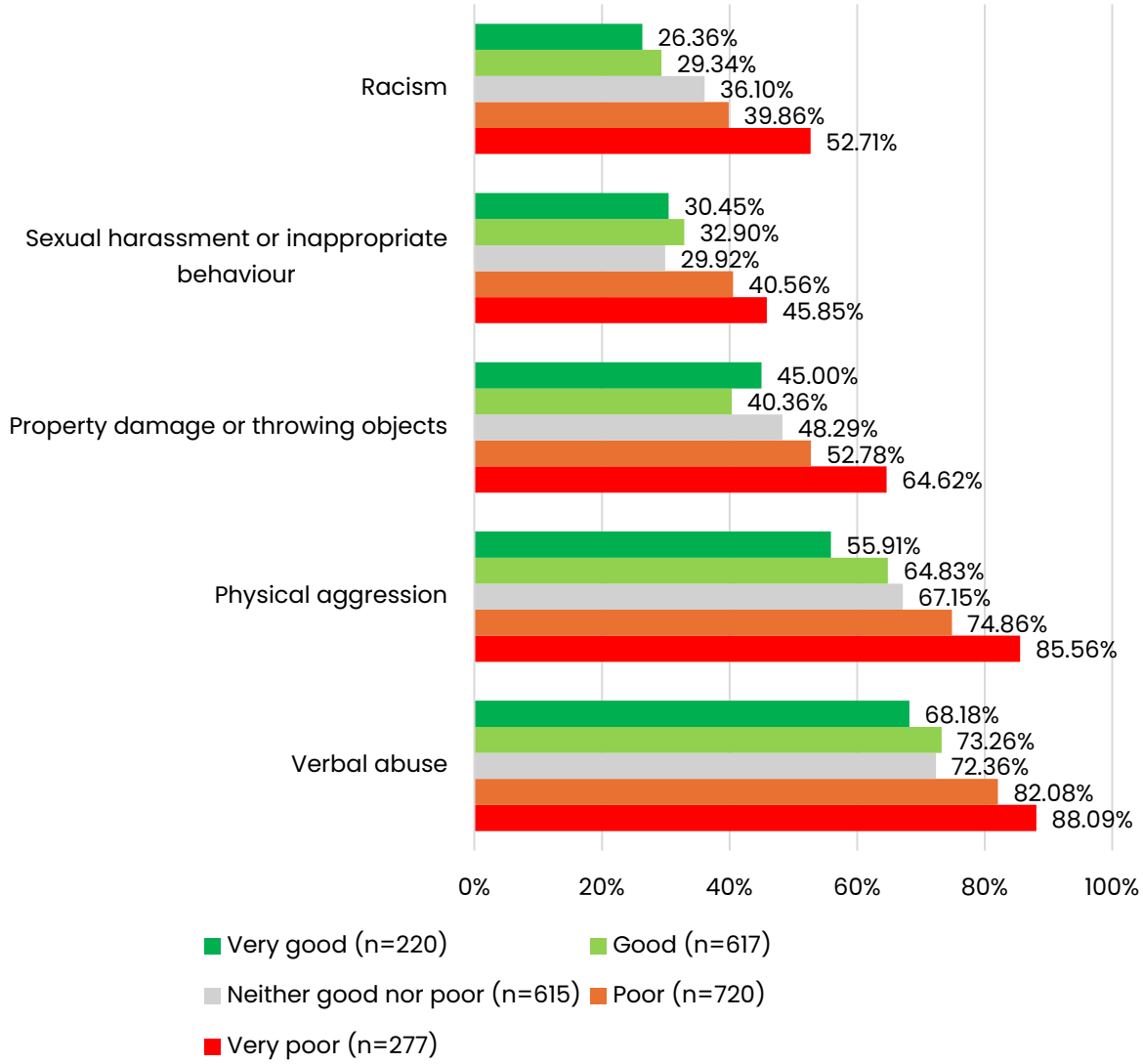

Figure 23. Percentage of respondents reporting workplace violence and aggression within the past 12 months, by overall staffing rating

3.2. Perpetrators of workplace violence and aggression

Respondents[††] who reported experiencing WVA were asked to identify the perpetrator(s) of these behaviours. The majority of respondents identified residents/clients as the perpetrators in one or more of their experiences of verbal abuse (n=1,799, 95.08%), physical aggression (n=1,680, 97.73%), property damage (n=1,164, 96.28%), and sexual harassment (n=823, 93.84%) [see Figure 24].

[††] As carry-forward logic was applied, the denominator was calculated as the number of respondents who answered that they had 'experienced' that behaviour in the previous question. Note this is a 'select all that apply' question, therefore, percentages do not equal 100%.

Respondents also, although less frequently, identified that visitors/family members of residents demonstrated verbal abuse towards staff (n=1,030, 54.44%) and racist behaviours (n=435, 48.39%). Respondents also attributed experiences of verbal abuse (n=411, 21.72%) and racism (n=436, 48.50%) to other aged care staff [see Figure 24].

When examined by respondents' main role in aged care, differences in who respondents attributed experiences of WVA to were minimal. However, RNs were more likely to report experiencing verbal abuse from visitors/family members (n=494, 63.17%) compared to ENs (n=286, 57.31%) and PCWs (n=160, 33.40%) [see Figure 25]. Similarly, RNs reported racism being directed by visitors/family members (n=257, 59.35%) more frequently than ENs (n=82, 44.57%) and PCWs (n=57, 25.33%) [see Figure 26]. This trend may reflect RNs' more frequent interaction with visitors/family members or perceived increased responsibility for the quality of care from visitors/family members.

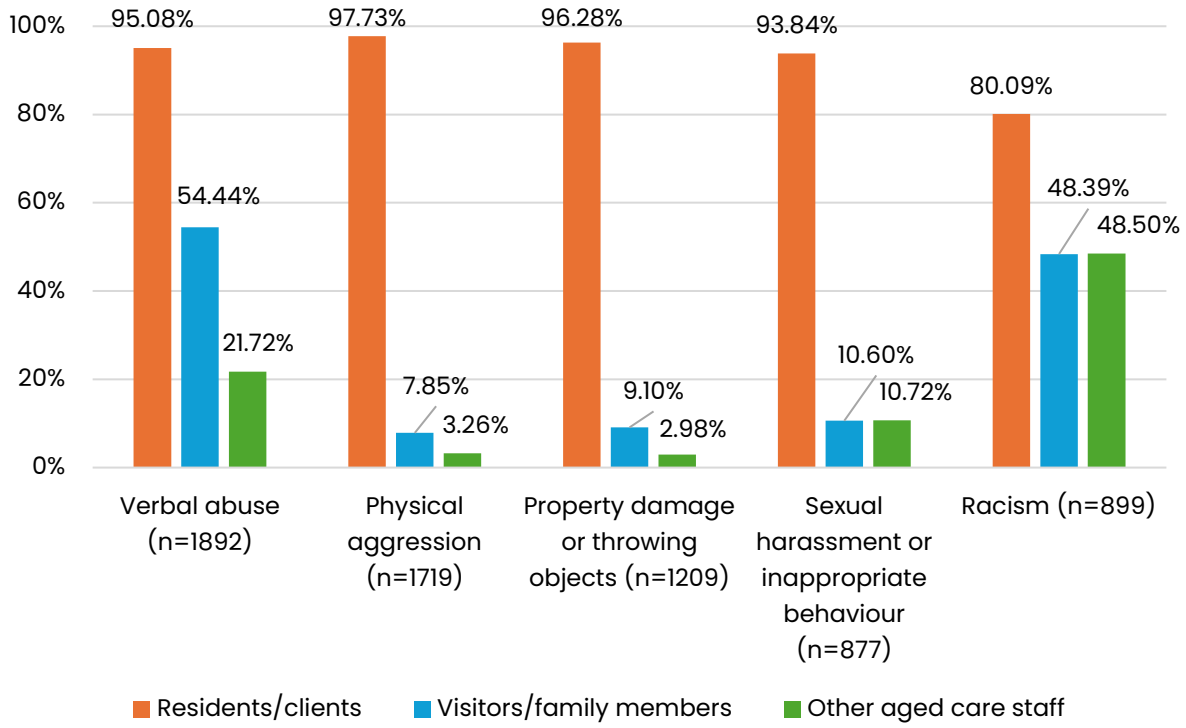

Figure 24. Perpetrators of workplace violence and aggression by behaviour type (experienced incidents only)

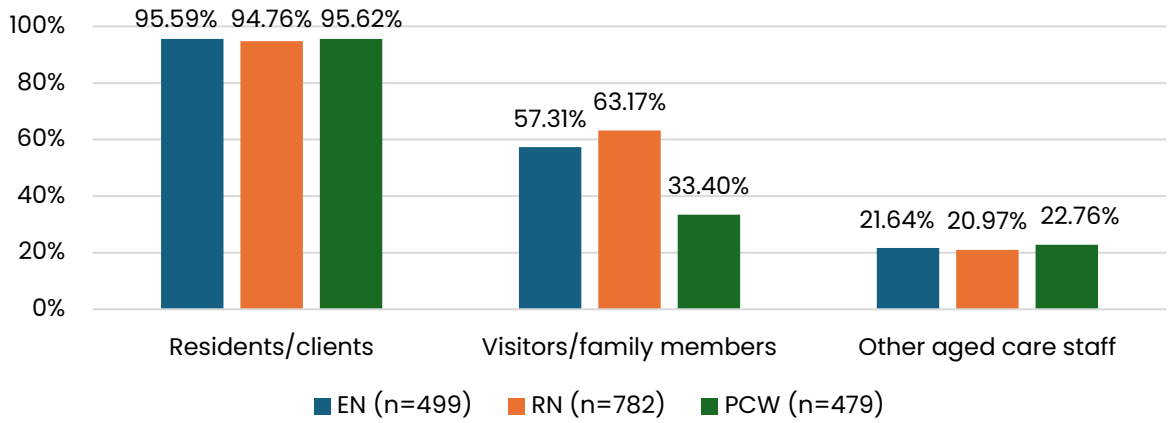

Figure 25. Perpetrators of verbal abuse by primary role (experienced incidents only)[‡‡]

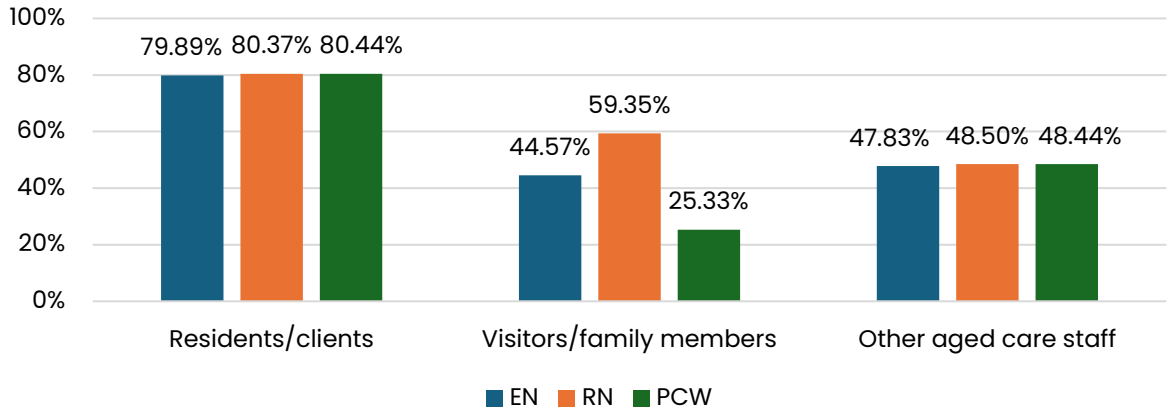

Figure 26. Perpetrators of racism by primary role (experienced incidents only)[§§]

3.3. Frequency of workplace violence and aggression

Respondents who reported experiencing WVA were asked to indicate the frequency with which these behaviours occurred [see Figure 27]. Respondents indicated that they experienced WVA on a frequent or semi-frequent basis. Of those who reported experiencing verbal abuse (n=1,840), over half (n=943, 51.25%) indicated that it occurred either "very frequently" (multiple times per day) (n=591, 32.12%) or "frequently" (daily) (n=591, 32.12%), with a further 34.08% (n=627) reporting that this occurred "occasionally" (weekly). Physical aggression was also frequently experienced, with 13.90% (n=231) reporting "very frequent" incidents,

[‡‡] As carry forward logic was applied, the denominator was calculated as the number of respondents who answered that they had 'experienced' that behaviour in the previous question.
[§§] As carry forward logic was applied, the denominator was calculated as the number of respondents who answered that they had 'experienced' that behaviour in the previous question.

over one-quarter (n=448, 26.96%) reporting daily incidents, and 38.15% (n=634) experiencing physical aggression weekly.

In contrast, property damage and sexual harassment were more likely to be reported as "occasional" (weekly) or less frequent compared to the other WVA categories. Property damage was most commonly experienced weekly (n=489, 42.23%) or monthly (n=309, 26.68%), while sexual harassment was most frequently reported as occurring weekly (n=311, 37.11%) or monthly (n=206, 24.58%).

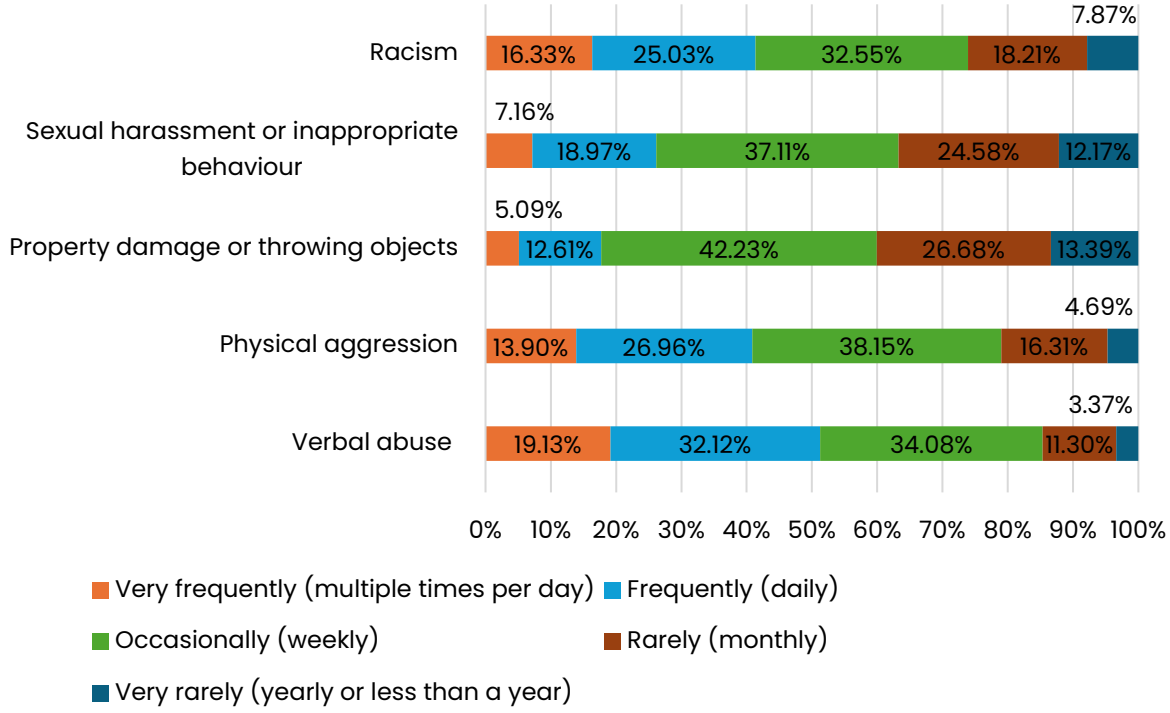

Figure 27. Frequency of experienced workplace violence and aggression by behaviour type***

3.4. Employer support for workplace violence and aggression

Respondents (n=2,408) were asked to rate the level of support provided by management regarding incidents of violence, aggression, and/or abuse at their workplace [see Figure 28]. Overall responses were mixed, with 41.40% (n=997) rating support negatively (as either "poor" or "very poor") and 35.51% (n=855) rating support positively (as either "good" or "very good").

*** As carry forward logic was applied, the denominator was calculated as the number of respondents who answered that they had 'experienced' that behaviour in the previous question.

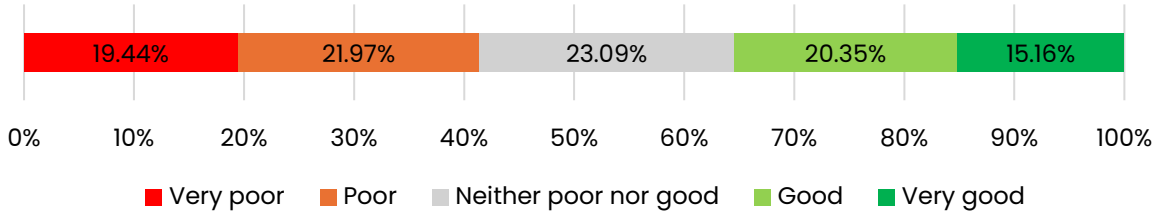

Figure 28. Ratings of management support following incidents of violence, aggression, or abuse

3.5. Respondent comments related to workplace violence and aggression

Respondents (n=595) were asked to share any comments or examples related to WVA and the management of these incidents at their workplace**.**

3.5.1. Violence and aggression from residents

Respondents highlighted the challenges of managing residents'/clients' behaviours, particularly those with dementia and/or other cognitive difficulties. While respondents understood that these behaviours were often unintentional and a result of aged-related conditions, the frequency and severity of these behaviours placed respondents at risk.

Respondents highlighted how risk was not mitigated by their organisation, and many systems such as behavioural planning, preventative, and follow-up actions were not in place. Further, understaffing and poor skill mix were identified as limiting staff capacity to anticipate, de-escalate, and safely manage behaviours. This resulted in residents being left unsupervised or receiving rushed care, increasing the likelihood of aggressive incidents.

> "*There are never enough staff to manage all behaviours from residents. They have to be unsupervised to provide appropriate care to all others.*" – PCW, QLD, Private (for-profit) RACF

The absence or poor implementation of behavioural support plans further intensified risks. Staff described how residents'/clients' history of violence and/or aggression was often undocumented, and behaviour management plans were often absent, outdated, or ineffective.

> "*[I'm] currently involved [with] the union at our workplace as we are working with no behaviour plans.*" – PCW, QLD, Public RACF

Many respondents also felt that residents/clients were often put above their safety, creating an unsafe work environment. Respondents reported a culture of resignation among management, where resident aggression was framed as inevitable and unmodifiable. This framing shifted responsibility away from organisational accountability and instead placed blame on workers for not managing situations correctly.

> "*Management say that's just what the residents do and there's nothing you can do about it. You're made to feel guilty if you refuse care due to threats of violence, refusal of care, or verbal abuse…*" – PCW, VIC, Private (for-profit) RACF

3.5.2. Violence and aggression from families and visitors

Respondents indicated that abuse from visitors/family members of residents/clients included verbal aggression, intimidation, and threats of formal complaints. Respondents described how family members were often adversarial towards staff regarding dissatisfaction with the level of care provided, with respondents often describing this as unrealistic assumptions about staffing capacity and service delivery. Respondents highlighted that these factors were often outside of their control, adding to the frustration. Respondents also described surveillance-like behaviours, including photographing staff and using group chats to critique care practices.

> "*…Families expect too much as the expectation is high, and often make threats to the staff when they are not happy with some care*." – RN, NSW, Private (not-for-profit) RACF

> "*Family members ganging up on staff, monitoring of staff using photos, chat groups to make comments on people or alleged practices*." – Other (educator), NSW, Private (for-profit) RACF

> "*…I got abused /yelled at/threatened by a family member for "neglecting" the resident, when in fact we have done everything under the sun for her…*" – RN, NSW, Private (not-for-profit) RACF

3.5.3. Bullying and aggression from other staff and management

Respondents also described bullying, intimidation, and verbal aggression from colleagues and management. Reports of managerial behaviour were particularly concerning, including public reprimands, yelling, and humiliation.

:*Management are often the abusers*." – RN, VIC, Private (for-profit) RACF

"*Everyday I am feeling consistent stress, anxiety before going to workplace… Our team of care manager is yelled/ screamed out by General manager in front of other staff members*." – RN, VIC, Private (for-profit) RACF

3.5.4. Management of incidents

Respondents emphasised how staff abuse was often overlooked or dismissed as **"***part of the job***"** by management. Managers were frequently perceived as diminishing staff concerns and blaming staff for incidents, rather than addressing root causes or the impact on staff wellbeing. When staff did report incidents, the response was often to question their competence and ask, "*what could you have done differently*?", rather than offering support. Respondents highlighted a lack of mental health support and follow-up after incidents, often being required to continue work for the day.

"*Violence, aggression, and/or abuse is treated as part of the job, the norm…*" – RN, WA, Private (not-for-profit) RACF

"*The what could you have done differently is said before giving some understanding*." – RN, VIC, Support at Home (not-for-profit)

"*I was injured by a resident and was questioned by manager at the time what did I do to make the resident lash out, then told I should of done it differently…*" – PCW, NSW, Private (not-for-profit) RACF

"*Staff not being checked on to see how they are going post incident. Staff having to keep working even after a threatening event*." – RN, WA, Other (staff education)

"*Incidents are "managed" as per guidelines to meet compliance but the impact on staff is usually overlooked.*"- EN, SA, Private (not-for-profit) RACF

This lack of support contributed to significant under-reporting, as staff lost confidence that anything would be done or feared negative repercussions.

"*…Staff no longer report physically assaults from residents as they see no action being taken or fearing they will be deemed incompetent or unable to manage behaviours*." – RN, NSW, Private (not-for-profit) RACF

"*Management do not listen even encourage us not to report it.*" – Other (team leader), NSW, Private (not-for-profit) RACF

"*These incidents are not reported often as nothing much is done in the past.*" – RN, WA, Private (not-for-profit) RACF

4. Financial transparency

While questions directly related to financial transparency were not included in the survey, as most of the workforce has little interaction with the way in which providers utilise government funding, some responses nevertheless highlighted respondents' concerns regarding providers' tendency to prioritise profitability over care quality.

4.1. Adequacy of funding provided for care

Respondents (n=2,725) were asked if the lack of funding/budget means that residents/clients don't receive the services they need. Responses indicate that this does occur, with 35.74% (n=974) indicating this happens 'some of the time', 20.22% (n=551) indicating that this occurs 'most of the time', and 13.91% (n=379) indicating that this 'always' occurs [see Figure 29].

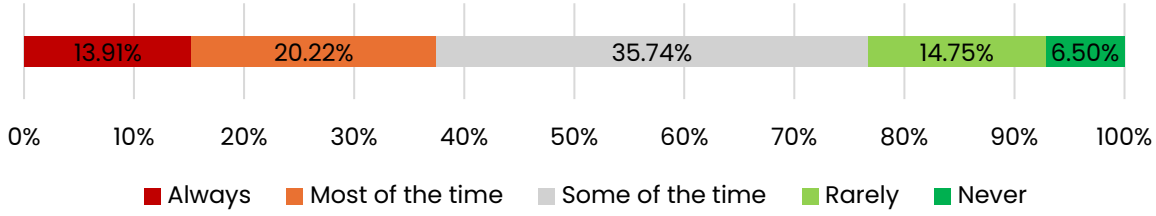

Figure 29. Frequency with which insufficient funding resulted in unmet resident or client service needs

4.2. Respondent comments around funding allocation

Qualitative responses (n=791) noted chronic understaffing and misallocation of resources, which respondents perceive as providers prioritising profit over resident well-being.

"I think there's enough funding, but the facility wants to maximise profits." – RN, NSW, Private (for-profit) RACF

> *"Due to the facility being for profit, funding is not channelled towards providing residents' services, but towards purchasing more facilities"* – EN, QLD, Private (for-profit) RACF

Respondents reported that management frequently failed to cover for sick staff or hire agency workers, which was perceived as a measure to control costs. This leads to excessive workloads and a lack of time to provide quality care.

> *"When someone calls in sick, management usually doesn't arrange a replacement, which puts even more pressure on the remaining staff."* -RN, SA, Private (for-profit) RACF

> *"Residents needing increased care requirements but no budget puts staff at increased WHS risks."* – RN, NSW, Private (for-profit) RACF

Further, respondents reported that essential supplies were rationed, such as a lack of quality wound dressings, poor quality or limited food and nutrition options, and restriction of continence aids.

> *"The RNs at work have been told they are spending too much on dressings. We had a few residents with complicated wound care requiring daily dressings. The other RN was so scared to ask for stock that we ended up running out altogether. It was a terrible situation to manage."* – RN, NSW, Private (not-for-profit) RACF

> *"Aged care facilities are very reluctant to spend money on updating essential equipment…"* – EN, VIC, Private (for-profit) RACF

Discussion and recommendations

The results of the ANMF 'pulse check' survey provide valuable insight into the real impact of recent reform across the aged care sector from the perspective of the workforce which supports the system. While recent reforms represent a step forward, the results of this survey suggest that they are continuing to fail to meet the needs of the workforce.

Despite positive progression on minimum staffing levels, with the mandating of minimum levels of direct care time, survey findings suggest that continued shortfalls in the number of staff continue to leave workers without enough time to deliver care and at risk of violence and aggression. This results in instances of rushed and missed care, degrading overall care quality, and leaves workers struggling to meet their responsibilities, often working through breaks, contributing to high levels of fatigue and burnout. Poor staffing levels also appear to have left the workforce at higher risk, with almost all respondents reporting having experienced or observed instances of WVA in the last 12 months. This was further compounded by respondents highlighting providers' lack of preventative and follow-up actions, leading to a culture of non-reporting, with perceptions that nothing would be done or fear of reprisal from non-supportive management. The above factors were compounded by reports that many providers' tendency to prioritise profitability above the quality of care delivered at their facility or the safety and needs of the workforce including in terms of nurses' requirements around professional practice.

Staffing levels and skills mix

Survey findings suggest that while mandated care minutes may have increased the reported amount of care delivered to residents, this has not necessarily translated into increased workforce capacity or improved care quality. National data from the Department of Health, Disability and Aged Care's Quarterly Financial Snapshot demonstrates that direct care minutes rose from 187 to 218.87 minutes per resident per day between Q1 2022–23 and Q4 2024–25,[10] indicating progress towards the ANMF's recommended minimum level of 258 minutes of direct care per resident per day.[11] However, responses from this survey highlight a gap between these aggregate gains and day-to-day staffing realities.

Nearly 40% of respondents rated overall staffing levels as "poor" or "very poor" over the past 12 months. While RN coverage was viewed more positively, likely due

to the 24/7 RN requirement, EN and PCW staffing were frequently rated poorly, particularly in for-profit facilities. Almost half of respondents also reported inadequate nursing-to-care staff ratios, reinforcing concerns about both staffing levels and skill mix.

These perceptions align with sector data showing a shift in how care minutes are delivered. Although RN care increased slightly as a share of total care (from 18.18% to 20.43%), EN care has declined (from 8.02% to 5.47%),[10] leaving the overall proportion of nursing care essentially unchanged. Further, respondents of the survey highlighted how both RNs and ENs were being moved away from clinical care delivery, with RNs being placed in increasing administrative roles and the EN role being diluted to personal care delivery.

The decline in EN roles emerges as a key factor shaping skill mix. Under earlier policy settings, the absence of EN-specific requirements and the structure of the AN-ACC funding model inadvertently created incentives to substitute ENs with lower-cost PCWs to make up direct care minute requirements. Although adjustments were introduced in October 2024, allowing EN care to count toward a portion of RN targets, respondents of this survey report ongoing role dilution, redundancies, and a shift of ENs toward non-clinical duties. At a system level, between Q1 2022-23 and Q4 2024-25, EN care minutes have fallen by 3.02 minutes per resident per day. Scaled nationally, this equates to roughly 598,000 fewer EN minutes per day or around 9,967 hours. This equates to the estimated loss of approximately 1,840 full-time EN positions. This contraction in the EN workforce is significant, particularly given its implications for clinical care capacity and supervision within residential aged care.[12-14]

Recommendations

To increase the quality and safety of care delivered in residential aged care, further efforts, alongside continued progress to implement the Royal Commission's recommendations, are required. This includes:

Mandating staffing ratios and skills mix

While the implementation of the Royal Commission's recommendations on direct care time has established minimum benchmarks and increased what was previously an unregulated level of care, these targets were not grounded in robust empirical evidence and were intended as a baseline rather than an optimal standard. Evidence from the 2016 National Aged Care Staffing and Skills Mix

Project, led by the ANMF in partnership with Flinders University and the University of South Australia, demonstrates that residents require an average of 258 minutes of direct care per day to support safe, restorative, and person-centred care.[11] This care should be delivered with a skill mix of 30% registered nurses (RNs), 20% enrolled nurses (ENs), and 50% personal care workers (PCWs).[11] Compared to this benchmark, current policy settings of 215 minutes per resident per day fall short in both total care time and the proportion of nursing care, limiting the capacity of services to meet resident need, which have likely become increasingly complex since this study was conducted.

Although mandated care minutes were supported, in principle, by the ANMF as a mechanism to increase care levels in line with assessed resident needs, unfortunately, this intent does not appear to have been realised in practice. Minimum direct care minute requirements do not appear to have translated into increased staffing presence on individual shifts where care is actually delivered. Instead, reported increases in care minutes appear to have been achieved, at least in part, through intensified workloads for existing staff, task compression, and the redistribution of duties. This contributes to rushed or missed care, reduced opportunities for relational and preventative care, and increased workforce fatigue and burnout, all of which undermine the quality and safety of care. This suggests that, in the current landscape, direct care minute requirements are not fit for purpose and require reconsideration.

The current use of aggregated reporting of care minutes over quarterly periods obscures day-to-day staffing realities and creates opportunities for providers to meet targets on paper without always ensuring safe staffing levels. This limits transparency and weakens accountability, particularly in relation to what care is considered 'direct' care.

To ensure safe, dignified, and enabling levels of care, **the ANMF recommends replacement of care minutes with mandated staffing ratios that increase the presence of nursing staff and align with evidence-based benchmarks and the complexity of care to create a clearer and more enforceable staffing standard to ensure safe staffing levels across all shifts.**

Mandated staff-to-resident ratios applied across all shifts would provide a clearer, more enforceable standard. This approach would also reduce the potential for manipulation inherent in aggregate reporting and support more transparent regulatory oversight.

Mandated ratios should align with the evidence-based benchmarks identified in the ANMF's 2016 report, including a skills mix of 30% RN, 20% EN, and 50% PCW,[11] or be updated in line with new high-quality research. Importantly, ratios must be designed to strengthen the presence of nursing staff, reversing the current trend toward substitution with lower-cost labour. This includes EN-specific care requirements to attract this workforce back to the sector.

Recognising current workforce and operational constraints, implementation could occur through a staged approach. This should include interim ratio targets, workforce development strategies, and targeted investment to grow the RN and EN workforce. Over time, this approach would progressively increase staffing levels, improve skill mix, and deliver care that better meets resident needs and supports the aged care workforce.

Safe staffing levels

To meet the increasing demand for high-quality aged care, **the ANMF recommend implementing a national workforce strategy focused on attraction, retention, and training which will support staffing and skills mix reforms and development of the aged care workforce.**

First, competitive wages, secure employment, and improved working conditions are critical to attracting new entrants to the sector, particularly registered and enrolled nurses. Second, retention can be enhanced through workforce incentives, reduced workloads, and career progression opportunities that recognise advanced skills and experience. Mandated staffing ratios are also critical to effective recruitment and retention. Finally, sustained investment in education and training pathways is required to build a pipeline of skilled workers, including scholarships, FEE-free VET study places, increased CSP for nursing degrees, clinical placement opportunities, and targeted pathways for school leavers, migrants, and career changers. These initiatives should be supported by national workforce planning that aligns supply building with projected demand.

Recognition of the importance of enrolled nurses in aged care

The role of ENs in residential aged care has been largely overlooked in recent reforms, particularly in relation to the absence of dedicated EN direct care minute targets. This has inadvertently contributed to the dilution and undervaluation of this essential role. Although the evidence base specific to EN contributions in aged care is currently limited and requires further strengthening,[13] ENs are regulated,

skilled practitioners who play a critical role in delivering safe, person-centred nursing care.[15] Positioned between PCWs and RNs, ENs provide both clinical continuity and an important career progression pathway within the aged care workforce.

To improve care quality, ENs must be recognised and supported as integral members of the aged care team. To support this, **the ANMF recommends attracting enrolled nurses back to the sector through dedicated staffing targets and a range of workforce incentives that recognise and strengthen the role of enrolled nurses.** Incentives may include an EN workforce incentive payment scheme that provides direct financial recognition to ENs for their expertise and contribution to quality care, alongside an incentive program for aged care providers to recruit and retain EN positions.

Removal of "universal" worker models

The introduction of "universal" worker models that combine direct care and non-care duties, such as hotel, food, or domestic tasks, represents a step backwards for resident safety, care quality, and workforce sustainability. These models dilute the expertise of PCWs, ENs, and RNs and draw their time away from clinical and relational care. The Royal Commission identified such practices as contributors to systemic failures, including medication errors, falls, and neglect.[16] This practice, often committed by for-profit providers in attempts to cut domestic service staffing costs and game the direct care requirements, is of serious concern. To prevent such practices, **the ANMF recommends establishing a national AHPRA-consistent registration scheme and minimum training standards to professionalise the personal care worker workforce.** The establishment of this standard would strengthen role integrity and clarity, ensuring that PCW time is directed towards care rather than subsidising non-care functions. Further, **the ANMF recommends prohibiting "universal" worker models that dilute clinical roles and divert staff from direct care**

Workplace violence and aggression in aged care

Respondents highlight the profound difficulties staff face when striving to support older people exhibiting complex behaviours. Workers widely recognise that these actions are often involuntary responses to mental health issues, underlying trauma, or dementia/cognitive decline. This is linked to the Royal Commission's recommendations regarding increasing staff training in dementia care. However, navigating the intensity of these situations safely makes providing day-to-day

care a high-risk responsibility. Here, continued substandard staffing levels appear to have resulted in continued experiences of WVA. Survey findings demonstrate that among those who reported inadequate staffing, a larger proportion reported experiencing one or more instances of WVA in the previous 12 months. Overall, close to all respondents reported having experienced and/or observed one or more instances of WVA at their workplace in the past 12 months.

The experience of WVA is extremely distressing and can result in developing mental disorders, including post-traumatic stress disorder, depression,[17, 18] and sleep disturbances.[19] Further, experiencing WVA is associated with impaired job performance, resulting in reduced quality of clinical care,[20-22] and higher rates of occupational burnout and absenteeism.[22, 23]

While in this survey, WVA was commonly reported, there is a known trend of underreporting of incidents,[5, 6, 24] suggesting that rates may be higher than otherwise reported. A large contributor to this underreporting is the perception that WVA is an expected and acceptable part of the role and that reporting WVA does not lead to improved working conditions.[3-8] The findings of this survey build on this, with respondents describing how providers mismanaged WVA incidents and failed to implement preventative measures.

Recommendations

To eliminate and prevent workplace violence and aggression in the aged care sector, a suite of reforms is required, including:

Safe staffing and skill mix

As identified in this survey, staffing levels are a key contributing factor to the prevalence of WVA in aged care settings.[25] Inadequate staffing reduces the capacity of workers to anticipate, prevent, and respond safely to behavioural incidents, particularly where residents present with complex cognitive or behavioural needs. To reduce WVA, providers must be required to maintain staffing levels and skill mix that reflect resident acuity and behavioural risk.

This includes ensuring sufficient numbers of appropriately qualified staff, including RNs, are available at all times to support clinical decision-making and incident response. Staffing models must also account for periods of increased risk, such as during intimate personal care, and provide for additional staff where residents are identified as high risk for WVA. **As above, the ANMF recommends replacement of care minutes with mandated staffing ratios that increase the**

presence of nursing staff and align with evidence-based benchmarks and the complexity of care to create a clearer and more enforceable staffing standard to ensure safe staffing levels across all shifts.

Improved risk assessment and care planning

As identified in this survey, a key contributing factor to WVA is the absence of identified, anticipated, and managed risk. To reduce preventable incidents, aged care providers should be required to implement routine comprehensive assessments of residents for factors associated with increased risk of WVA, including behavioural challenges, cognitive impairment (such as dementia-related agitation), and underlying psychiatric conditions.

These assessments should directly inform the development and regular review of individualised care plans. Such care plans must clearly identify early warning signs, known triggers (for example, specific times of day or particular personal care activities), and appropriate de-escalation strategies. They should also outline practical measures to minimise risk and protect aged care workers, ensuring that exposure to WVA is reduced to the greatest extent reasonably achievable. To support consistent implementation, **the ANMF recommends implementing mandatory, standardised risk assessments and person-centred care planning to prevent and manage WVA as part of standard care with regular review and auditing of compliance, including the number of WVA instances.**

Environmental and design controls

The physical environment within aged care facilities is an important, but often overlooked, aspect of WVA prevention. Environments that are noisy, overcrowded, or lack appropriate spaces for de-escalation can contribute to heightened distress and agitation among residents, particularly those living with dementia.[26]

To reduce environmental triggers, providers should be required to implement environmental risk mitigation strategies. These include ensuring clear and safe workspace layouts, minimising overstimulation, and providing access to designated low-stimulation or quiet areas for de-escalation. Staff should also have access to appropriate safety infrastructure, such as duress alarms and rapid response systems. **The ANMF recommends incorporating consideration of environmental WVA risk factors into the design, refurbishment, and accreditation of aged care facilities.**

Workforce training on WVA prevention and management

To support the prevention and safe management of WVA, staff must be provided with regular, high-quality training that equips them with the skills to recognise and respond to escalating behaviours. This includes training in de-escalation techniques, advanced communication strategies, and identifying clinical contributors such as delirium or dementia-related anxiety.

The ANMF recommends the development and delivery of Government-funded, nationally consistent, competency-based workforce training on WVA prevention and management in aged care. Training should be delivered during paid working hours and include practical, scenario-based learning. While training is an important component of prevention, it must not place the onus on individual workers or reinforce the perception that WVA is an expected part of the role. Instead, it should form part of a broader, system-wide approach to reducing risk.

Discontinuation of restrictive practices unless absolutely necessary

Due to a lack of preventive measures and limited workforce capacity, the use of restrictive practices, such as physical and/or pharmacological restraints, is often relied upon to prevent harm.[27] However, such practices must represent an absolute last resort and only be used in situations where there is a significant and immediate risk of harm to the individual, workers, or other residents.[28]

It is well established that physical and chemical restraints can place individuals at higher risk of harm and limit their rights and freedoms.[29] Despite existing legislative restrictions and reporting requirements, the inappropriate use of restrictive practices continues within the sector. **The ANMF recommends ensuring that restrictive practices involving physical or chemical restraint must not be used except as a last resort and that providers must demonstrate that all reasonable, least restrictive, evidence-based alternatives have been explored and implemented before restraint is considered.** Increased access to specialist behavioural support services and direct employment of nurses and nurse practitioners with dementia and mental health specialisations and expertise should also be prioritised to reduce reliance on restrictive practices.

Strengthened incident reporting and accountability

Underreporting of WVA remains a significant barrier to effective prevention and response. This is often driven by a lack of confidence in reporting systems, fear of reprisal, and perceptions that reporting does not result in meaningful change.

To address these issues, aged care providers must be required to implement robust, transparent, and accountable reporting systems. This includes mandating the reporting of all WVA incidents, including near misses, and ensuring that workers have access to confidential and, where appropriate, anonymous reporting mechanisms. Providers must also demonstrate that incident reports are reviewed and translated into tangible improvements in practice, including changes to staffing, care planning, and environmental controls.

The ANMF recommends strengthening WVA incident reporting systems, including mandatory reporting and systems that ensure transparency and accountability in how providers respond to incidents.

Workforce incident support and recovery

Survey respondents consistently reported inadequate post-incident support and follow-up, contributing to underreporting and significant distress. A timely, worker-centred response is essential to support recovery and maintain workforce wellbeing.

The ANMF emphasises that providers must prioritise both immediate and ongoing support for workers affected by WVA. This includes practical assistance, access to confidential counselling services, and the provision of Psychological First Aid where appropriate. Flexible responses that account for individual needs should be prioritised, including workload adjustments or leave following serious incidents.

Leadership, culture, and a zero-tolerance approach

A persistent barrier to addressing WVA in aged care is the perception that violence and aggression are an expected part of the role. This normalisation undermines reporting, weakens prevention efforts, and contributes to poor workforce outcomes.

To shift this culture, a clear, sector-wide zero-tolerance approach to WVA must be established and enforced. Aged care providers must be required to demonstrate commitment to preventing WVA, including embedding prevention strategies into organisational policies and performance indicators. Leaders and managers must be accountable for fostering a workplace culture in which staff feel safe to report incidents and confident that appropriate action will be taken. **The ANMF recommends that the Department of Health, Disability and Ageing implement a 'zero tolerance' approach to preventing and managing violence in all health, disability, and ageing sectors.**

Data collection, monitoring, and continuous improvement

A lack of consistent and comprehensive data on WVA limits the sector's ability to identify trends, evaluate interventions, and drive continuous improvement.

To address this gap, a coordinated approach to data collection and monitoring is required. This should include the establishment of a national framework for reporting and benchmarking WVA incidents. Aged care providers and government should be required to use this data to inform prevention initiatives and demonstrate measurable reductions in WVA over time. Governments and regulatory bodies must support ongoing research into effective WVA prevention strategies and ensure that findings are translated into practice across the sector.

The ANMF recommends establishing national WVA incident data collection, monitoring, and continuous improvement frameworks to track outcomes and inform policy.

Financial transparency

While this survey did not include questions directly related to the ways in which providers use public funding, findings throughout point towards providers' tendency to prioritise profitability over resident needs. Across survey findings, respondents from private for-profit facilities reported the highest level of dissatisfaction in regard to staffing factors and were more likely to report experiences of WVA.

In Australia, aged care operates largely based on market competition, a situation arguably perpetuated by past governments who have sought to rely on a market economy and 'healthy competition' between providers to win consumer favour and market share. Here, the assumption is that consumer choice will effectively drive competing providers to raise care quality and reduce costs in order to gain the edge over competitors. However, this is not often the case. International evidence of healthcare privatisation demonstrates that healthcare quality and outcomes for patients appear to be worse under private ownership.[30] This pattern is reflected within the Australian residential aged care context, where privately owned, for-profit facilities consistently deliver less direct nursing care than not-for-profit and government-operated services. Survey respondents repeatedly identified staffing levels and skill mix in for-profit facilities as being shaped primarily by cost-minimisation strategies aimed at meeting compliance

requirements and maximising government funding with minimal expenditure, rather than by clinical need or care quality considerations.

Recommendations

Improve transparent reporting of provider financial transactions

While recognising that there is an increase in publicly available data concerning sector performance, including financial performance, this has not gone far enough to address public concerns around providers' misallocation of public funding.

The ANMF recommends requiring stronger and more transparent, standardised public reporting of provider financial performance and use of funds. Providers should be mandated to publicly report detailed, standardised financial statements that clearly outline expenditure on direct care, staffing, administration, and profitability. This should include publicly available aggregate reports, with individual provider reports to be reviewed and audited by an independent aged care financial auditor. Any public funds used for private profit generation should be subject to serious regulatory actions.

Enhancing the role of the regulator in aged care

For too long, providers have been allowed to get away with financial malpractice due to a lack of regulatory enforcement. **The ANMF recommends strengthening the role, resourcing, and enforcement powers of the aged care regulator to ensure compliance and accountability.** This should include routine and random audits of provider financial practices, staffing levels, and care outcomes. Regulatory bodies, such as the Aged Care Quality and Safety Commission, must be empowered with stronger enforcement mechanisms, staffed to appropriate levels to ensure a sufficient level of oversight and timely review and action, and encouraged to take action. This action should include increased penalties and the revocation of provider registrations in cases of repeated or serious non-compliance.

De-privatisation of the aged care sector

The Australian aged care sector has become heavily privatised since the 1990s,[31] with for-profit providers now operating around 38% of residential aged care facilities.[32] This shift has correlated with chronic understaffing and compromised quality of care, and financial prioritisation over resident outcomes, as highlighted by the Royal Commission.

The ANMF recommend developing and implementing a staged de-privatisation strategy to reduce for-profit ownership of aged care services and expand public and not-for-profit care. The establishment of a national de-privatisation strategy should include targeted buybacks of underperforming for-profit facilities, incentives for not-for-profit expansion (e.g., concessional loans and priority bed allocations), and regulatory caps on new for-profit licences. Over 10 years, this strategy should aim to reduce for-profit market share to below 20%, with public providers managing at least 50% of beds in high-need areas. This approach would enhance accountability, align funding with evidence-based staffing needs, and rebuild public trust in the sector.

Conclusions

The findings of the ANMF 'Pulse Check' survey provide a timely assessment of the impact of recent aged care reforms from the perspective of one of the groups most affected, the aged care workforce. While recent reforms have driven some improvements in the aged care sector, the ANMF contests that in many cases they have not gone far enough and serious systemic concerns persist, including unsafe staffing levels and skills mix, unacceptably high levels of WVA, and a lack of transparency in how providers use government-provided funding. These concerns continue to compromise both the quality of care provided to older Australians and the wellbeing of the workforce.

To address these concerns, structural change that places workforce capacity, clinical expertise, and accountability at the centre of policy is required. This includes mandating staffing ratios and evidence-based skill mix, strengthening protections against WVA, enhanced financial transparency, and stronger regulatory oversight. These reforms are essential to achieving the intent behind the Royal Commission's recommendations.

Ultimately, the quality of Australia's aged care system depends on the strength of the workforce that sustains it. By implementing the recommendations outlined in this report, governments can build a sustainable, accountable, and high-performing aged care system that delivers safe, person-centred care, supports and retains its workforce, and restores public confidence in the care provided to our elderly generation.

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