Australian Nursing & Midwifery Federation

NATIONAL COVID-19 SURVEY 2022 - PUBLIC AND PRIVATE HOSPITALS

March 2022

Australian Nursing and Midwifery Federation National COVID-19 Survey 2022 – Public and Private Hospitals

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Key Points

- The survey was open from 18 January and closed on 11 February 2022 and focussed on the period of time since 1 December 2021 when many Australian State/Territory borders and social restrictions were eased and the SARS-CoV-2 Omicron variant of concern began to emerge in Australia.
- By mid-January 2022, the 'Omicron wave' appeared to have hit a peak, from which point while reported deaths had somewhat stabilised, newly acquired cases, hospitalisations, intensive care unit (ICU) admissions, and patients requiring ventilation began to show signs of abating.
- By the start of March 2022, almost four percent of hospital beds were occupied by patients with COVID-19 down from around 8.5% in mid-January at the peak of the Omicron wave.
- 791 participants began the survey and answered at least one question with 761 participants making it to the end of the survey. The results below report percentages in relation to the number of participants who responded to each question.
- The average age of participants was 43 years which is consistent with other reports of the age of Australia's hospital-based nursing and midwifery workforce.
- The largest groups of participants by age were people aged between 40-49 years (27%/n=199) and 30-39 years (26%/n=192).
- The largest number of participants were from Victoria (31%/n=239), the Northern Territory (26%/n=200), and South Australia (15%/n=117).
- Three quarters of the participants were registered nurses (76%/n=578). Enrolled nurses (10%/n=80), dual registered nurses and midwives (7%/n=54), and midwives (5%/n=35) accounted for the next largest participant groups.
- Most participants (87%/n=675) reported that they worked in a public hospital, while 7% (n=52) worked in private for-profit hospitals, and 6% worked in private not-for-profit hospitals.
- Around 21% (n=166) reported planning to leave their position within the next 12 months and approximately 36% (n=281) of participants reported plans to leave their job within 1-5 years.
- Thirteen percent of participants (n=103) reported that they planned to leave their profession (e.g., nursing/midwifery).
- The group aged between 20-29 years was the most likely to report an intention to leave their current role within the next year (23%), while the aged group over 60 years were most likely to report plans to retire.
- Intention to leave a current role in the next 1-5 years ranged from 32% in the 40-49- and 50-59-year age groups to 53% in the 60+ age group.
- Dual registered nurses and midwives included the largest proportion of participants reporting intention to leave within 12 months (30%) while registered nurses included the highest proportion (38%) that reported intending to leave in the next 1-5 years.
- Enrolled nurses included the largest proportion of participants who reported intending to leave the profession (18%).
- Participants reported a range of experiences at work including working mainly 8-hour shifts (64%/n=482), long periods without sufficient breaks (55%/n=416), paid overtime (55%/n=416), double shifts (40%/n=300), unpaid overtime (35%/n=269), and consecutive shifts (33%/n=253).

- Most participants (80%/n=630) had received three doses of a COVID-19 vaccination while 19% (n=152) had received two doses.
- Most participants (83%/n=772) reported that their experiences of accessing COVID-19 vaccines were 'good' to 'excellent', however challenges regarding access were raised by participants in open-ended responses.
- Most participants reported accessing COVID-19 tests from multiple sources. While 37% (n=276) of participants reported solely using employer-provided COVID-19 tests, 323 (44%) participants that did not report acquiring a test through their employer reported accessing mass testing sites and/or buying their own tests.
- The largest group of participants reported that their experiences of accessing COVID-19 testing as 'fair' (23%/n=170) or 'good' (22%/n=162). 16% (n=121) rated access as 'very good' while 13% (n=96) rated access as 'excellent'. 26% (n=189) reported access to COVID-19 testing as 'very poor' or 'poor'.
- While most participants (85%/n=673) reported that they have not been diagnosed with COVID-19, 10% (n=80) reported having been diagnosed with COVID-19. 85% percent (n=68) of those infected reported being infected after 1 December 2021.
- Just over a quarter (28%/n=84) of those who reported being infected with COVID-19 reported that they believed that this had occurred at work.
- 62% (n=484) of participants reported that their workplace had experienced a COVID-19 outbreak since December 2021.
- 9% (n=68) of participants reported that they have had to go into isolation/quarantine because of COVID-19 since 1 December 2021 due to being diagnosed and 20% (n=162) had to go into isolation/quarantine because of COVID-19 since 1 December 2021 because they were a close contact of a case.
- The most common place that participants reported isolating/quarantining was or would be in their own home with their entire household (54%/n=327) while 27% (n=161) participants reported that they have or would isolate at home but separate to their family.
- While the largest group of participants (35%/n=273) reported that their working hours were 'about right', 61% of participants reported that their hours were 'a bit more' (33%/n=254) or 'a lot more' (28%/n=216) than they would like.
- 18% (n=142) reported that their employer had asked them to cancel or delay planned leave or return to work from leave due to COVID-19.
- Almost half of the participants (47%/n=360) reported that their employer had a policy that asymptomatic workers can/should return to work before the end of their isolation period.
- While most participants (88%/n=547) reported that their employer had not asked them to return to work during their COVID-19 isolation/quarantine period, 12% (n=74) responded that they had been, including eight people who had been diagnosed with COVID-19.
- Almost half of the participants (42%/n=329) reported that their employer provided leave with pay due to exposure to COVID-19 and subsequent isolation, while a quarter (25%/n=193) reported that leave with pay was not provided for COVID-19 exposure and isolation.

- Most participants (84%/n=633) reported that their employer provided information regarding policies for testing and isolation while 16% (n=128) reported that no information had been provided. Participants generally reported that the information provided was moderately clear (weighted average of 3.18 on a scale of 1-6).
- Of 777 participants, similar proportions of participants reported that their workplace did (44%/n=341) and did not know (45%/n=349) if their workplace had an up-to-date outbreak management plan in place since December 2021. 11% (n=87) reported that their workplace did not have an up-to-date outbreak management plan.
- The largest groups of participants reported that they 'always' (43%/n=334) or 'often' (40%/306) had enough PPE at their workplace while 12% (n=93) reported 'sometimes' having enough PPE. 5% (n=39) reported 'rarely' or 'never' having enough PPE at work.
- Most participants reported that they 'always' (40%/n=309) or 'often' (39%/n=304) typically had the right types of PPE (e.g., gloves, gowns, masks, respirators) at their workplace. 14% (n=19) reported 'sometimes' having the right types of PPE while 7% percent (n=49) of participants reported 'never' or 'rarely' having the right types of PPE.
- Most participants (82%/630) reported that their workplace's PPE policy include the need for both fit testing and checking while 12% (n=90) reported that the policy did not include the need for fit testing and checking.
- The largest group of participants (39%/n=300) reported that their workplace 'often' typically had the right size of PPE. The next largest group (34%/n=263) reported 'always' having the right sized PPE. Almost 10% (n=75) of participants reported either 'rarely' (7%/n=52) or 'never' (3%/n=23) having the right size of PPE.
- The largest number of participants (40%/n=311) reported that they did not know if their employer had a policy for breaks while working in PPE, while similar numbers reported that their employer's policy did (~30%/n=228) or did not (~30%/n=234) include a policy for breaks while working in full PPE.
- From an analysis of open-ended responses, the main challenge identified by participants was primarily an overwhelming need for more staff. With a lack of available staff, respondents described having to work long gruelling shifts in PPE that often did not fit correctly with no opportunity for adequate breaks. Respondents were also frustrated at a lack of planning, and the confusing and often changing directives from management and government. Further to poor management, respondents also felt unsupported and anxious when redeploying into other areas of their facility to cover patient load. While facing each of these challenges, respondents were concerned for the safety and wellbeing of their patients, colleagues, family, and themselves.
- From an analysis of open-ended responses, the main solutions to these challenges included overwhelmingly the need for more staff with a better skills mix of expertise to care for patients and work safely, improved policies and processes for breaks at work and leave, enhanced preparation, and workforce and pandemic planning and communication underpinned by proactive and evidence-based policy. Participants also demanded action and to be heard, rather than words and assurances of change that might not occur.

Acknowledgements

We would like to acknowledge and thank the nearly 800 nurses, midwives, and personal care workers who donated time out of their very busy schedules to undertake the survey at a time when the COVID-19 pandemic reached unprecedented peaks in Australian healthcare settings. Your input is invaluable to ensuring that, collectively, the voices of the healthcare community is heard regarding the challenges faced on the frontline of the COVID-19 pandemic response in Australia. We would also like to acknowledge the ANMF Federal Office's Kristy Male for her work laying out and formatting the report for publication.

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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Executive Summary

"Nurses should have a voice in the public arena instead of being gagged. The public and government should be aware of the dire situation in nursing and if they don't act soon there will be no nurses left to care for the public."

Hospital Nurse

Introduction

On 18 January the Australian Nursing and Midwifery Federation (ANMF) launched a survey to explore the experiences of nurses, midwives, and assistants in nursing/personal care workers/aged care workers regarding the unfolding COVID-19 pandemic. The survey primarily focussed on the period of time since 1 December 2021 which roughly marks when many Australian State/Territory borders and social restrictions were eased and the SARS-CoV-2 'Omicron' variant of concern began to emerge in Australia. This report focusses solely on responses gathered from participants who worked in acute care settings (i.e. public and private hospitals). The background section of this report provides details and analysis regarding the unfolding COVID-19 crisis in Australia's healthcare system.

This report is based on the data collected from participants who self-reported primarily working in public and private hospitals. There are over 310,000 ANMF members across the eight state and territory branches with around 230,000 to 240,000 working in public and private hospitals.

Australia has faced immense challenges throughout the COVID-19 pandemic which began in Australia in January 2020. In response to the unfolding crisis, elective surgeries were cancelled or postponed, and hospital operations were significantly impacted as COVID-19 dedicated hospitals and wards were established. As the pandemic progressed, so did the severity of staff shortages with many staff furloughed and required to isolate as a result of COVID-19 exposure or infection. While many nurses, midwives, and care workers were called to the frontline to provide care to people infected with COVID-19, almost every hospital service and operation was in some way impacted by the pandemic as case numbers rose in the community and in healthcare due to the growing Omicron wave throughout December 2021 to February 2022.

The background section of this report has used data regarding the COVID-19 pandemic, outbreaks, case numbers, hospitalisations, and deaths to provide analysis and insight into the nature and magnitude of impact of the pandemic on Australia and the hospital sector throughout the period the survey was open. Understanding this background information is important for interpreting the context within which acute care staff were living in the lead up to and throughout the 'Omicron wave'.

This survey focussed on issues including; vaccination uptake, infection and exposure isolation and quarantine, work experiences with infection prevention and control including with personal protective equipment and workplace policies, challenges in the workplace, intention to leave, and staff-proposed solutions to the challenges faced by staff working in acute care during COVID-19.

Methods

The online survey opened on 18 January and closed on 11 February 2022. The 43 questions were developed by the ANMF Federal Office Research Unit and Rosemary Bryant AO Research Centre in consultation with representatives from the ANMF Federal Office and ANMF state and territory branches. The survey was designed to replicate some questions posed in the ANMF/Rosemary Bryant AO Research Centre's 2020 COVID-19 survey with updated items to capture contemporary developments around the COVID-19 context in Australia. The ANMF promoted the survey online via social media and websites. Data analyses in this report used descriptive quantitative and qualitative techniques.

Results

Demographics

791 participants that reported working in acute care began the survey with 761 making it to the end of the survey and answering the final question.*

- The average age of participants was 43 years. The largest groups were people aged between 40-49 years (27%/n=199), 30-39 years (26%/n=192), and 50 and 59 years (20%/n=142), followed by 20-29 years (15%/n=110), and 60-69 years (11%/n=79).
- Most participants (76%/n=578) were registered nurses (RN), 10% (n=80) were enrolled nurses (ENs), 7% (n=54) were dual registered nurses and registered midwives, and 5% (n=35) were registered midwives. Each of the remaining groups (e.g., students, assistants in nursing) made up 1% or less of the sample.
- Most participants mainly worked in Victoria (31%/n=239), Northern Territory (26%/n=200), and South Australia (15%/n=117).
- The majority of participants worked in public hospitals (87%/n=675), 7% (n=52) worked in private for-profit hospitals, and 6% worked in private not-for-profit hospitals.
- Most participants (98%/n=774) had been employed since 1 December 2021, while 2% (n=16) participants reported that they had not been employed.

Intention to leave

- The largest group of participants (41%/n=326) reported that they did not intend on leaving their current position within the next five years, while 36% (n=281) reported plans to leave within 1-5 years, and 21% (n=166) reported planning to leave their position within the next 12 months.
- The largest group of participants (46%/n=365) reported that they did not plan on leaving their profession (E.g., nursing) to work in another field. 33% (n=259) reported that they were 'undecided', and 13% (n=103) reported that they planned to leave their profession. 8% (n=60) plan to retire.
- Intention to leave their current position within the next 12 months was relatively consistent across age groups, with the group aged between 20-29 years the most likely to report intention to leave their current role within the next year (23%).
- Intention to leave a current role in the next 1-5 years ranged from 32% in the 40-49- and 50-59-year age groups to 53% in the 60+ age group. The 30–39-year age group included the second highest proportion of participants who reported intention to leave within the next 1-5 years.

* Because participants could skip questions, percentages in the results are expressed in relation to the total number of participants who responded to that question alone.

- Intention to leave the profession was relatively consistent across most age groups (7-15%), with the 50–59-year age groups least likely to report intending to leave their profession. The aged group over 60 years were most likely to report plans to retire.
- Dual registered nurses and midwives included the largest proportion of participants reporting intention to leave within 12 months (30%), while registered nurses included the highest proportion (38%) that reported intending to leave in the next 1-5 years. Enrolled nurses included the largest proportion who reported intending to leave the profession (18%).

COVID-19 vaccination and testing

- Most participants (80%/n=630) had received three doses of a COVID-19 vaccination while 19% (n=152) had received two doses.
- Most participants (83%/n=772) reported that their experiences of accessing COVID-19 vaccines were 'good' to 'excellent'.
- Many participants accessed COVID-19 tests from multiple sources as multiple responses were able to be selected for this question. 65% (n=478) of respondents reported that their employer provided RAT kits.
- Almost half (44%/n=323) of the participants that did not report acquiring a test through their employer reported accessing mass testing sites and/or buying their own tests while 276 participants (37%) reported only accessing tests provided by an employer.
- The largest group of participants reported that their experiences of accessing COVID-19 testing as 'fair' (23%/n=170) or 'good' (22%/n=162). 16% (n=121) rated access as 'very good' while 13% (n=96) rated access as 'excellent'. A quarter of participants (26%/n=189) reported access to COVID-19 testing as 'very poor' or 'poor'.

COVID-19 infection

- While most participants (85%/n=673) reported that they have not been diagnosed with COVID-19, 10% (n=80) reported having been diagnosed with COVID-19. 85% (n=68) of those infected reported being infected after 1 December 2021.
- 28% (n=84) of those who reported being infected with COVID-19 reported that they believed that this had occurred at work.
- Most participants (n=654/83%) reported that members of their immediate household had not tested positive for COVID-19 since 1 December 2021.
- 9% (n=68) participants reported that they have had to go into isolation/quarantine because of COVID-19 since 1 December 2021 due to being diagnosed. 20% (n=162) had to go into isolation/quarantine because of COVID-19 since 1 December 2021 because they were a close contact of a case.

Workplace experiences

- Participants reported a diverse array of work experiences in terms of shift length, rostering, and overtime. Of the selection provided, the top six were: mainly 8-hour shifts (64%/n=482), long periods without sufficient breaks (55%/n=416), paid overtime (55%/n=416), double shifts (40%/n=300), unpaid overtime (35%/n=269), and consecutive shifts (33%/n=253).
- The largest group of participants indicated that their working hours were 'about right' (35%/n=273) followed by 'a bit more that I would like' (33%/n=254) and 'a lot more that I would like' (28%/n=216). Four percent of participants (n=27) reported that their working hours were 'a bit' or 'a lot less' than they would like.

- While most participants (82%/n=645) reported that their employer had not asked them to cancel or delay planned leave or return to work from leave due to COVID-19 since 1 December 2021, 18% (n=142) participants reported that their employer had asked them to cancel or delay planned leave or return to work from leave due to COVID-19.
- The largest group of participants (47%/n=360) reported that their employer has a policy that asymptomatic workers can/should return to work before the end of their isolation period.
- Most participants (88%/n=547) reported that their employer had not asked them to return to work during their COVID-19 isolation/quarantine period, however 12% (n=74) responded that they had been, including eight people who had been diagnosed with COVID-19.
- A quarter of participants (25%/n=193) reported that leave with pay was not provided for COVID-19 exposure and isolation.
- Most participants (84%/n=633) reported that their employer provided information regarding policies for COVID-19 testing and isolation.
- On average, participants reported that their employer's information regarding policies for testing and isolation was moderately clear (weighted average of 3.18 on a scale of 1-6). Participants noted that information was often hard to stay up to date with because it often changed.

Managing COVID-19 in acute care settings

- Most participants (62%/n=484) reported that their **workplace had experienced a COVID-19 outbreak since December 2021**.
- Similar proportions of participants reported that their workplace had an up-to-date outbreak management plan in place since December 2021 (44%/n=341) or did not know (45%/n=349) if their workplace had an updated plan.
- The largest groups of participants reported that they 'always' (43%/n=334) or 'often' (40%/n=306) had enough PPE at their workplace, while 12% (n=93) reported 'sometimes' having enough PPE. Five percent (n=39) reported 'rarely' or 'never' having enough PPE at work.
- The largest groups of participants reported that they 'always' (40%/n=309) or 'often' (39%/n=304) typically had the right types of PPE (e.g., gloves, gowns, masks, respirators) at their workplace. Fourteen percent (n=19) reported 'sometimes' having the right types of PPE while seven percent (n=49) of participants reported 'never' or 'rarely' having the right types of PPE.
- The majority of participants (82%/n=630) reported that their workplace's PPE policy included the need for both fit testing and checking.
- The largest group of participants (39%/n=300) reported that their workplace 'often' typically had the right size of PPE. The next largest group (34%/n=263) reported 'always' having the right sized PPE. Almost 10% (n=75) of participants reported either 'rarely' (7%/n=52) or 'never' (3%/n=23) having the right size of PPE.
- The largest number of participants (40%/n=311) reported that they did not know if their employer had a policy for breaks while working in PPE, while similar numbers reported that their employer's policy did (~30%/n=228) or did not (~30%/n=234) include a policy for breaks while working in full PPE.

Workplace challenges and solutions

- Primarily respondents noted an overwhelming shortage of staff as the most challenging aspect of dealing with COVID-19. This lack of staffing exacerbated almost every challenge faced by respondents as they dealt with COVID-19.
- Respondents described working long gruelling hours without adequate breaks in PPE that they found often was not a correct fit. Concerningly, in an effort to conserve PPE, and being understaffed and unable to take a break, staff frequently noted not being able to stop for water or the bathroom.
- While facing these challenges, respondents noted their frustration at the poor management, and confusing and constantly changing directions of management and government. Their frustration also extended to a need to take personal leave when COVID-19 positive or designated a close contact.
- This poor management and lack of support also generated anxiety in those who were required to redeploy to different areas of their facility, or anticipated needing to redeploy, citing a need for skills they felt unable to provide, and unease at the prospect of providing unsafe care in the effort to cover patient load.
- As they met these challenges, respondents voiced their concern for the wellbeing and safety of patients, colleagues, their family, and themselves. Respondents felt sadness where patients were unable to visited by relatives, distress at seeing the conditions under which they and their colleagues were required to work and were fearful of bringing COVID-19 home to their families.
- In answer to “what can be done to fix or address the challenges respondents faced”, most responses contained clear calls to increase the skills mix, and availability of staff in hospitals. This was called for to ensure care can adequately be provided both to COVID-19 patients, and others presenting with a variety of issues.
- Further to calls for more staff, respondents again voiced their frustration at not being heard or listened to, suggesting that government, employers, leaders and decision makers could actually listen and take action on the feedback nurses and midwives have provided, and have consistently provided for some time.
- Respondents also highlighted a need for better policies and processes for taking breaks at work and provide adequate spaces for staff to take breaks while caring for COVID-19 patients. Working long hours without adequate toilet and drink breaks clearly contributed to burnout and exhaustion and there were many calls for measures that would allow for staff to take them.
- Respondents called for greater forethought, planning, and evidence-based policy in future. This included suggestions to improve communication and messaging, and for improved workforce planning – noting outstanding staffing deficiencies, workloads and poor skills mixes that were occurring prior to the pandemic.

Considerations for policy and practice

Based on the findings of this study, the following considerations are made to advance policy and practice to address the challenges faced by Australia’s hospital-based nursing and midwifery workforce.

- Interventions must be deployed to address the attraction and retention of high-quality staff in hospitals. Improvements to staffing levels and skills mix, remuneration, and the education and training of surge workforces are required to alleviate problems amplified by the ongoing pandemic and Omicron wave.
- Preparation and planning for future disasters and pandemics must occur to ensure sustainable best practice care during and beyond the COVID-19 pandemic.

- The deployment of staff in hospitals should be considered within the context of ensuring that surge workforces have the skills and training required to provide best practice care.
- Education and training of staff must be an urgent priority to ensure that all staff have current, evidence-based skills appropriate to their employment category, registration, and scope of practice including in infection control.
- High-quality clinical governance, improved communication and dialogue, and genuine understanding of the needs and experiences of staff is required at all levels of leadership including direct managers up to government.
- A stronger skills mix of direct care staff is required to provide safe best-practice care and to supervise new graduates and students on placement.
- Improved policy, process, and systems for sufficient breaks for staff is urgently required especially for staff working in PPE and with patients with COVID-19.
- Staff should be able to access a convenient, employer-provided sufficient supply of COVID-19 testing resources at no cost and in a way that does not detrimentally impact upon them financially or in terms of time take out of working hours.
- Workplaces must prioritise staff wellbeing, and safety as a core business objective in policy and practice to ensure that staff are not avoidably exposed to potential infection risks.
- Employers should not require staff to return to work during mandated isolation periods and should provide paid COVID-19 leave to staff required to take leave due to COVID-19 infection or exposure.
- Employers should ensure staffing levels are sufficient to ensure manageable workloads for staff and that adequate, appropriate breaks, leave, and shifts can be taken.
- Policies for COVID-19 testing and isolation should be reviewed for currency, clarity, and appropriateness and listen and act on feedback from staff.
- Policies for COVID-19 infection prevention and control should be reviewed for currency, clarity, and appropriateness and listen and act on feedback from staff.
- Sufficient supplies of the right type and size of PPE must be secured and sustainable and policies for use must include fit testing and checking and policies for breaks while using full PPE.
- Consistent, up to date, evidence-based, and standardised, communication, education and training in infection protection and control must be provided to all staff.
- Evidence-based programs designed to provide structured, tailored, and meaningful support, and that actively engage staff, especially during times of significant disruption and/or significant trauma must be implemented.

"This experience has caused burnout for [me] and many of my colleagues, the situation at work with added pressures/workload/and staff shortages are horrendous. I no longer want to work as an emergency nurse after 22 years of loving it. I'm not sure I even want to nurse anymore. The testing situation over Christmas/January was a joke. The govt. has a lot to answer for their appalling handling of this."

Registered nurse, age 44, Victoria

Introduction

"This is a very broken system that needs fixing now. We are so over worked and understaffed. There's never enough beds or staff. That needs to be fixed."

Registered nurse, age 40, New South Wales

On 18 January the Australian Nursing and Midwifery Federation (ANMF) launched a survey to explore the experiences of nurses, midwives, and assistants in nursing/personal care workers/aged care workers regarding the unfolding COVID-19 pandemic. This report focusses solely on the participants who reported working in the acute care sector including public and private hospitals.

The survey was advertised primarily to ANMF members nationally. There are over 310,000 ANMF members across the eight state and territory branches with around 230,000-240,000 working in public and private hospitals. This report is based on the data collected from participants who self-reported primarily working in public and private hospitals.

Australia has faced immense challenges throughout the COVID-19 pandemic which began in Australia in January 2020. The background section of this report has used data regarding the COVID-19 pandemic, outbreaks, case numbers, hospitalisations, and deaths from various sources to provide analysis and insight into the nature and magnitude of impact of the pandemic on Australian hospitals throughout the period the survey was open. Understanding this background information is important for interpreting the context within which hospital staff were living in the lead up to and throughout the 'Omicron wave'.

This survey focussed on issues including; vaccination uptake, infection and exposure isolation and quarantine, work experiences with infection prevention and control including with personal protective equipment and workplace policies, challenges in the workplace, intention to leave, and staff-proposed solution to the challenges faced working in Australian hospitals during COVID-19.

Background

The background section of this report provides details and analysis regarding the unfolding COVID-19 crisis in Australia. The survey primarily focussed on the period of time since 1 December 2021 to mid-January 2022, which roughly marks when many Australian State/Territory borders and social restrictions were eased and the SARS-CoV-2 Omicron variant of concern began to emerge in Australia. Since January 2020, Australia has experienced four distinct waves of COVID-19; most recently peaking in December 2021-January 2022 (See **Figure 1**).

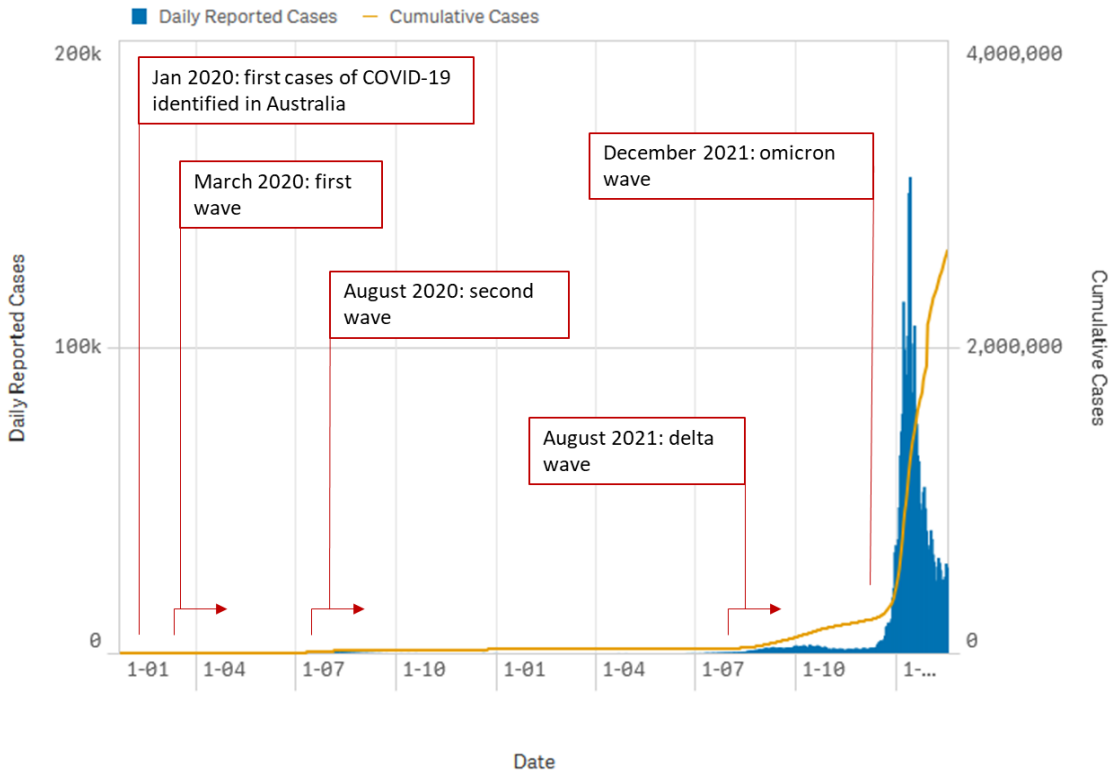

Figure 1: *Number of daily reported cases and cumulative cases of COVID-19 from 1 January 2020 to 31 January 2022. Source: Department of Health*[2]

To gain a clear insight into the ways that the unfolding COVID-19 pandemic has impacted upon Australians, conversion and plotting of daily totals for reported new cases, tests, hospitalisations, Intensive Care Unit (ICU), ventilator, and deaths to a logarithmic scale demonstrates the relationships between each of these factors.

Figure 2 provides an indication of the cross-sectional relationship between each variable and allows an understanding of how each has changed over time (from 1 November 2021, to 28 February 2022), and how those changes have occurred in relation to changes in the other variables. For example, observing cross-sectional information for 13 January (as indicated by the dashed grey line) shows that 219,303 PCR tests were conducted, and 150,702 new cases of COVID-19 were confirmed. On this same day, 4,227 patients were recorded as being currently hospitalised, 350 of whom were in the ICU and 109 ventilated, 56 people died.

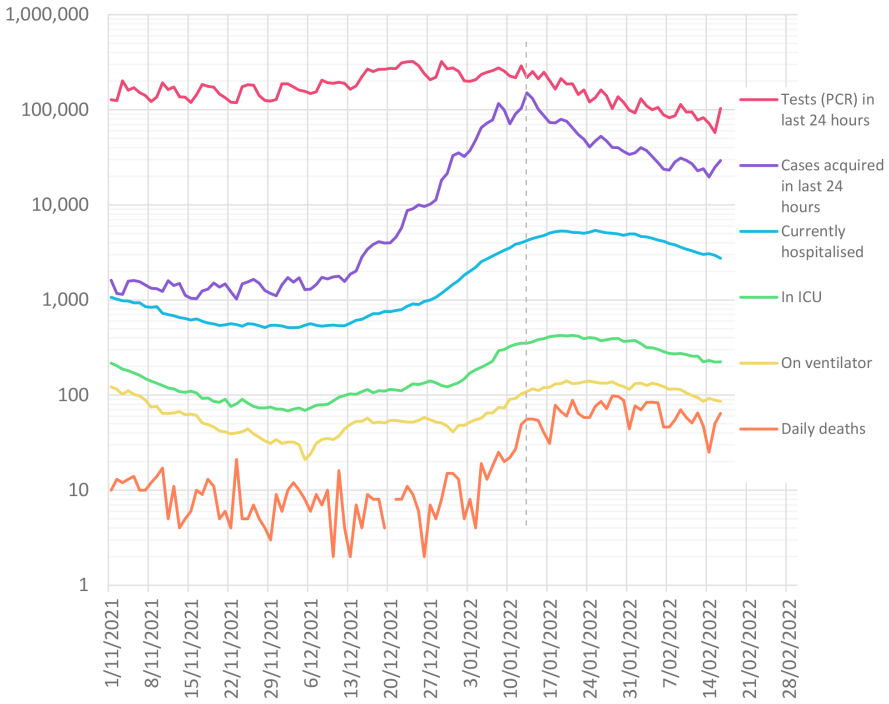

Figure 2: *Log-scale relationship between the number of PCR confirmed daily cases, number of daily tests, number of patients hospitalised, number of patients in the ICU, number of patients on a Ventilator, and number of daily recorded deaths between 1 November 2021 and 16 February 2022. Source: covid19data.com.au*

Understanding that the first cases of the Omicron variant were recorded in Australia on 27 November, **Figure 2** also shows how numbers and rates of each variable have changed as the Omicron wave progressed through December 2021 into January and February 2022. Observing the number of daily tests shows the number of tests conducted moving in a cyclical pattern and over the period 1 November to February, averaged 180,348 tests per day. A peak in testing occurred on 24 December, immediately before the Christmas and holiday period, and progressively declined to less than 100,000 tests per day through February. Observing the number of cases shows a sharp rise in cases from the middle of December through to the second week of January, where the number of confirmed daily cases increasingly became a larger proportion of daily tests being conducted. This trend continued to 13 January where 69% of tests identified a COVID-19 positive result. After 13 January, rates of testing continued to decline as did the number of recorded new COVID-19 cases. Over this same period however, observation of the number of ongoing hospitalisations, ICU, and ventilator use shows a flatter trend, indicating that (although decreasing) the number of people requiring hospitalisation and care is not decreasing at the same rate as the number of new recorded COVID-19 cases. The number of daily deaths follows the hospitalisation, ICU, and ventilator trend. This indicates that although recorded cases of COVID-19 are decreasing alongside the number of tests being conducted, providing care to COVD-19 patients continues to require a significant hospital resources and staff time. This has significant bearing on the healthcare system's ability to cope with both hospitalisation of community members with and without COVID-19 as well as with patients being transferred to hospital from nursing homes and in-home aged care.

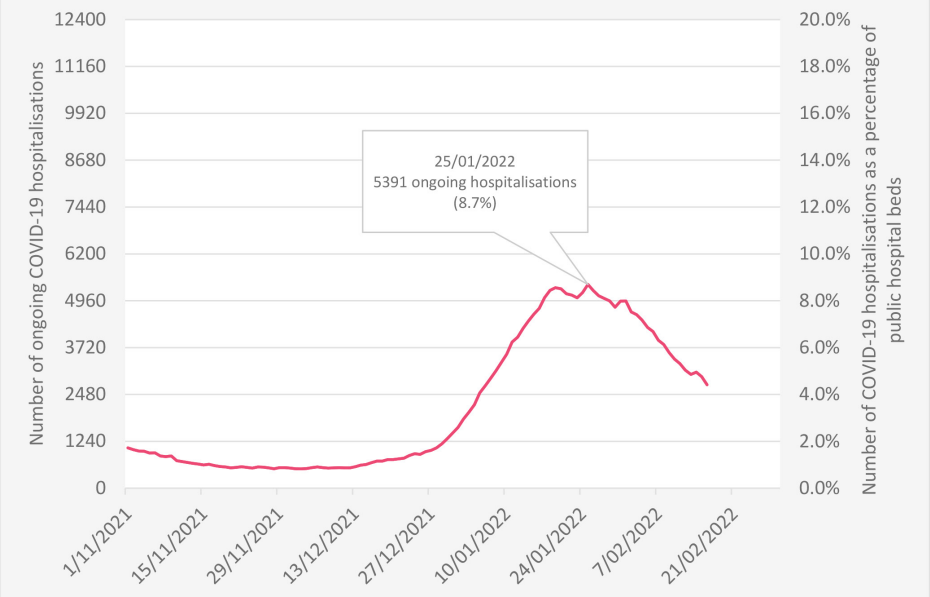

Figure 3: *Number of ongoing hospitalisations, and number of ongoing COVD-19 hospitalisations as a percentage of total Australian public hospital beds, between 1 November 2021 and 16 February 2022. Source: covid19data.com.au*

Figure 3 shows the number of ongoing COVID-19 related hospitalisations in Australia between 1 November 2021 and 16 February 2022. As reported by the Australian Institute of Health and Welfare (AIHW) there were 62,000 hospital beds in 2017/18 and when presenting the number of ongoing cases of COVID-19 hospitalisations as a percentage of that number we can see that at the peak of the Omicron wave 8.7% of beds were occupied by patients admitted for COVID-19.[3] This figure may be an over-estimate, as figures for the current number of beds in Australia do not appear to be publicly available. What is not captured here however, is the impact on the workload of staff when attending to nearly 10% of beds across Australia with COVID-19 positive patients. It is important to also understand the remaining proportion of beds are not unoccupied, they are occupied by other people receiving healthcare.

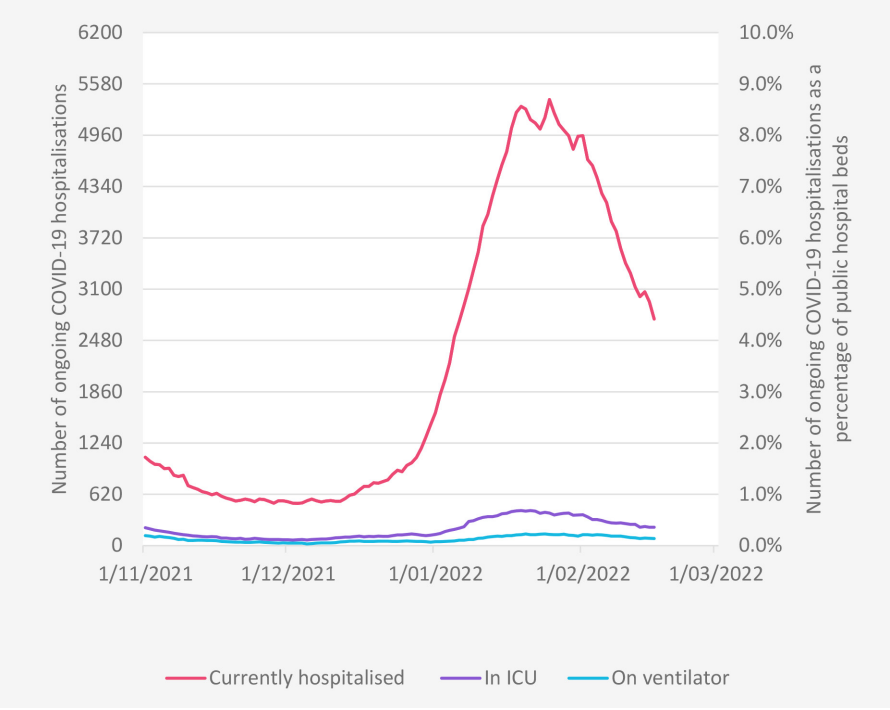

Figure 4: *Number of ongoing hospitalisations, people in ICU, and on ventilation, presented in total and as a percentage of the total number of public hospital beds in Australia between 1 November 2021 and 16 February 2022. Source: covid19data.com.au*

Further to that described above in **Figure 3**, **Figure 4** indicates the number and proportion of ICU beds in use and number of ventilated COVID-19 patients. Although the total number of ICU beds and ventilators in use appears low (less than 1%) these figures are presented as a proportion of the total number of public hospital beds in Australia. As such, a more representative figure of the impact of hospital bed use can be seen in the following graphs.

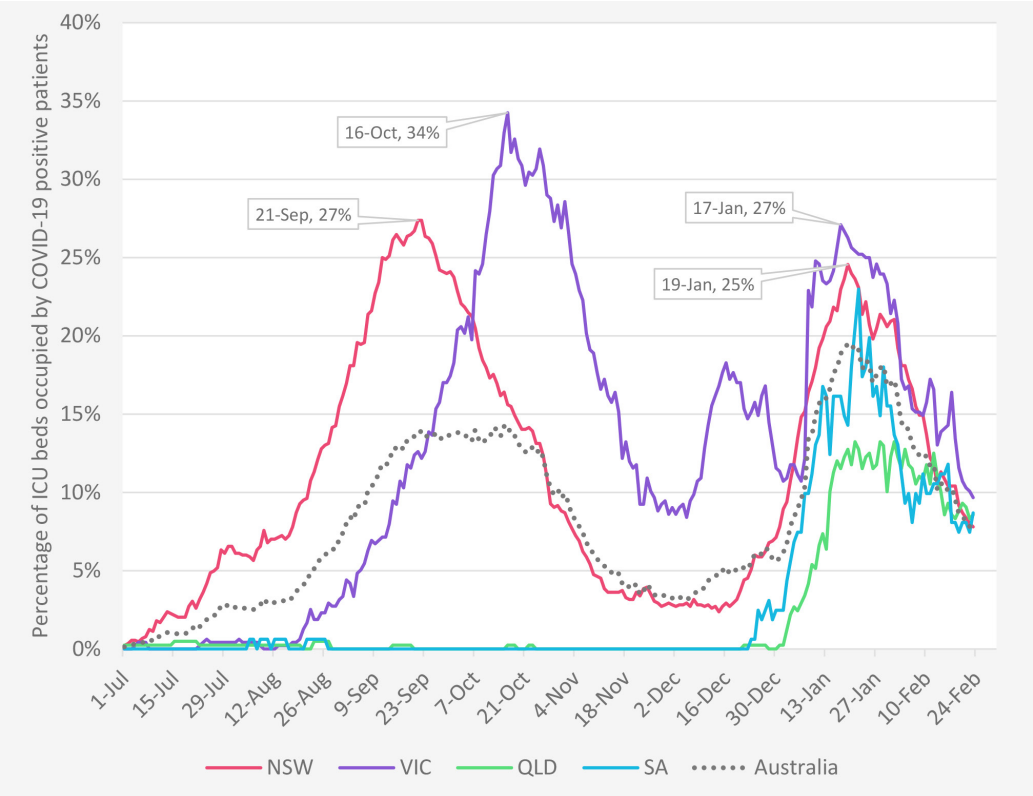

Figure 5: *Percentage of available ICU beds (NSW, Vic, Qld, SA) occupied by COVID-19 positive patients between 1 July 2021 and 16 February 2022. Source: covid19data.com.au*

Figures 5 and **6** show the proportion of ICU beds occupied in each state and territory, and across Australia, by COVID-19 patients through the Delta and Omicron waves, occurring between July 2021 to current. A survey of all 194 public and private Australian ICUs conducted between August and November of 2021 indicated the number of staffed and available ICU beds in each state and territory.[4] Observing **Figure 6** we can see that in September 2021 during the Delta wave, 27% of ICU beds in NSW were in use by COVID-19 patients, Victoria exceeded this peak in October 2021 with 34% of ICU beds in use. The subsequent Omicron wave saw slightly lower peaks of 25% and 27% respectively.

Figure 6 (below) however shows that although the majority of cases, particularly during the Delta wave were concentrated in NSW and Victoria, a similarly overwhelming percentage of ICU beds were in use by COVID-19 patients in the smaller territories. The ACT saw 32% of ICU beds in use during October 2021, in line with similar experience of NSW at that time, and concerningly the NT with a reported total of 20 available ICU beds saw a 30% occupation rate through the Omicron wave in early February 2022.

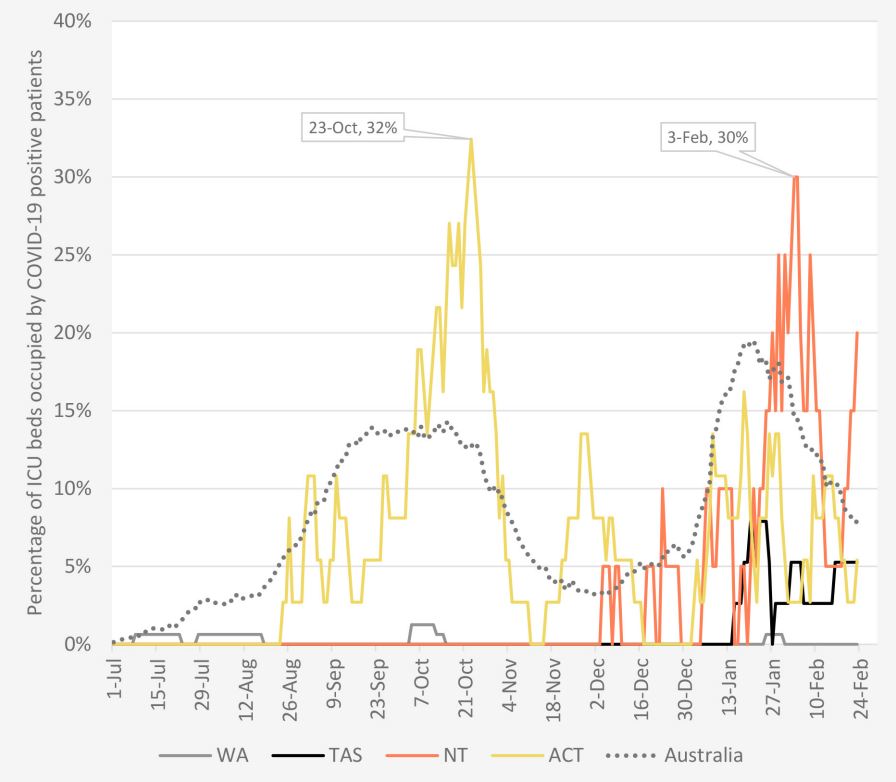

Figure 6: *Percentage of available ICU beds (WA, Tas, NT, ACT) occupied by COVID-19 positive patients between 1st of July 2021 and 16th of February 2022. Source: covid19data.com.au*

In considering the potent duality of increased workloads for staff providing care during the COVID-19 pandemic, and reduced numbers of staff as a result of quarantine and isolation requirements, this data highlights the magnitude of the challenge the Australian health care system has, and continues to meet.

"Our major public hospital has been a mess since December 1. Staff are not being cared for by their managers and are taking ratios well above their legal requirement. The patient care is very unsafe. Staff are being asked to complete tasks outside of their scope of practice and are being redeployed to units without the necessary skills or knowledge. On my ward, payroll is not properly providing red zone payments to those caring for covid positive children, as we are not deemed a 'hot ward' but instead a normal ward caring for both covid and non-covid patients. Staff should be provided with free RATs before every shift."

Registered nurse, age 22, Victoria

Methods

The online survey opened on 18 January and closed on 11 February 2022. The 43 questions were developed by the ANMF Federal Office Research Unit and Rosemary Bryant AO Research Centre in consultation with representatives from the ANMF Federal Office and ANMF state and territory branches. The ANMF promoted the survey online via social media and websites.

Participation in the study was voluntary and anonymous, and respondents were informed that by completing the survey, they would be providing consent for the ANMF to use and report the information anonymously.

The survey was formatted and a link made available to participants via Survey Monkey hosted at the Federal Office of the ANMF.

The survey was designed to replicate some questions posed in the ANMF/Rosemary Bryant AO Research Centre's 2020 COVID-19 survey with updated items to capture contemporary developments around the COVID-19 context in Australia. Specific research questions underpinning the study and survey questions included:

1. How has COVID-19 impacted upon staff in aged care in terms of infection/close contacts, testing, isolation, and working/leave arrangements?
2. What is the experience of aged care staff regarding COVID-19 vaccination and testing including access to vaccines and testing services?
3. What are the views of aged care staff regarding employer policies and practices regarding leave/return to work, infection prevention and control, testing, and vaccination?
4. What are the work experiences of aged care staff during the COVID-19 'Omicron wave' between 1 December and 11 February 2022 including self-reported intention to leave?
5. What work experiences of aged care staff regarding PPE have occurred during the 'Omicron wave'?
6. What key challenges have aged care staff experienced during the 'Omicron wave' and what are their identified solutions to addressing these challenges?

There were approximately 43 questions in the final survey (depending on how participants responded) addressing the domains depicted in **Figure 7**.

COVID-19 status and isolation	COVID-19 vaccinations and testing	Workplace experiences
• COVID-19 infection/ exposure • Isolation and quarantine • Leave from work due to COVID-19	• Vaccination access and experiences • Testing access and experiences	• Employment experiences • Intention to leave • Infection prevention • PPE • Challenges and solutions

Figure 7: *Domains assessed within the National COVID-19 Aged Care Survey 2022*

Results

791 participants answered at least one survey question with 761 participants making it to the end of the survey. Because participants could skip questions, percentages in the results below are expressed as a proportion of the total number of participants who responded to that question alone. Throughout this report, percentages have been rounded to the nearest complete number.

Of 791 participants who began the survey, 92% (n=703) were **ANMF/NSWNMA/QNMU** members, 7% (n=55) were not members, and less than 1% (n=3) were not sure.

Of 765 participants who responded to the question on **job classification**, 76% (n=578) were registered nurses (RN), 10% (n=80) were enrolled nurses (ENs), 7% (n=54) were dual registered nurses and registered midwives, and 5% (n=35) were registered midwives. Each of the remaining groups made up 1% or less of the sample. There were eight registered nursing students, five assistants in nursing/ personal care workers, three nurse practitioners, and two registered midwifery students.

Most participants mainly worked in Victoria (31%/n=239), Northern Territory (26%/n=200), and South Australia (15%/n=117). **Figure 8** shows the **breakdown of participants by the state or territory** they worked in.

Figure 8: *Participant distribution by state/territory*

Participant age

726 participants provided a valid response regarding their age. **The average age of participants was 43 years**. Of the valid responses, the largest groups were people aged between 40-49 years (27%/n=199), 30-39 years (26%/n=192), and 50 and 59 years (20%/n=142), followed by 20-29 years (15%/n=110), and 60-69 years (11%/n=79). There were four participants aged between 70 and 75. **Figure 9** shows the breakdown of **participants by age**.

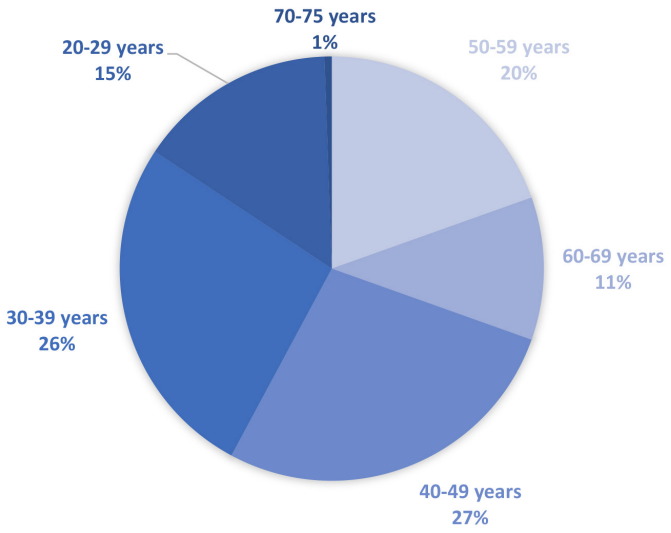

Figure 9: *Participants by age group*

Employment

777 participants answered a question regarding the type of hospital where they worked most often since 1 December 2021. 87% (n=675) worked in public hospitals, 7% (n=52) worked in private for-profit hospitals, and 6% worked in private not-for-profit hospitals.

Of 790 responses, most participants (98%/n=774) had been employed since 1 December 2021, while 2% (n=16) participants reported that they had not been employed. The reasons why **participants reported they had not been employed were**; maternity or long service leave (n=2), involuntarily left employment (n=2), non-COVID-19 sick leave (n=1), non-COVID-19 carers leave (n=1), voluntarily left employment (n=1), or undisclosed/ other/undisclosed (n=6).

"I am a casual RN, 3 shifts cancelled due to isolating with symptoms and close contacts. Promised initially from employer that I would be paid for lost work. Subsequently HR informed manager they are NOT paying casual workers anymore for shifts lost due to Covid and FT staff would have to use sick leave entitlements. I'm not entitled to anything from government because I have some savings. So basically, front line workers are at the forefront of everything, entitled to nothing and left to fend for ourselves. What a joke."

Registered nurse, age 60, New South Wales

Intention to leave

Of 791 responses the largest group of participants (41%/n=326) reported that they did not intend on leaving their current position within the next five years, while 36% (n=281) reported plans to leave within 1-5 years and 21% (n=166) reported planning to leave their position within the next 12 months. Just under 2% (n=13) reported leaving their job after 1 December 2021 and fewer than 1% (n=5) were not employed. **Figure 10** shows the **breakdown of participants' responses regarding their intention to leave their current position**.

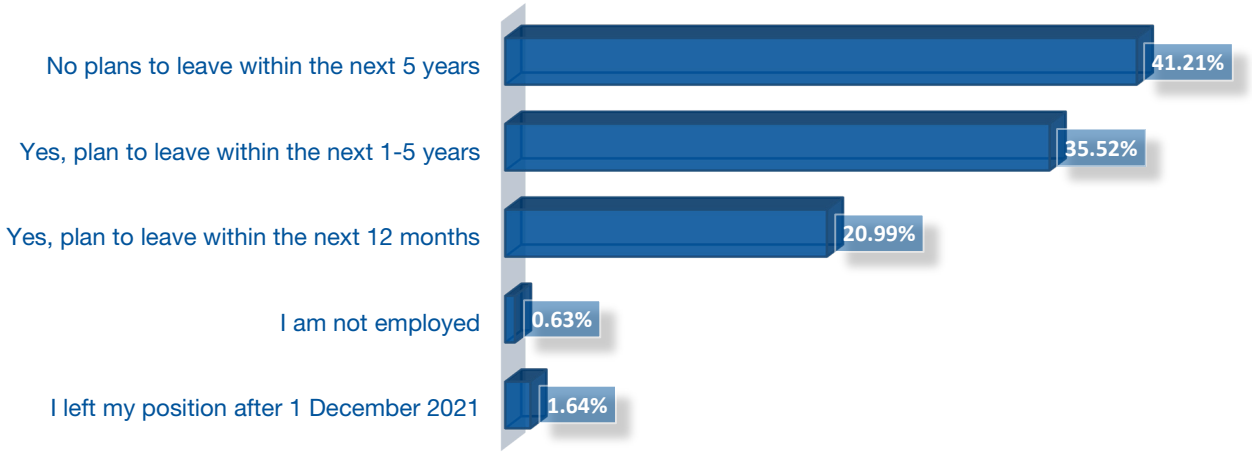

Figure 10: *Do you plan to leave your current position?*

Of 789 responses, almost half of all participants (46%/n=365) reported that they did not plan on leaving their profession (E.g., nursing) to work in another field. Thirty three percent (n=259) reported that they were 'undecided' and 13% (n=103) reported that they planned to leave their profession. 8% (n=60) plan to retire. **Figure 11** shows the **breakdown of participants' responses regarding their intention to leave their current profession**.

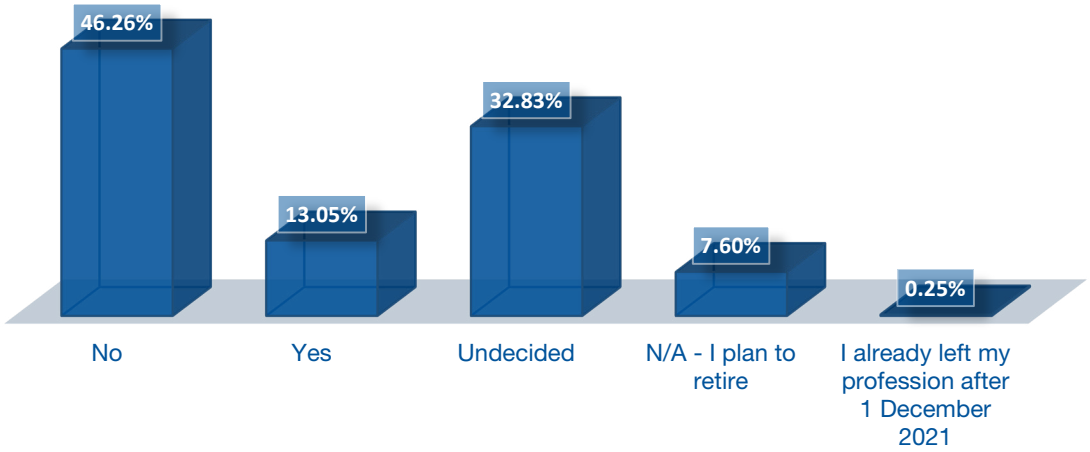

Figure 11: *Do you plan to exit your profession (E.g., nursing) to work in another field?*

In terms of participant intentions to leave their position or the profession by age group, there were 726 valid responses to allow categorisation of intention to leave by age. **Intention to leave current position within the next 12 months** was relatively consistent across age groups, with the group aged between 20-29 years the most likely to report intention to leave their current role within the next year (23%). **Intention to leave a current role in the next 1-5 years** ranged from 32% in the 40-49 and 50-59-year age groups to 53% in the 60+ age group. The 30-39-year age group included the second highest proportion of participants who reported intention to leave within the next 1-5 years.

Intention to leave the profession was relatively consistent across most age groups (7-15%) with the 50-59-year age groups least likely to report intending to leave their profession. The aged group over 60 years were most likely to report plans to retire. **Table 1** shows a breakdown of intention to leave by age group.

Table 1: *Intention to leave current position and profession by age group*

Participants who answered this question N = 726	Intend to leave position within next 12 months	Intend to leave position within 1- 5 years	No intention to leave within 1-5 years	Intend to leave profession (e.g., nursing/ aged care)	Retiring	Undecided about leaving the profession	Not employed/ left work since 1 Dec 2021*
Age group	**% / n**	**% / n**	**% / n**	**% / n**	**% / n**	**% / n**	**n**
18-29 years (n=110)	23% / 25	35% / 39	39% / 43	14% / 15	-	14% / 15	3
30-39 years (n=192)	20% / 39	45% / 68	42% / 80	15% / 29	1% /1	31% /59	5
40-49 years (n=199)	21% / 42	32% / 63	46% / 92	15% / 30	-	40% / 80	2
50-59 years (n=142)	22% / 31	32% / 45	44% / 63	7% / 10	11% / 15	39% / 55	3
60+ years (n=83)	19% / 16	53% / 44	24% / 20	8% / 7	46% / 38	16% / 13	-
Total **	21% / 153	36% / 259	41% / 298	13% / 91	7% 54	31% / 222	2% /13

*Not counted in the percentages these participants were not employed

** Counts and percentages in this row are slightly different from figures that included participants who did not provide a valid age.

Exploring intention to leave by employment category revealed that participant groups for personal care workers/assistants in nursing, nurse practitioners, and students were likely to be too small to contribute to a meaningful analysis (**Table 2**). Of the larger employment groups, dual registered nurses and midwives included the largest proportion of participants reporting intention to leave within 12 months (30%) while registered nurses included the highest proportion (38%) that reported intending to leave in the next 1-5 years. Enrolled nurses included the largest proportion who reported intending to leave the profession (18%).

Table 2: *Intention to leave current position and profession by employment category*

Participants who answered this question N = 880	Intend to leave position within next 12 months	Intend to leave position within 1- 5 years	No intention to leave within 1-5 years	Intend to leave profession (e.g., nursing/ aged care)	Retiring	Undecided about leaving the profession	Not employed/ left work since 1 Dec 2021*
Employment category	% / n	% / n	% / n	% / n	% / n	% / n	n
Registered nurse (n=578)	20% / 114	38% / 217	40% / 233	13% / 77	8% / 44	34% / 198	14
Registered nurse and midwife (n=54)	30% / 16	28% / 15	39% / 21	13% / 7	9% / 5	28% / 15	2
Registered midwife (n=35)	20% / 7	31% / 11	46% / 16	11% / 4	9% / 3	46% / 16	1
Enrolled nurse (n=80)	21% / 17	35% / 28	44% / 35	18% / 14	5% / 4	31% / 25	-
Personal care worker/ Assistant in nursing (n=5)	60% / 3	20% / 1	20% / 1	-	20% / 1	20% / 1	-
Nurse practitioner (n=3)	33% / 1	33% / 1	33% / 1	-	-	33% / 1	-
Registered nurse or midwifery student (n-10)	60% /6	20% /2	10% /1	-	-	10% /1	1

*Not counted in the percentages these participants were not employed.

"We are short staffed and burnt out. Many are leaving the entire nursing profession."

Enrolled nurse, age 33, New South Wales

COVID-19 vaccination

Of 791 responses, most participants (80%/n=630) had received three doses of a COVID-19 vaccination while 19% (n=152) had received two doses. Only seven participants reported not receiving any doses and five of these also reported that they were on extended leave or had left their job. **Figure 12** shows the breakdown of **participants by vaccination status**. Participants who indicated not having received any COVID-19 vaccines had been employed previously but were not employed at the time of the survey.

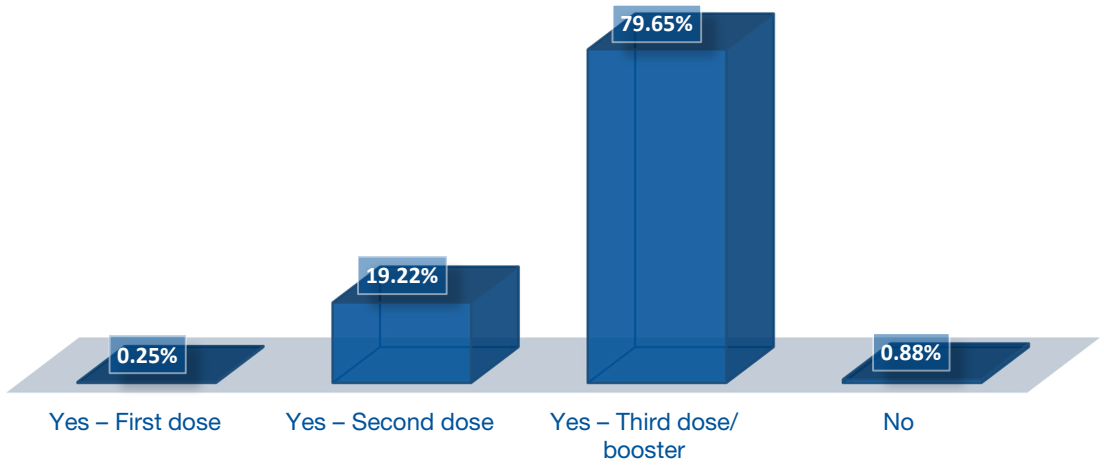

Figure 12: *Have you received a COVID-19 vaccination?*

Of 786 responses, most participants (83%/n=772) reported that their experiences of accessing COVID-19 vaccines were 'good' to 'excellent'. Eleven percent (n=85) reported access was 'fair'. Six percent (n=45) of participants reported that their experiences of vaccine access were 'very poor' or 'poor'. **Figure 13** shows the breakdown of **participants' reported experience of accessing COVID-19 vaccines**.

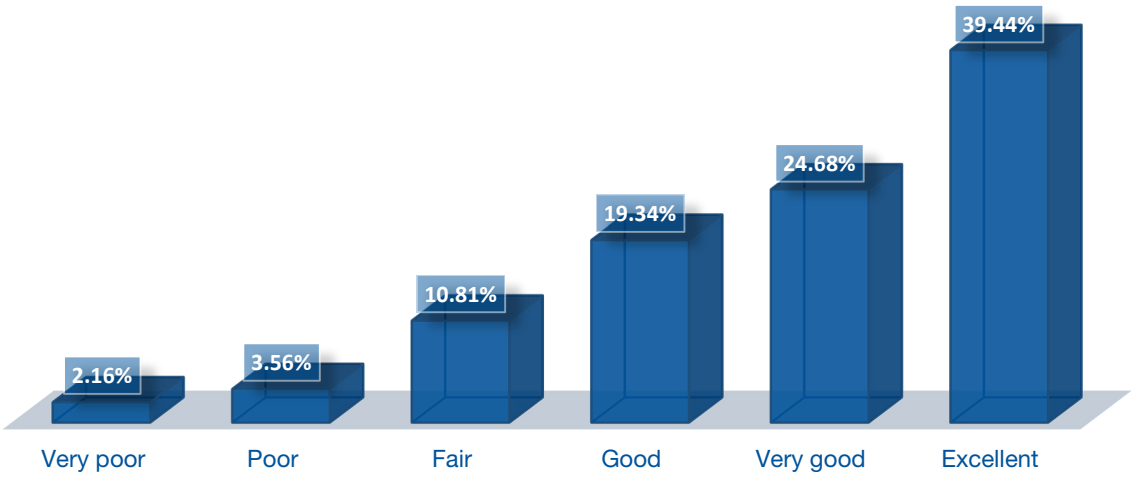

Figure 13: *What has been your experience regarding access to the COVID-19 vaccines?*

Participants were invited to comment on their response to this question. While reflective of the results, most people were positive about their experiences and commented on ease and timeliness of bookings, appointments, and access, some participants reported negative experiences and challenges. Some participants highlighted that accessing the third dose was more challenging than previous doses and that workplace-organised vaccines would have been preferable and much more convenient. Many participants who had their vaccines organised via their employer reported positive experiences.

"Lack of access to testing is appalling considering many staff members become exposed or infected at work. I believe employers should offer staff PCR testing and provide RAT tests free of charge."

Care worker, age 21, New South Wales

COVID-19 testing

"As healthcare professionals I think we should have free access to RAT [kits] and our employer should provide them to us freely."

Registered midwife, age 56, Victoria

Of 730 responses, many participants accessed COVID-19 tests from multiple sources as multiple responses were able to be selected for this question. Sixty five percent (n=478) of respondents reported that their employer provided COVID-19 testing. Twenty nine percent (n=213) of participants reported buying their own tests and 35% (n=255) reported accessing a mass testing site. Almost half (44%/ n=323) of participants that did not report acquiring a test through their employer reported accessing mass testing sites, buying their own tests, or getting tests via other means (e.g., friends or family). Fifty-seven participants (8%) reported purchasing their own tests but not using mass testing sites or employer-provided tests. 276 participants (37%) reported only accessing tests provided by an employer. One hundred and twenty-seven (17%) participants reported accessing tests through other sources (e.g., from family or friends) or that they had not used a test. **Figure 14** shows the breakdown of where **participants reported accessing COVID-19 tests (RAT and/or PCR).**

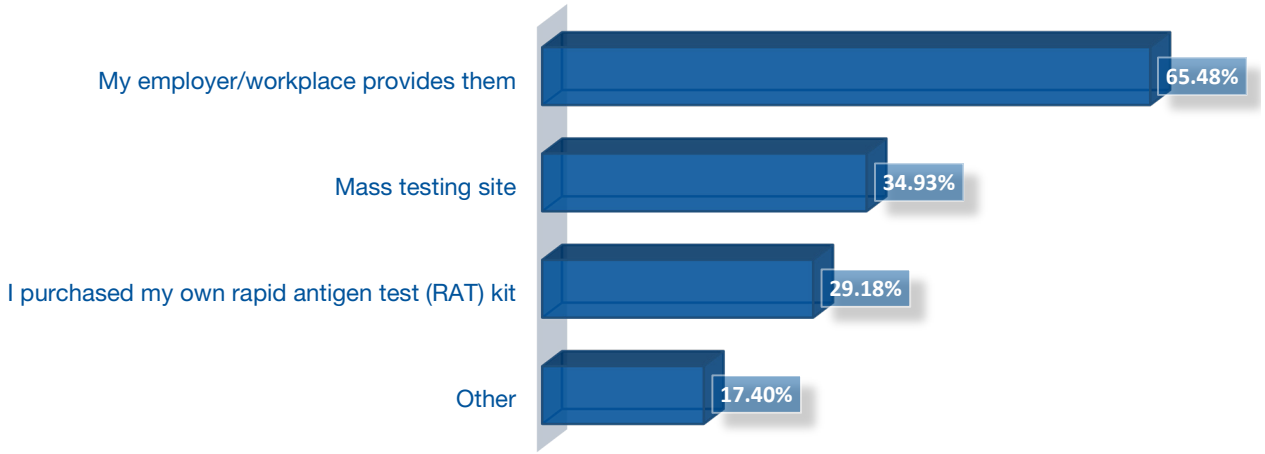

Figure 14: *Where participants reported accessing COVID-19 tests*

Of 738 responses, the largest group of participants reported their experiences of accessing COVID-19 testing as 'fair' (23%/n=170) or 'good' (22%/n=162). Sixteen percent (n=121) rated access as 'very good' while 13% (n=96) rated access as 'excellent'. 26% (n=189) reported access to COVID-19 testing as 'very poor' or 'poor'. **Figure 15** shows the breakdown of **participants' reported experience of accessing COVID-19 testing**.

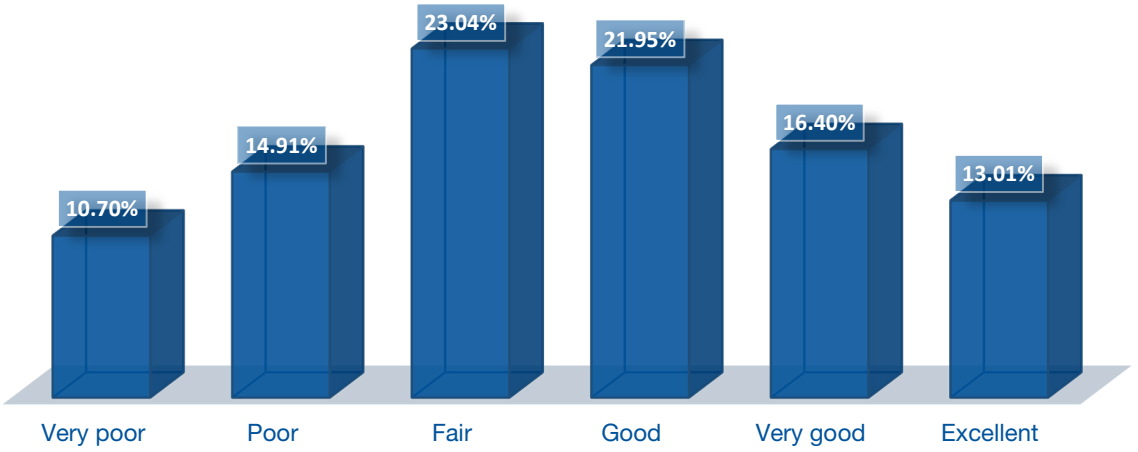

Figure 15: *What has been your experience regarding access to COVID-19 testing since 1 December 2021?*

Participants were invited to comment on their response to this question regarding experiences of accessing COVID-19 testing. While many participants had positive comments regarding accessing testing services, many commented on the fact that accessing tests was often time consuming and inconvenient in terms of being able to work. This was particularly burdensome for staff who had been close contacts on multiple occasions. Some participants commented that while accessing testing through work was relatively simple, using community testing sites was very time consuming and often associated with long queues, waiting times, and discomfort. Extended turnaround times for test results were often also commented upon, with some participants noting that they could not work while waiting for test results which detrimentally impacted upon income. Other participants highlighted that problems with accessing timely tests and results meant not knowing if they were positive and potentially infectious. A number of participants noted that because many community members were accessing testing sites to travel over the Christmas and New Year Break, healthcare workers results often took a long time to return. Many participants also commented on the difficultly they experienced finding RAT kits when their workplace was not able to provide them which was especially pronounced in regional Australia.

"I've waited between 4 days and 12 days for PCR test results. Meaning I couldn't work while I waited for results."

Registered nurse and registered midwife, age 41, Victoria

"In the community - only two testing sites were open for the whole Geelong area, waiting lines closing before 6am for being at capacity already, having to drive around for hours to find testing sites that were not already at capacity, all this while very symptomatic, then results not being provided because the samples were unsuitable for testing 8-10 days later. At work (one hour from home) - asymptotic surveillance testing is quick and simple. Symptomatic testing often has longer waiting times in a waiting room full of other symptomatic people."

Registered nurse and registered midwife, age 49, Victoria

"The inappropriate use of testing facilities due to travel requirements overloaded the system and created a knock-on effect for poor outcomes via testing clinic. RATs have been very hard to purchase and remain difficult to get within rural and regional centres."

Registered nurse, age 63, New South Wales

"No proper protocol in place in case you become a close contact at work. You have to wait for contact tracing to contact, it took them 7 days to get back to me. Would already be too late if one of us were infected, we would have been spreading the virus already. We were not asked to do any tests at all even a RAT. They would not provide."

Registered nurse, age 33, Northern Territory

"We don't have any routine testing, we are not provided access to RATs even when we are caring for covid positive patients. Policies are confusing and difficult to access and follow. PPE guidance is confusing and difficult to follow if you are new to looking after covid patients. Minimal education. Practice is not up to date."

Registered nurse, age 27, Queensland

"Nurses and healthcare staff need free access to testing more often to ensure our and our family's (and our colleagues and patients') safety. It feels unsafe currently."

Registered nurse, age 38, Victoria

COVID-19 infection

"I am an infection control nurse at a major public hospital. Our resources are stretched extremely thin and the work pressures are enormous. Our system is struggling."

Registered nurse, age 24, Tasmania

Of 791 responses, most participants (85%/n=673) reported that they **have not been diagnosed with COVID-19**. Ten percent (n=80) reported having been diagnosed with COVID-19 while 4% (n=30) reported that they think they might have had COVID-19 but hadn't been formally diagnosed. One percent (n=8) of participants were awaiting results of a test at the time of completing the survey. **Figure 16** shows the breakdown of **participant reports of COVID-19 diagnosis**.

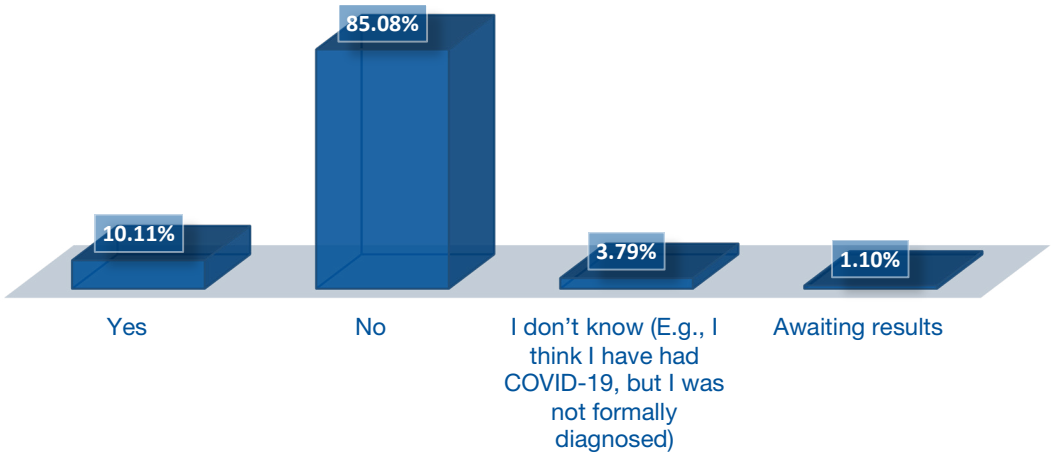

Figure 16: *Participants that reported having been diagnosed with COVID-19.*

Among the participants that had been diagnosed with COVID-19 (n=80) or were not sure if they had contracted COVID-19 (n=30) such as those that suspected but no formal diagnosis, 70% (n=77) reported being **infected after 1 December 2021** and 15 (n=16) were not sure when they had been infected. 85% (n=68) of those infected reported being infected after 1 December 2021. Only 17 percent (n=19) of respondents reported having been infected prior to 1 December 2021.

Most participants (n=654/83%) reported that members of their **immediate household had not tested positive for COVID-19 since 1 December 2021**, while 17% (n=132) reported that a member of their immediate household had been infected since 1 December 2021.

While around half of the participants who responded (51%/n=325) had not been infected with COVID-19 or been a close contact, of 314 participants that reported having been infected with COVID-19, suspected it, or became a close contact 84 (29%) reported they believed they had been infected or become a close contact at work. Just over a quarter (28%/n=84) of those who reported being infected with COVID-19 reported that they believed that this had occurred at work.

Figure 17 shows the breakdown of **participant reports of where they believed they were infected with COVID-19 or became a close contact**.

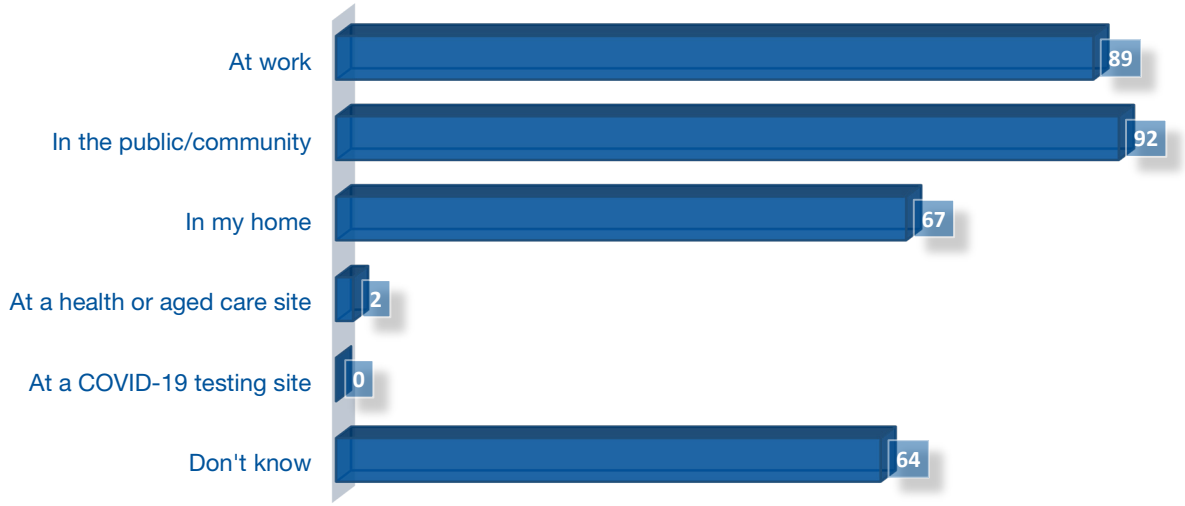

Figure 17: *Where do you think you were infected with COVID-19?*

Of 791 responses, 9% (n=68) participants reported that they have had to go into **isolation/quarantine because of COVID-19 since 1 December 2021** due to being diagnosed. Twenty percent (n=162) had to go into isolation/quarantine because of COVID-19 since 1 December 2021 because they were a close contact of a case. Almost three quarters of participants (71%/n=561) have not had to go into isolation/quarantine because of COVID-19 since 1 December 2021.

Participants reported the **number of times they have needed to isolate/quarantine due to COVID-19 since 1 December 2021**. The most common answer was once (1), however many participants reported having to isolate two-three times or more.

Of 603 responses, the most common place that participants reported isolating/quarantining was or would be in their own home with their entire household (54%/n=327). Just over a quarter (27%/n=161) of participants reported that they have or would isolate at home but separate to their family. Five percent (n=28) participants did not know where they would isolate if they needed to. **Figure 18** shows the breakdown of **participant reports of where they had or would isolate due to COVID-19 diagnosis/close contact**.

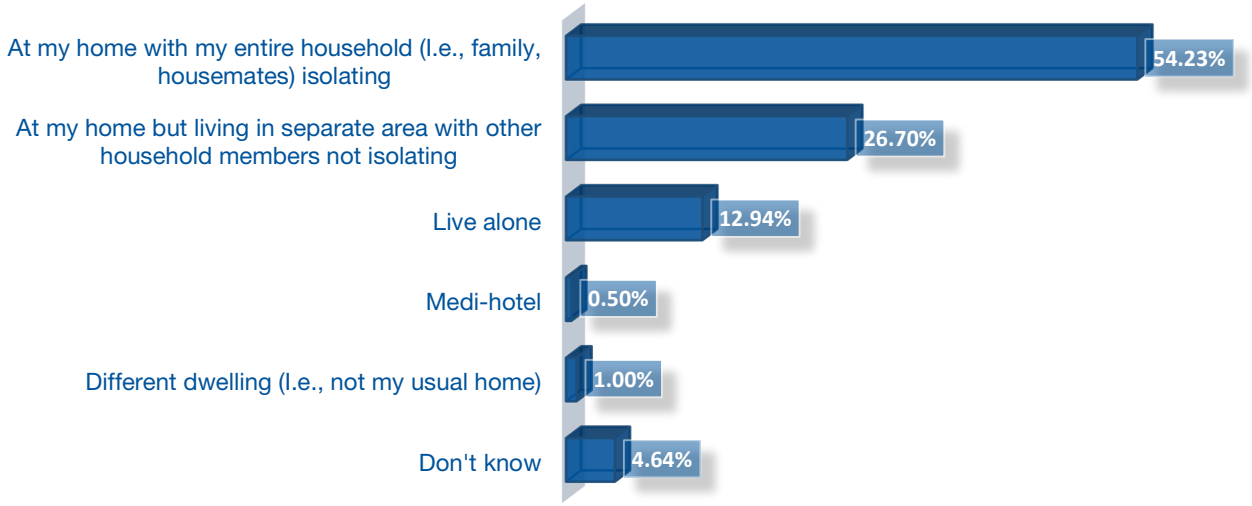

Figure 18: *Where did you isolate/quarantine or where would you isolate/quarantine (if you needed to)?*

Participants were asked to provide further comments on their response to where they have or would isolate/quarantine due to COVID-19 infection or being a close contact. Many participants commented on the challenges of having to isolate at home with their family members and especially about their concern and fears of passing COVID-19 onto their loved ones from an exposure at work. Participants were especially worried about passing on COVID-19 to vulnerable family members including parents and children as well as how they would cope if they needed to isolate away from dependents when no one else would be able to care for them.

"Live in one bedroom place with partner, so unsure of where I would go if I had to quarantine, plus on how to afford it if that has to happen."

Registered nurse, age 32, Northern Territory

"Single parent living with teenager. House quite small so difficult to separate. Biggest fear is getting sick enough for hospitalisation as all relatives are older, so no one to care for teen...who is just 13 so not quite independent."

Registered nurse, Tasmania

"Tested positive yesterday, awaiting access to a Medi-hotel as we live in an apartment with all shared areas. I've been isolating separately to my family in my bedroom. They are negative but isolating."

Registered nurse, age 35, Victoria

Work experiences

"I am SICK OF GETTING EXPOSED AT WORK. I'm in ICU. And of course, we don't do nursing for money, but I could sit on my […] somewhere with minimal exposure risk, for the same amount of money. Three times in two weeks I got exposed to COVID-19, at work. I have young kids, elderly parents. I come home every day with a migraine from wearing an N-95 and face shield all day. And for what? "

Registered nurse, age 42, Australian Capital Territory

758 participants reported a diverse array of work experiences in terms of shift length, rostering, and overtime. Of the selection provided, the top six were: mainly 8-hour shifts (64%/n=482), long periods without sufficient breaks (55%/n=416), paid overtime (55%/n=416), double shifts (40%/n=300), unpaid overtime (35%/n=269), and consecutive shifts (33%/n=253). **Figure 19** shows the breakdown of **participants reports of workplace experiences**.

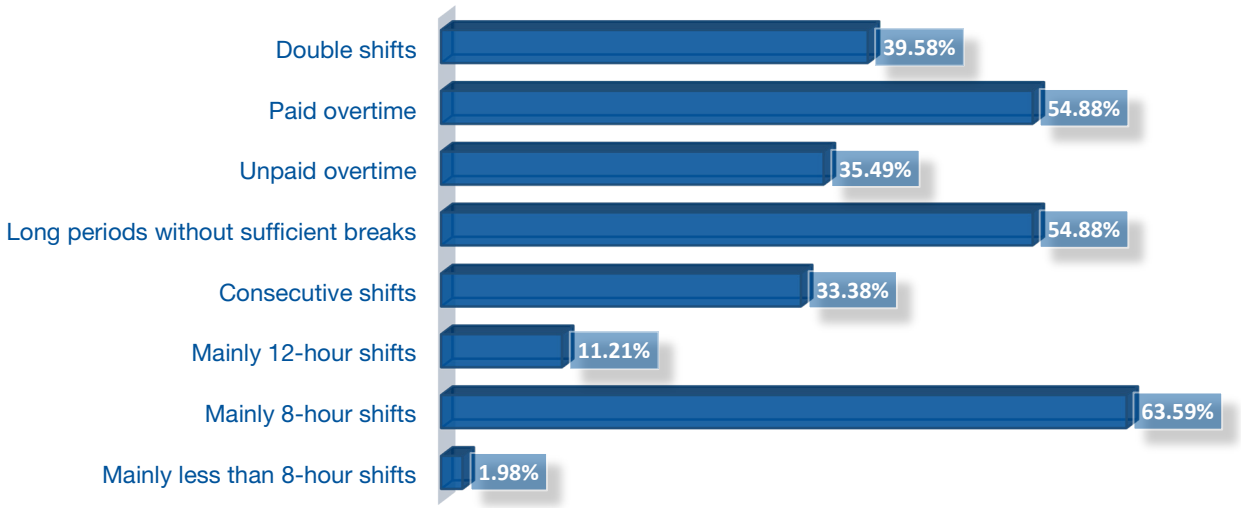

Figure 19: *Participants' reports of workplace experiences.*

Of 770 responses, the largest group of participants indicated that their working hours were 'about right' (35%/n=273) followed by 'a bit more than I would like' (33%/n=254) and 'a lot more than I would like' (28%/n=216). Four percent of participants (n=27) reported that their working hours were 'a bit' or 'a lot less' than they would like. **Figure 20** shows the breakdown of **participants' satisfaction with working hours**.

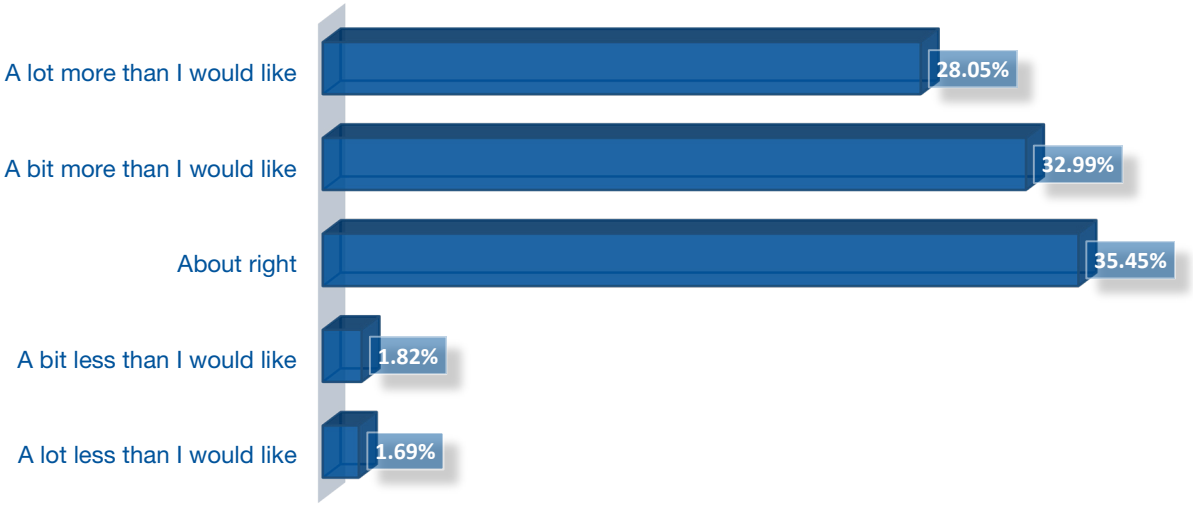

Figure 20: *Since 1 December 2021, are your working hours?*

Of 787 responses, most participants (82%/n=645) reported that their employer had not asked them to cancel or delay planned leave or return to work from leave due to COVID-19 since 1 December 2021. Eighteen percent (n=142) of participants reported that their employer had asked them to cancel or delay planned leave or return to work from leave due to COVID-19. **Figure 21** shows the breakdown of **participants' reports of delayed or cancelled leave since 1 December 2021 due to employer requests**.

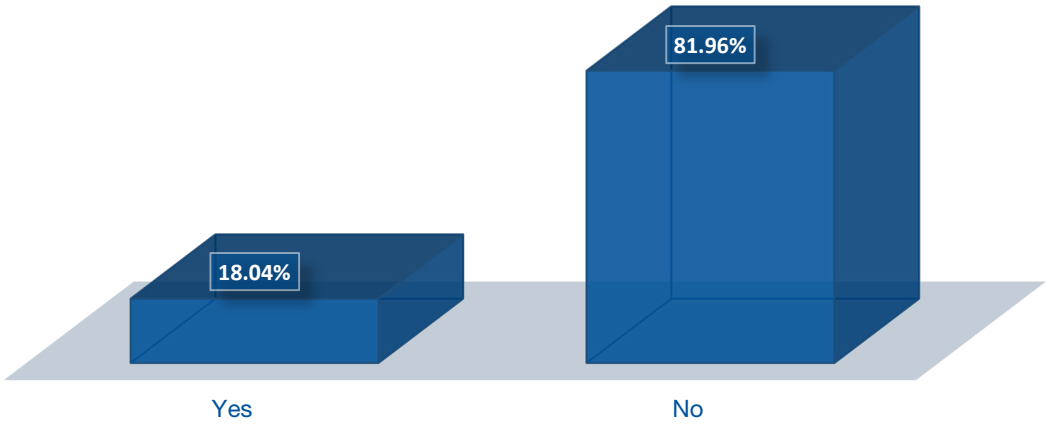

Figure 21: *Since 1 December 2021, has your employer asked you to cancel or delay planned leave or return to work from leave due to COVID-19?*

Of 788 responses, the largest group of participants (46%/n=360) reported that their employer has a policy that asymptomatic workers can/should return to work before the end of their isolation period. Thirty-two percent (n=249) of participants did not know if their employer had such a policy while almost a quarter (23%/n=179) reported that their employer did not have a policy that asymptomatic workers can/should return to work before the end of their isolation period. **Figure 22** shows the breakdown of **participants' reports of employer policies regarding return to work during a COVID-19 isolation period**.

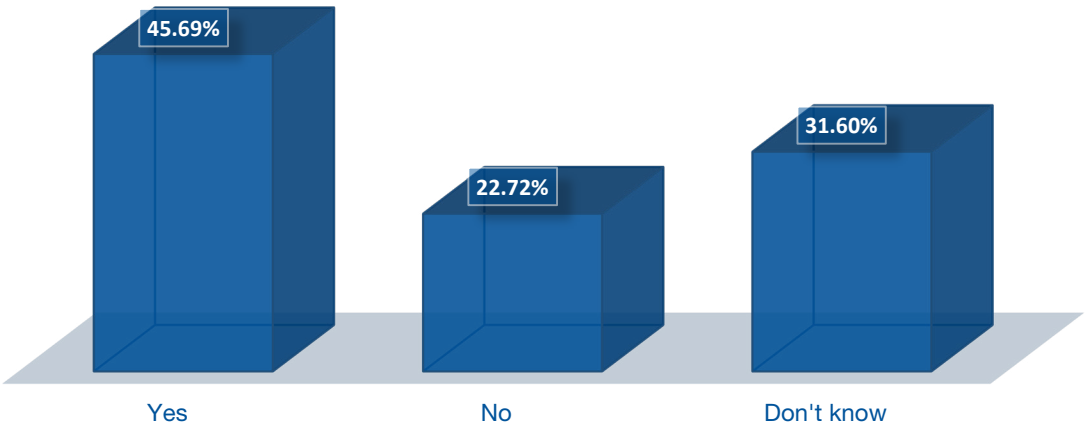

Figure 22: *Does your employer have a policy that asymptomatic workers can/should return to work before the end of their isolation period?*

Of 621 responses, most participants (88%/n=547) reported that their employer had not asked them to return to work during their COVID-19 isolation/quarantine period while 12% (n=74) responded that they had been including eight people who had been diagnosed with COVID-19. **Figure 23** shows the breakdown of **participants' reports of employer requests to return to work during a COVID-19 isolation period**.

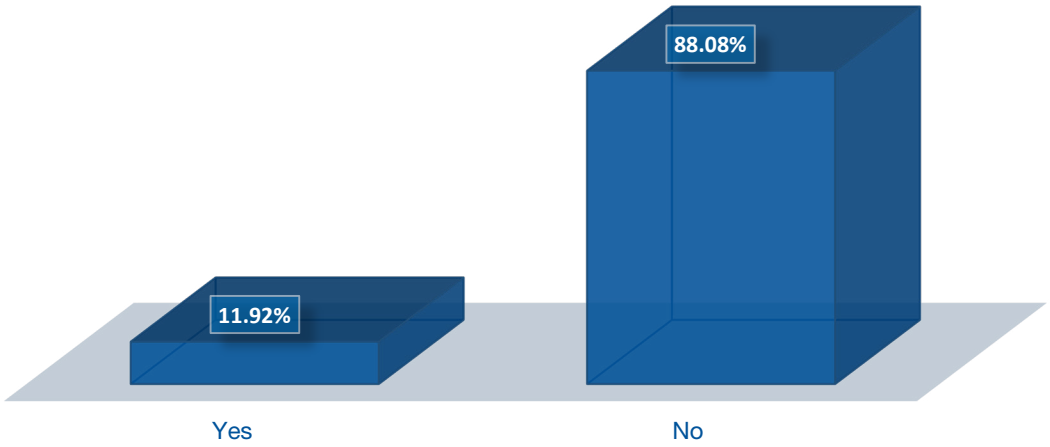

Figure 23: *If you have had to isolate/quarantine due to exposure to COVID-19, has your employer asked you to return to work during the isolation period?*

Of 776 responses the largest group of participants (42%/n=329) reported that their employer provided leave with pay due to exposure COVID-19 and subsequent isolation while a quarter (25%/n=193) reported that leave with pay was not provided for COVID-19 exposure and isolation. **Figure 24** shows the breakdown of **participants' reports of employer provision of leave with pay during a COVID-19 isolation period**.

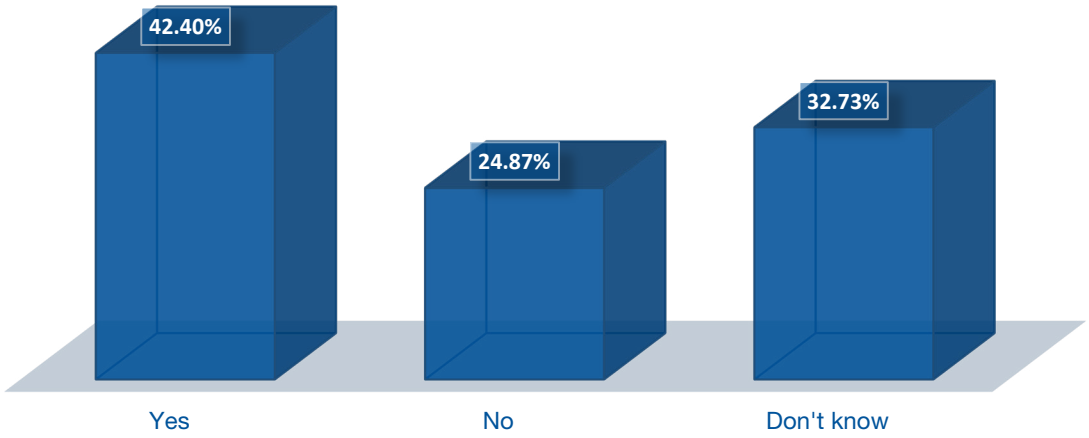

Figure 24: *Does your employer provide leave with pay if you need to isolate due to exposure to COVID-19?*

Of 791 responses, most participants (84%/n=633) reported that their employer provided information regarding policies for testing and isolation while 16% (n=128) reported that no information had been provided. **Figure 25** shows the breakdown of **participants' reports of employer provision of information regarding policies for testing and isolation**.

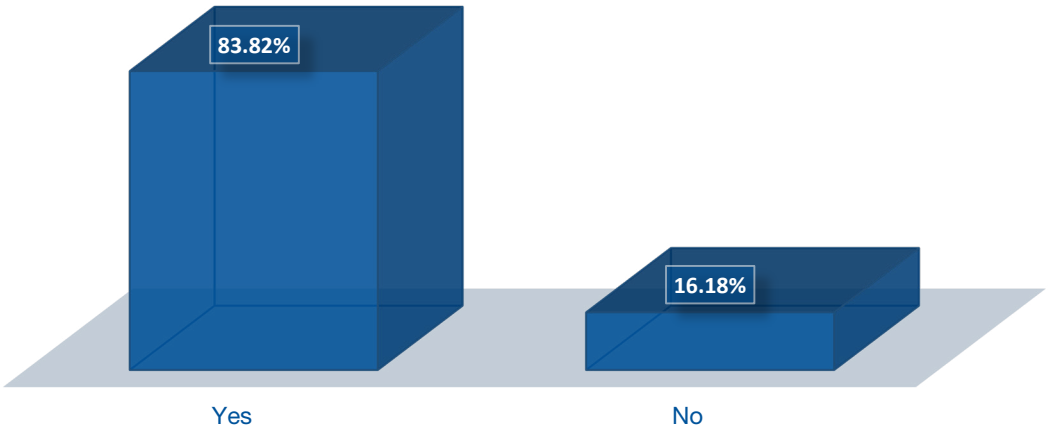

Figure 25: *Since 1 December 2021, has your employer provided you with information regarding policies for testing and isolation?*

Of 662 responses the largest group of participants (31%/n=171) reported that their employer's **information regarding policies for testing and isolation** was moderately clear (weighted average 3.18). **Figure 26** shows the breakdown of **participants' reports of the clarity of employer information regarding policies for testing and isolation**.

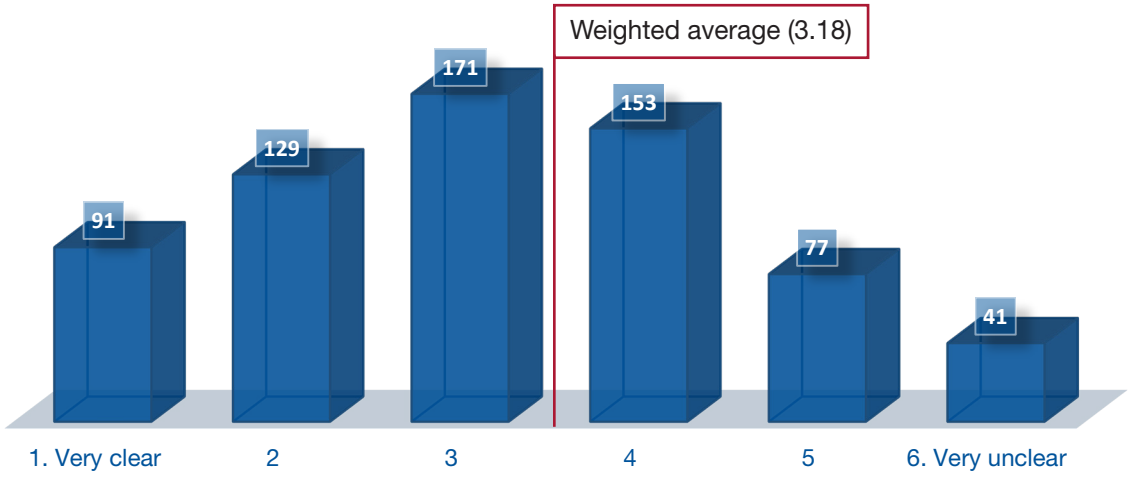

Figure 26: *At your workplace, on a scale of 1-6 (where 1 is 'Very Clear' and '6' is 'Very Unclear) how clear are the information and policies for staff COVID-19 testing and isolation?*

An overwhelmingly majority of the 662 participants who responded to this question reported that even when the information was perceived to be clear, frequent changes and updates make information difficult to keep up with and stay aware of. Many participants also reported inconsistencies in the information provided to staff and difficulty ensuring that the information that they had been given was correct and up to date.

"We have transitioned to being a COVID orange zone and all the staff are confused about the requirements should this occur. Staff are being told different things. I.e., some close contacts of a staff member who tested positive were told they could be at work for 7 days, while other staff who were also close contacts of the same positive staff member were told they could work so long as they did a RAT before every shift, but could not go out in the community even for groceries. We are all confused."

Registered nurse, age 25, Northern Territory

"Have had bombardment of links and email policies with changes. Very difficult to keep up with current information and both times very limited contact from the hospital. When had to isolate due to exposure at work from a patient. Had no idea if was allowed to return and had finally got a not to come message less than half hour before my shift. Others had turned up at work and later were told to go home. It truly has been a debacle and caused so much stress to staff."

Registered nurse, New South Wales

Managing COVID-19 in acute care settings

"We are being slammed, every single day we are so short staffed and all of my colleagues are at breaking point. It's so hard working constantly in PPE and not even being able to have water. Everyone is doing their best and so sick of the government saying oh don't worry we are coping. We are NOT coping this is not sustainable."

Registered nurse student, age 48, Victoria

Of the 775 participants who responded to this question, 62% (n=484) participants reported that their **workplace had experienced a COVID-19 outbreak since December 2021** while 27% (n=207) reported not having experienced an outbreak at work.

Of 777 participants who responded, similar proportions of participants reported that their workplace did (44%/n=341) and did not know (45%/n=349) if their workplace had an up-to-date outbreak management plan in place since December 2021. Eleven percent (n=87) reported that their workplace did not have an up-to-date outbreak management plan. **Figure 27** shows the breakdown of **participants' reports of workplace outbreak management plans**.

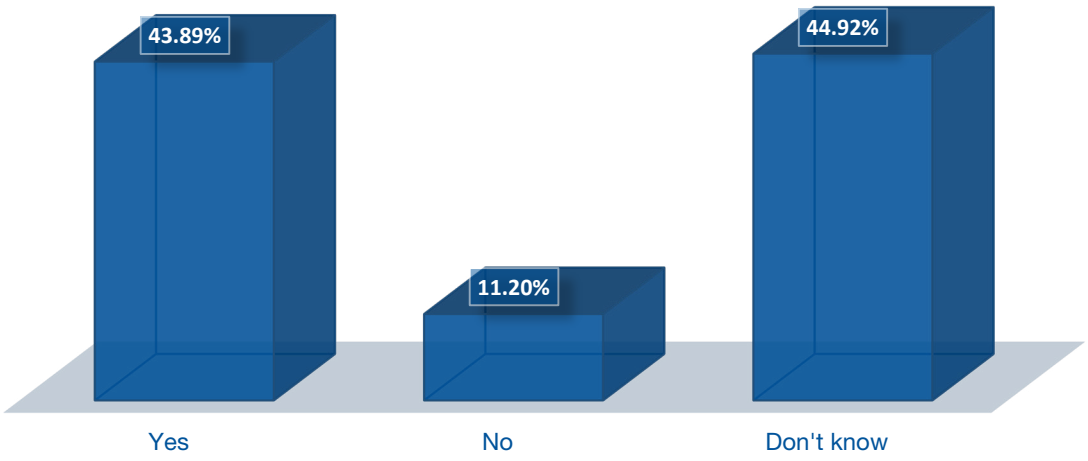

Figure 27: *Since 1 December 2021, does your workplace have an up-to-date outbreak management plan?*

"I do not agree with the instructions from my employer regarding PPE. We are instructed to remove our masks inside the room and hold our breath."

Registered nurse, Victoria

"My workplace has not been proactive in P2/N45 mask fit testing. they are only offering it over a 2 week period, which is impossible to attend when rostered at work. They also make us wear the same mask for 8 hours which we have to take off and put on to drink and eat, which is exposing us to touching the outside of the mask. The hospital hasn't followed their own processes in which all patients to have a PCR result prior to coming into surgery, which has resulted in a patient being positive which was only discovered after their surgery and therefore exposing staff."

Registered nurse, age 43, Tasmania

Personal protective equipment (PPE)

"Access to N95 masks at work is becoming a big issue. We're told to wear them, but there aren't any in stock. Orders approved from stores are taking days to get to the ward, and we're becoming concerned for staff safety in that respect."

Registered nurse, age 35, Northern Territory

Of 772 participants, the largest groups of participants reported that they 'always' (43%/n=334) or 'often' (40%/306) had enough PPE at their workplace while 12% (n=93) reported 'sometimes' having enough PPE. Five percent (n=39) reported 'rarely' or 'never' having enough PPE at work. **Figure 28** shows the breakdown of **participants' reports of workplace availability of PPE**.

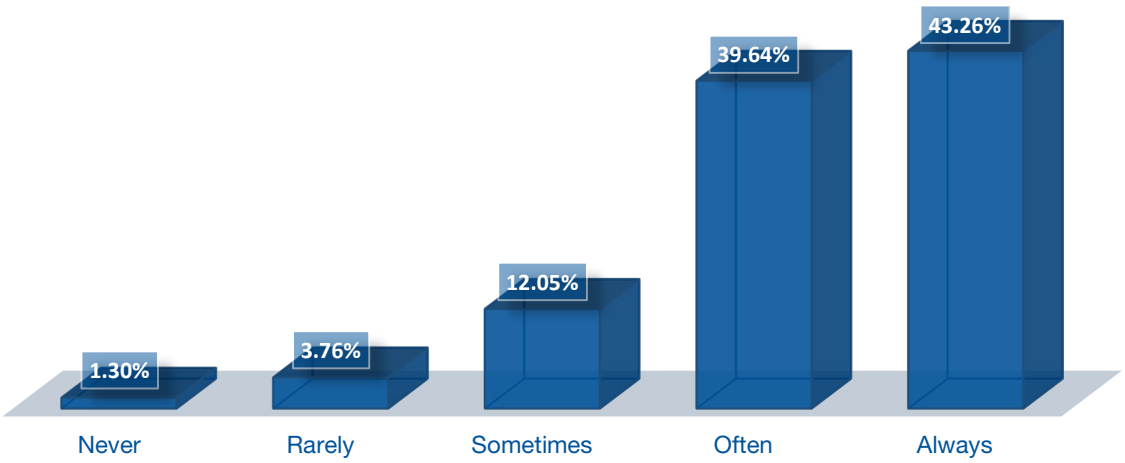

Figure 28: *Since 1 December 2021, at your primary workplace, how often do you typically have a sufficient amount of PPE?*

Of 771 participants, most participants reported that they 'always' (40%/n=309) or 'often' (39%/n=304) typically had the right types of PPE (e.g., gloves, gowns, masks, respirators) at their workplace. Fourteen percent (n=19) reported 'sometimes' having the right types of PPE while seven percent (n=49) of participants reported 'never' or 'rarely' having the right types of PPE. **Figure 29** shows the breakdown of **participants' reports of workplace suitability of PPE**.

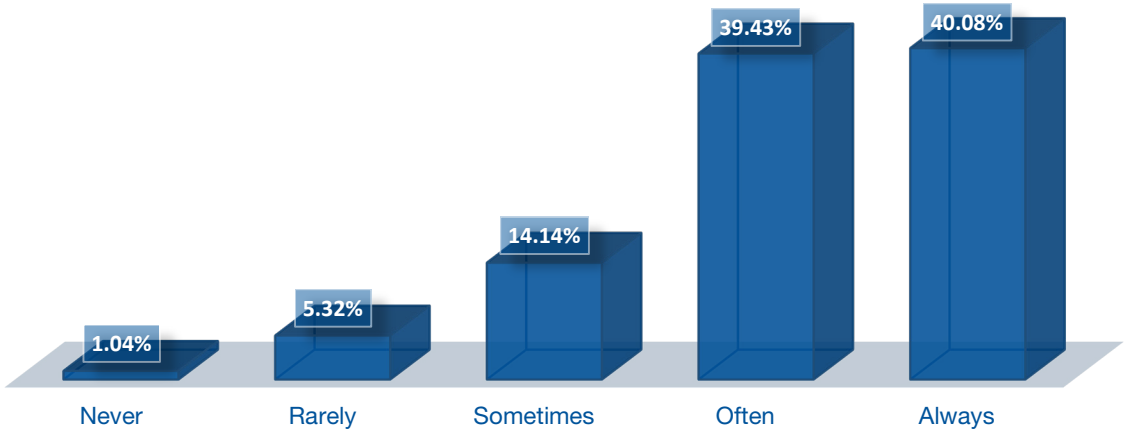

Figure 29: *Since 1 December 2021, at your primary workplace, how often do you typically have the right types of PPE?*

Of 773 participants, the majority (82%/630) reported that their workplace's PPE policy include the need for both fit testing and checking, while 12% (n=90) reported that the policy did not include the need for fit testing and checking. **Figure 30** shows the breakdown of **participants' reports of workplace policy regarding PPE fit testing and checking**.

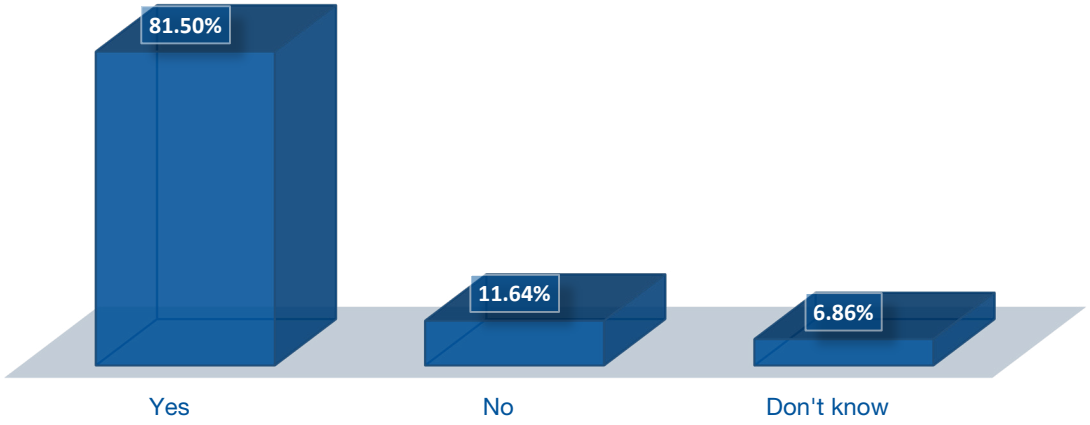

Figure 30: *Does your employer's current PPE policy include the need for both fit testing and fit checking?*

Fit testing and checking are vital to ensure that staff can select the right type and size of respirator that is safe for them to use. The largest group of participants (39%/n=300) reported that their workplace 'often' typically had the right size of PPE. The next largest group (34%/n=263) reported 'always' having the right sized PPE. Almost 10% (n=75) of participants reported either 'rarely' (7%/n=52) or 'never' (3%/n=23) having the right size of PPE. **Figure 31** shows the breakdown of **participants' reports of workplace availability of suitably sized PPE**.

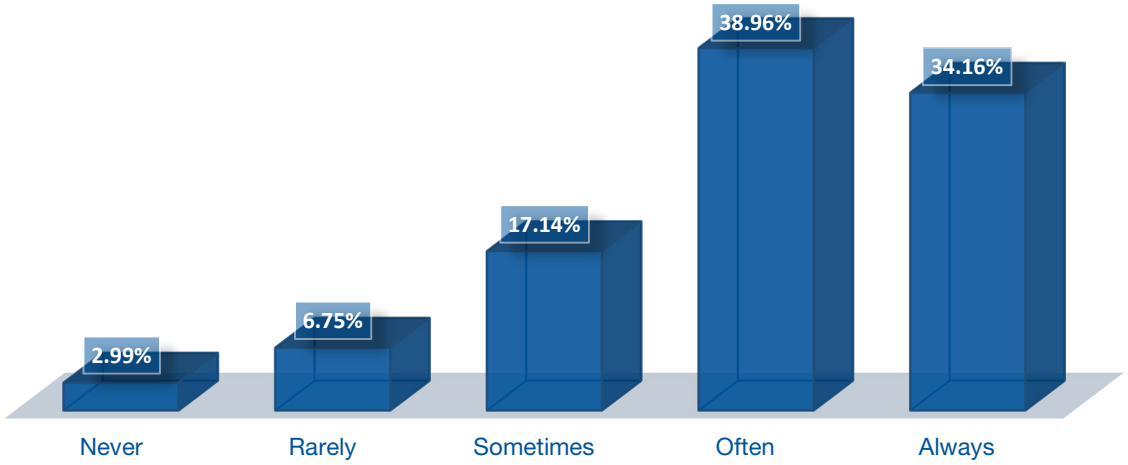

Figure 31: *Since 1 December 2021, at your primary workplace, how often do you typically have the right size of PPE?*

Working for long periods of time in PPE without a break is dangerous and negatively impacts on workplace health and safety and infection prevention and control-related outcomes. Policies for breaks when using PPE is important to ensure the health and safety of staff and residents/clients. The largest number of participants (40%/n=311) reported that they did not know if their employer had a policy for breaks while working in PPE, while similar numbers reported that their employer's policy did (~30%/n=228) or did not (~30%/n=234) include a policy for breaks while working in full PPE. **Figure 32** shows the breakdown of **participants' reports of workplace policies for breaks when working in full PPE**.

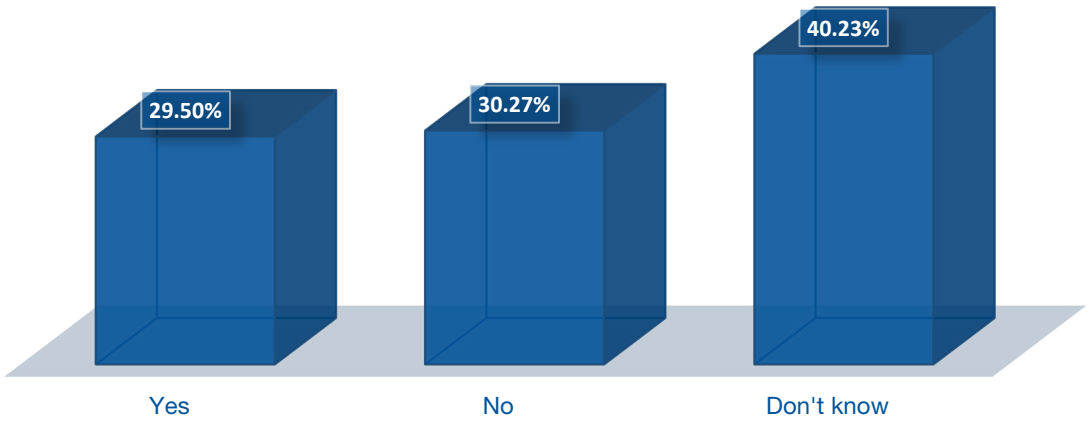

Figure 32: *Since 1 December 2021, does your workplace have a policy for breaks while working in full PPE?*

"N95 mask & protective eyewear 24/7 is tough when you only get 1 x 15-20min break if time and staffing allows. We can't have any drinks outside of our break room, therefore, we often go a full 8-10hr shift with only one drink."

Registered nurse, age 23, Tasmania

Workplace challenges

Participants were offered the opportunity to provide open-ended responses to the question; "What has been the most challenging aspect of your employment situation?". There were 655 responses to this question. Through reading and re-reading the responses, similarities and patterns were identified and a number of key findings emerged. By grouping the words and meanings of the responses to the question, several themes were developed and are discussed with illustrative quotes below.

Not enough staff!

Overwhelmingly respondents raised a lack of available staff as the main challenge they faced when dealing with COVID-19. As a result of staff testing positive to COVID-19, furloughing, and loss of staff that left their jobs because of refusal to be vaccinated, respondents reported the pressure and expectation to cover these shortages and to do more with less. Coupled with the ongoing expectation of management, government and the community to continue to deliver care, respondents were left feeling stressed, anxious and overworked. Rising to meet the need by taking on the shifts of others, working overtime, and taking on increased workload when no others were available, staff were left feeling exhausted. Respondents found this exhaustion left them at risk of making clinical errors and impacted on the quality of care they felt able to provide, indicating that a lack of staffing had significantly impacted on their ability to care for their patients.

"Always understaffed, sometime only 2 on nights when there should be 3, when understaffed on other shift sending agency staff who don't have access to medications or epas."

Enrolled nurse, age 38, South Australia

"There is too much work and the focus is always COVID. We have cut elective cardiology services to redeploy staff. These patients need these procedures because they then become emergencies or suffer massive heart attacks and die. We can't provide the best care. It's bare minimum at best. We were short staffed and under resourced before the pandemic, and are holding the system together by a thread without appropriate recognition or expectation that we will leave. Nurses will leave. Nobody should be treated like this."

Registered nurse, age 41, Victoria

"So many staff are out doing other COVID roles at the moment, this is leaving areas of the hospital very short staffed. Staff left in their usual roles are then required to pick up additional workloads, shifts, overtime etc."

Registered nurse, age 47, South Australia

"Poor staffing levels, poor skill mix, high potential for errors and extremely high stress levels due to expectation maintaining high level of care which is unachievable due to staffing levels."

Registered nurse and registered midwife, age 56, South Australia

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"Overworked. The amount of work we need to do has increased (PCR testing/ rat testing/ putting on PPE/ acutely unwell patients/ in and out of isolation rooms) however our patient to nurse ratio has stayed the same which is already too much! Everyone is burning out! Fast!"

Registered nurse, age 29, Northern Territory

"The constantly changing guidance and directives. The clear abandonment of any kind of infection control principles in favour of workforce policies which just create more infections."

Registered nurse, age 40, Queensland

Long hours in gruelling conditions with little to no breaks

Not only did respondents report an increased workload, and longer hours; they also reported the gruelling conditions under which they were required to work. Although acknowledged as important in protecting the health and safety of themselves, patients, and colleagues, respondents described long hours in hot, sweaty PPE. Working day after day with less staff, for long hours in full PPE, respondents conveyed a deep level of exhaustion.

"…[W]orking 18-20hr shifts in plastic PPE. Feeling sweat from behind your mask dribbling into your mouth, feeling so thirsty you may pass out during a code, nobody is available to relieve your breaks, seeing workmates dropping like flies from the profession…"

Registered nurse, age 40, Queensland

The gruelling nature of these long days and hours was further compounded by a reported lack of PPE, and where PPE was available, it wasn't always the right fit. This left respondents feeling anxious about the amount of PPE they were consuming as they described efforts to ration, or reserve it for use on their ward or facility. Where PPE did not fit respondents described significant difficulty in being able to do their job and adhere to infection prevention and control measures.

"The changing rules, and having to constantly fight for appropriate PPE to keep myself, my family, my colleagues and my patients safe."

Registered nurse, age 42, Victoria

"There are none of the masks that I 'passed' available for me to wear (Dräger) and I cannot see with the goggles as they fog up constantly because my masks don't fit and so I have to wear the big face shields instead of goggles and I feel short of breath, suffocated and dehydrated, for 10 hrs straight overnight. It's actually quite unpleasant and my vision is obscured and I need to often remove my mask to draw up meds. Plus the issue of constantly being short staffed."

Registered nurse, age 34, Northern Territory

Not only did staff describe their anxiety about the use of PPE and the exhaustion they felt as they rose to meet the increased workload, but they also reported working long periods of time without breaks, sometimes without being able to take a break for the entirety of their shift. This was due both in part to the increased workload, but also in an effort to reduce the use of PPE. Concerningly, respondents frequently reported being unable to take breaks for water when they needed it, citing a lack of staff to cover, and not always having time to go the bathroom when needed.

"There's a guide for breaks but no practical way to take them without PPE, lots of staff have PPE related skin injuries, work keep trying to stop essential services so we constantly have to advocate."

Nurse Practitioner, age 42, Victoria

"Always feeling rushed, breaks shortened bc I need to put on ppe to get back to work, donning doffing time not accounted for, expected to achieve the same level of productivity and task achievement despite having to take extra precautions due to ppe application or the physical challenge of working 12 hours in full ppe. No reimbursement for expenses relating to changed requirements to cleaning uniforms, their deterioration bc of hot water laundering or needing more uniforms to account for this. Laundry allowance is so antiquated! $2.30 a week, c'mon now."

Registered nurse, age 48, Victoria

"Unable to have breaks on night shift 10 hour shifts. Short staffed on wards. If you take a break you cannot finish paperwork."

Registered nurse, age 64, Northern Territory

"Triaging and caring for covid patients in a tent that can get up to 40 degrees inside on a hot day. Unable to eat or drink with regular breaks."

Registered nurse, age 29, South Australia

Beyond the exhaustion conveyed resoundingly throughout responses, the respondents described the physical impact of working long hours in PPE without adequate breaks and water. Responses noted staff as suffering headaches, skin irritation, dehydration, UTI's and body aches as a result of the conditions they were expected to work under.

"Wearing of N95 masks at all times. The combination of N95, eye protection and yellow gown makes you feel very hot with lots of mouth breathing and a sore nose. In addition we sometimes have to wear lead gowns under the PPE which adds to levels of dehydration, headaches, sweating and fatigue."

Registered nurse, age 58, South Australia

"Wearing n95 masks and encouraged to only drink water on breaks to reduce to use of PPE. It's hot and sweaty and uncomfortable, often leaving work with a headache from dehydration."

Registered nurse, age 27, South Australia

"Getting UTIs from not enough breaks for drinks. Short staffed being moved into shifts instead of being on call creating stress for women due."

Registered nurse and registered midwife, age 37, Northern Territory

Poor management and planning

Further to a lack of staff and long gruelling hours in full PPE, respondents also voiced their frustration at poor management, inconsistent communication and constantly changing directions. This frustration wasn't only directed at facility level management but also at Government, noting changes to advice were often made late on Fridays which impacted the ability of teams to prepare ahead of weekend shifts. This poor management was also apparent where staff found directions unclear when handling COVID-19 positive patients, or when it was unknown whether the patient was positive or not.

Their frustration was not just directed at the clinical level of management, respondents were also frustrated at the lack of support available to them where they were required to take leave as a result of contracting COVID-19 or being a close contact, respondents noted having to take personal leave to cover their time away from work.

"First positive case through ED, management had no policy/procedure for staff to follow, ED staff weren't allowed to leave the ED department at all (no breaks) until management had advise from CDCB on isolating requirements for staff & other ED patients."

Registered nurse, age 41, South Australia

"They have a policy for meal and drink breaks but not the staffing to back it up making the policy useless."

Enrolled nurse, age 37, Tasmania

"Busy, low staff due to isolating, increased patient loads, lack of management and direction on the floor. Team leaders all have a different idea on the way things get done so a lot of cross contamination and mis information provided to staff and patients in the covid zone."

Care worker, age 30, Queensland

"The rule changes! Often changes or advice comes out late on a Friday which makes it impossible to try and fix before the weekend. We are always mindful that ppe is limited and we all worry that we are going to run out. There are no assurances that this won't happen. We seem to get less resources as we are rural. The ratios are difficult as well- we should be at same ratios are larger hospitals!!"

Registered nurse, age 47, Victoria

"Understaffed, poor direction/guidance in response to Covid positive patients. Disjointed positive patient flow through the ED to Covid specific rooms."

Registered nurse, age 55, South Australia

Unsupported redeployment

As a result of a severe lack of staff, staff reported being redeployed to other parts of their facility, or anticipating being asked to provide support in other areas. Staff felt unsupported when redeploying and as a result were anxious at the prospect.

"As theatre staff with no current ward experience, being told we would be expected to work in wards and departments we do not have the correct skill set for and being forced to work outside current scope of practice. Even though it is 20 years since working on wards."

Registered nurse, age 62, Queensland

"The unknown of redeployment to places I do not feel safe working as a nurse, even though hospitals have now had years to perfect a plan."

Registered nurse, age 24, Victoria

"Dealing with the possibility of redeployment daily. I am 57, I have back and knee injuries and have worked in the same area for 21 years. I am an expert in my area but the anxiety of having to work in another ward without support is extremely challenging."

Registered nurse, age 57, Tasmania

Concerns for impact on patients, colleagues, family, and self

While working under difficult conditions, taking on a greater workload, wearing PPE all day with minimal breaks and water, respondents voiced their concern for the impact of COVID-19 on their patients, colleagues, families, and self. Respondents were distressed at the ability for patients to be visited by family, and at the hardship they could see their colleagues facing. They were also concerned that the high-risk environment they worked in might compromise the safety of their family.

"There was a requirement for N95 masks brought in but not provision at the same time, this required to be ordered however the ACNM was away and this was difficult to navigate. The distress and anger of relatives. I never thought in my long nursing experience that we would have to wear masks all day and see the extreme limitations for families to access their loved ones, I find the second the most distressing."

Registered nurse, age 60, Northern Territory

"Being unable to see end of life patients regularly due to covid diagnosis, the lack of relatives being able to visit family members which can assist nurses in busy times…"

Registered nurse, age 49, New South Wales

"Staffing. Having a constant fear of catching COVID and infecting my family. Upper management and NSW health / state governments idea that we can push through. It's not sustainable, it's a catastrophe!"

Registered nurse, age 48, New South Wales

"The changing rules, and having to constantly fight for appropriate PPE to keep myself, my family, my colleagues and my patients safe."

Registered nurse, age 42, Victoria

Solutions to the challenges

Participants were given the opportunity to provide open-ended responses to the question "what could be done to fix or address this challenge?" based on the challenge/s they identified in the previous question. 572 participants provided a response with the majority of responses being brief and only noting one of two key issues such as "more staff" or "access to the right PPE". Longer responses often contained several points offering solutions to noted challenges and problems in the workplace.

Several key findings emerged from reading and re-reading the responses to identify similarities and patterns among them. By combining the words and meanings identified in participants' responses to this question four themes were developed and presented below with illustrative quotes from participants.

We need more staff and better skills mix to care for our patients, each other, and ourselves

Most of the responses contained clear calls for increasing the number, skills mix, and availability of staff in hospitals both to care for people with COVID-19 and others presenting with a variety of issues. While many of these responses were stark demands; *"more nurses!"*, *"we need more staff"*, *"more staff"*, others provided further details regarding the type of staff and staffing solutions participants considered urgently necessary. Participants explained that more staff were necessary to cover shifts when regular workers could not come to work due to isolation or being on leave. Without a sufficient number of staff, many participants wrote of high workloads and the challenge of trying to provide safe, effective care to patients with untenably high patient to staff ratios.

"Fix our ratios. Country hospitals need equality to ratios. We can be looking after post ops, dementia, palliative (at end of life), medical patients and have higher ratios than metro hospitals on specific wards. It isn't fair! Get the government to stop making decisions based on politics Rather than health advice! Help with managing the no visitor rule which is terribly hard to implement."

Registered nurse, age 47, Victoria

"I'm hearing of so many third-year nursing students who have missed out on grad year positions for 2022. Why are they not being utilised for casual bank or agency? If they have passed placements, labs etc. and are qualified they should be offered bank as a backup with their first preference. Even if they did a transitional program and worked similar to a RUSON for a period of time while they learned the ropes. There are plenty of non-Covid wards and facilities screaming for extra hands."

Registered nurse, age 35, Victoria

"Safe staffing ratios!!!!!! Senior nursing management to be present and actually lead their teams."

Registered nurse, age 39, New South Wales

"Employment of more graduate nurses into the health system and aim for patient ratios so patients are given sufficient time for care. Patients are being admitted with more complex conditions (physical and mental health) and with every increasing paperwork leaving decreasing patient hours."

Registered nurse and registered midwife, age 59, New South Wales

Many participants provided suggestions for improving staffing including increased pay, better working conditions, improved support, enhanced education and training, and ensuring that staff feel more highly valued. Participants also called for the need for better pay and recognition of the work hospital nurses and midwives do as well as improved advertisement of positions, transition to practice programs, and staff retention programs. A number of participants suggested that improved placement of student nurses, paid employment models for Registered Undergraduate Students of Nursing (RUSON), and employment of graduate nurses and agency staff would improve workloads for nurses. It was clear from many responses that these problems with staffing predated the pandemic and had been exacerbated by it. Some participants that indicated that they worked in private hospitals reported feeling as though their sector and its challenges had been overlooked and that little focus had been levelled towards the workloads and conditions nurses were dealing with in the private sector in comparison to public hospitals.

Words are not enough: listen to us, understand us, and take action!

Many participants provided open-ended responses that contained a variety of suggested solutions to the challenges they faced at work. Within these were many responses that also included exhortations that leaders, government, employers, and decision makers needed to actually listen to nurses' and midwives' feedback and calls for change and more importantly act upon them. Here, clearly many participants felt that they had been overlooked and their expertise and hands-on experiences and knowledge ignored.

"Honestly, I'm sick to death of being asked this. Nurses have been answering this question for years. It doesn't matter what we put here. Put the answers and suggestions into action or stop bloody asking us. You know what to do. Do it. It's not up to me or us to keep parroting the answers to you in an effort to have someone else think anyone is listening. This has got to be the single most disappointing question we have always been asked."

Registered nurse, age 41, Victoria

"Nurses need to work what they can physically manage and be listened too. Strongly encourage breaks and safe break areas. Insist on extra staff to ensure staff have breaks. Support nurses to extra time off if have holidays cancelled due to code brown. Financial incentives to nurses working with students, grads for whole shifts, as it's hard talking and sharing knowledge with N95s on."

Registered nurse, age 40, Victoria

"Speak to employees and take into account their concerns. Don't just tell them things have been escalated. Actively be present and help."

Registered nurse, age 33, Queensland

"Management talking and listening to floor staff about policy/ procedures that do not work, increase staff numbers, fit testing masks to protect staff, better communication from management to staff about decisions."

Registered nurse, age 29, Northern Territory

"Acknowledging of situation by management. Talking to the staff on the floor. Stop focusing on the Vax Clinic and Swabbing clinic and take notice of the staff in the hospital working their butts off who are tired and feel totally forgotten."

Registered nurse, age 44, Victoria

These feelings of being side-lined were expressed in response to a range of issues and directed at a number of stakeholders; from management, to employers, through to government and policy decision-makers. While some participant's responses expressed feelings of helplessness and disappointment at feeling unheard, some participants were angry and frustrated by the lack of action.

We need improved policy and processes for breaks and leave

Many participants highlighted the need for better policies and processes for taking breaks at work and leave from work. Policies and processes as well as the spaces provided to staff to take breaks at work – especially when using full PPE and taking care of patients with COVID-19 or with colleagues who did were focussed on by many participants. It was clear from many participants' open-ended responses that working long hours without toilet or drinks breaks was contributing to exhaustion and burnout and that just by implementing reasonable policies and processes for taking a sufficient number and duration of breaks could have a significant impact on the staff's ability to work safely and effectively. A number of participants wrote about how the indoor or outdoor spaces to take breaks in were inadequate; indoor break rooms were seen as potential sites of exposure while outdoor locations were sometimes inappropriate. Many participants wrote of the difficulty accessing sufficiently long breaks to account for having to put on and take off PPE safely.

"Smaller periods between breaks with rotating staff with patient, but will never happen. Longer breaks would be good to give time to doff and don, and go outside for breaks as required. We should also be paid for the time after our shift when we need to shower and change. Would go a long way if we got paid extra for our time in PPE."

Registered nurse, age 55, Queensland

"Better staffing, and an executive team that understands what is really going on and works towards fixing this problem. For example, we are not allowed to have more than 2 people with masks off in the tearoom. We are not supplied with a safe alternative. We are expected to eat in an overgrown garden with no shade from the sun or rain. It has dead animals in it, and in a rural summer setting it is also a snake risk."

Registered nurse, age 41, Victoria

"Stop management from taking leave and ask them to come help us on the floor!! My annual leave has been revoked but my educators have been on annual leave for a month!!"

Registered nurse, age 38, Tasmania

"Consideration of additional paid personal leave/ COVID-19 leave entitlements. As professionals with accrued sick leave, [we] are not entitled to payments such as the Centrelink pandemic payment of up to $750. However, professionals who have used their sick leave in the past are able to claim these payments which is unfair for the health professionals have to use their leave."

Registered nurse, age 25, Northern Territory

Management encourages us to take breaks outside but break time has not increased to include time to actually get outside, if break time increased to include this time we could go outside and eat while socially distanced, instead we were all in a tearoom together and covid spread.

Registered nurse, age 28, Australian Capital Territory

Many participants also suggested that attention needs to be paid to the policies and processes that govern staff leave, with many participants expressing dismay that they could not access sufficient leave from work and needed this time off to recover from massive workloads throughout the pandemic. As with a number of other themes, many participants expressed feeling like their leaders and managers did not understand the situation from their perspective and would not listen to their concerns or take action.

Better preparation, planning, policy, and communication

It was clear in many participants' responses that many felt that the challenges they were dealing with now during the pandemic would have been much more manageable with greater forethought, planning, and evidence-based policy informed by knowledge from overseas and previous waves of the COVID-19 pandemic in Australia. Here, participants focussed on the need to improve communication channels and messaging in terms of clarity, consistency, and ensuring that guidance and policy was up to date and based on the best available evidence. Many participant's responses focussed on workforce planning and highlighted that the staffing deficiencies, workloads, and poor skills mixes were longstanding prior to the pandemic. A number of participants commented on issues such as ensuring hospitals and staff were better prepared to handle both COVID-19 and non-COVID-19 patients and expressed disappointment that many systems and policies could have been implemented or planned for in advance.

"Information coming from only one person. We get double ups of emails from the medical director and then from the CNC as well as hospital wide notifications. Sometimes there is conflicting information in these."

Registered nurse, age 37, Queensland

"Clear, consistent communication. We understand things are changing rapidly, but these waves have been expected for years now and it appears that no clear plan had been devised. Very disappointed with the ongoing lack of clarity."

Registered nurse, age 41, Northern Territory

"Planning ahead. Hiring more staff. We are now over 2 years into this - why haven't we sort things out!!!"

Registered nurse, age 28, Australian Capital Territory

"Long term workforce planning that has never been done. Fill vacancies rather than save money with same or higher workload. Build succession planning. Disaster planning and management. Lessons learnt not ignored from overseas."

Registered nurse, age 51, New South Wales

"Provide fit test to EVERY staff member and supply appropriate masks that fit. One style and size does not suit all. This needs to be somehow governed or supervised as my workplace does all it can to provide an image that it is complying and doing the right thing, yet staff do not wear/improperly wear PPE because we do not have access to what we need. I have purchased my own N95 masks at my own cost recently due to this problem as I do not feel safe at work."

Registered nurse, age 42, Victoria

"We need the right PPE available to us all the time. We are at the frontline dealing with positive covid-19 patients, and we don't have the correct PPE to keep ourselves safe."

Registered nurse, age 35, Northern Territory

Many participants raised issues with local policy and resources, noting that PPE supplies, policies, and processes for accessing and using PPE and taking breaks would be much improved with better planning and preparation with many people expressing frustration that employers, government, and decision-makers should have been much better prepared for a new wave of infections caused by a variant of concern. Participants demanded that preparations for ensuring evidence-based policy and access to best practice PPE should have been in place before the Omicron wave.

Discussion

This report has presented the results of a national survey of around 791 nurses and care workers in Australian acute care settings and focussed on the period between 1 December 2021 and 11 February 2022. This time period coincided with many states and territories opening their borders to allow travel in the lead up to the Christmas and New Year period as well as the arrival and rapid spread of the highly infectious Omicron COVID-19 variant. By mid-January, many jurisdictions around Australia, particularly in large population centres and capital cities were dealing with large numbers of COVID-19 cases in the community and presenting to acute healthcare facilities.

By the end of February, there was an estimated 205,889 active COVID-19 cases in the community along with 1,995 hospitalised patients of which 137 were in ICUs and 41 on ventilation.[1]

The Omicron wave in Australian hospitals

Almost all (92%) of the participants of this survey were ANMF members with the main participant groups coming from Victoria, the Northern Territory, and South Australia Victoria. Most participants were registered nurses followed by enrolled nurses and dual registered nurses and midwives. Five percent of the participants were registered midwives. This profile is similar to the overall profile of the Australian nursing and midwifery workforce.[5] These workers have been integral to operation of Australia's hospital sector including 693 public hospitals and 657 private hospitals. Almost all (87%) of participants worked in public hospitals while 13 percent worked in private hospitals.

Our survey participants had an average age of 43 years, which is consistent with other reports.[6] The age profile of participants was also consistent with the overall Australian nursing and midwifery workforce.[5]

Intention to leave

Intention to leave one's current position or the profession/sector to work elsewhere is a pressing topic in the Australian healthcare workforce as there are reports highlighting the need to both grow and retain a larger nursing and midwifery workforce to manage the impact of an aging population.[7]

When considering results of the present study, it appears that results regarding intention to leave are generally similar and consistent with earlier work as well as including a possible emerging phenomenon where younger workers are increasingly reporting intention to leave their position or the profession. This poses a significant risk to hospital sectors if they cannot retain and attract a suitably sized workforce to cope with an aging population or future disasters. Indeed, considerable attention will need to both focus on attracting new graduates as well as retaining skilled and experienced nurses and midwives to oversee them. This is likely to be even more serious in regional and remote areas that suffer from further challenges regarding attracting and retaining staff.

A national workforce survey conducted by the Rosemary Bryant AO Research Centre and the ANMF in 2020 measured staff's intention to leave their jobs and the professions.[8] In hospitals, reports of the intention to leave one's current position within 12 months were provided by 15.5% (n= 717) of participants. This is lower than the present study found with 21% (n=166) reporting plans to leave their position within the next 12 months. This highlights that the workforce may be under considerable strain. In terms of intention to leave their current role within one to five years 39.8% (n=1,841) said they would leave. This is slightly higher than the results of the present study that found that 36% (n=281) reported plans to leave within 1-5 years.

Taken together, it might be that workers who previously intended to remain in their roles now plan to leave sooner due to the burdens amplified by the Omicron wave. In terms of participant intentions to leave their position or the profession by age group, intention to leave current position within the next 12 months was relatively consistent across age groups, with the group aged between 20-29 years the most likely to report intention to leave their current role within the next year (23%). Intention to leave a current role in the next 1-5 years ranged from 32% in the 40-49- and 50-59-year age groups to 53% in the 60+ age group. The 30-39 year age group included the second highest proportion of participants who reported intention to leave within the next 1-5 years.

In this study, intention to leave the profession was relatively consistent across most age groups (7-15%) with the 50-59 year age groups least likely to report intending to leave their profession. The aged group over 60 years were most likely to report plans to retire. In the 2020 survey, overall, 17.1% (n = 440) of hospital-based participants who said they were planning on leaving their current position also said that they were planning on leaving their profession to work in another field. In terms of intention to retire, 26.9% (n=692) intended to retire.8 In the present survey, while 13% (n=103) reported that they planned to leave their profession and 8% (n=60) planned on retiring, 33% (n=259) reported that they were 'undecided' so may ultimately decide to leave if the stress and burden of working in Australia's hospital system continues unabated.

"Everyone is tired and it feels like there is no relief in sight. We leave work felling like we should be staying and feel guilty when we can't help out more. Staff shortages are terrible and there is no end in sight!"

Registered nurse, age 47, Victoria

"We are short staffed every shift, dangerously doubling and tripling patients who should be 1:1. It's a crazy and very frightening time!"

Registered nurse, age 48, New South Wales

COVID-19 vaccination and testing

This report showed that the majority of participants had already received a COVID-19 vaccine booster/third dose at the time they responded to the survey with all staff who reported currently working having had at least two doses in line with Government requirements at the time. This affirms wider observations and reports that the vast majority of hospital staff are accepting of the need to be vaccinated against COVID-19 to protect themselves, their patients, their families, and the wider community. Most participants reported that their experience of accessing vaccines was good to excellent. While reflective of the results, most people were positive about their experiences and commented on ease and timeliness of bookings, appointments, and access, some participants reported negative experiences and challenges. Many participants who had their vaccines organised via their employer reported positive experiences.

This survey found that around 10% of participants had been diagnosed with COVID-19, with 70% of that figure reporting that they had been diagnosed after 1 December 2021; in line with the severe uptick in the number of COVID-19 infections Australia-wide and in hospitals due to the Omicron and Delta outbreaks. Over a quarter of those who reported being infected reported that they believed they had been infected at work, with most of these people being infected after 1 December 2021.

Reassuringly, most participants reported that members of their immediate household had not tested positive for COVID-19 since December 1 2021, which is positive as earlier Australian national surveys have reported that concern for family members is a source of worry for many health workers who were found to mainly be isolating/quarantining either with their entire household or in a separate living area.[8]

Almost half of the participants reported that their employer had a policy that asymptomatic workers can/should return to work before the end of their isolation period, with 12% being asked to return to work which would have been challenging for participants who were worried about working with colleagues and patients during a period where they may still have been infectious. Another challenge that would have been experienced by many participants was the fact that many participants reported that their employer did not provide leave with pay or did not know if they would receive paid leave due to exposure COVID-19 and subsequent isolation after using up their own sick leave and annual leave. Many participants reported having to use up their sick leave and other leave entitlements such as annual leave and long service leave while isolating due to being a close contact or awaiting a test result. Almost all participants reported their employer had provided them with information regarding their policies for COVID-19 testing and isolation with most participants reporting that this information was moderately clear but could change regularly.

Due to the risk posed by working while infectious, many staff have had to test for COVID-19 numerous times, often daily. Most participants reported relying on tests from a variety of sources including employer-provided tests, mass testing sites, and through purchasing their own tests. While 65% of participants reported using employer-provided COVID-19 tests, 44% had not received any tests from an employer and relied solely on mass testing sites, self-purchased kits, or tests from friends, colleagues, or family. This highlights that many staff have had to foot the bill for costly tests or wait for long hours to receive a test and result in order to keep working. Overall, experiences with accessing tests were mostly 'fair' to 'good', however about the same percentage of people had 'very poor' – 'poor' and 'very good' – 'excellent' experiences accessing tests. This would appear to reflect the wider community's experience accessing costly and often time-consuming COVID-19 tests and a failure to secure sufficient access to tests for employers.

"I have been asking about staff testing as patients are tested but there is no clear answer as to whether staff will be tested. I have been exposed to patients who have returned a positive result and have expressed concern but just told to "monitor myself". There is not enough appropriate PPE, I did a mask fitting appointment and have not been provided with the masks that fit me properly. We are expected to wear full PPE (n95, face shield, gown and gloves) for 12 hours and it is too hard to even have a break to drink a sip of water"

Registered nurse, age 29, Northern Territory

Workforce issues

The survey included many questions regarding issues around current workplace practices and experiences relating to managing care and activities during the COVID-19 pandemic. While 35% of participants indicated that their working hours were 'about right'. Around half of the participants reported working mainly 8-hour shifts and long periods without sufficient breaks. Over half of all participants reported working long periods without breaks and paid overtime. These challenging working conditions almost certainly contributed to the around 60% of participants who reported that their working hours were either 'a lot more' or 'a bit more' than they would like.

With workforces facing high levels of staff absence due to sick leave (COVID-19 and non-COVID-19 related) and the traditional holiday period over Christmas and new year, almost 20% of participants reported that their employer had asked them to cancel, delay, or return to work from planned leave.

"Cancelled leave and T4 approval of any leave over 3 days, and this is WA. The work force here is already burnt out, we run short staffed every day and have so for the last few years and that's with minimal community spread."

Registered nurse, age 42, Western Australia

Managing the Omicron wave

Over half (62%/n=484) of participants reported that their workplace had experienced a COVID-19 outbreak since December 2021. Of 777 participants who responded, similar proportions of participants reported that their workplace did (44%/n=341) and did not know (45%/n=349) if their workplace had an up-to-date outbreak management plan in place since December 2021. Personal protective equipment, while but one element of an evidence-based respiratory protection program, has been a key area of investigation and concern throughout the pandemic for many staff who have experienced challenges accessing the quantities and types of PPE needed to safely and effectively care for residents. While the largest proportion participants (43%/n=334) reported that they 'always' typically had enough PPE at their workplace and 40% reported 'often' having the right type, around 16% reported 'never', 'rarely', or 'sometimes' having enough PPE. This lack of PPE demonstrates a widespread problem that must be rectified as a matter of urgency, as having an insufficient supply of PPE can lead to unsafely reuse or rationing resulting in infection. A similar pattern of results was also observed in relation to having the right types of PPE, such as gowns, gloves, respirators, masks, and goggles/glasses/face shields, with over 20% of participants reporting 'never', 'rarely', or 'sometimes' having the right types of PPE.

In terms of policies that guide the safe and effective use of PPE, 82% of participants reported that their workplace did have a PPE policy that included the need for both fit testing and checking. Despite this, many participants also reported in open-ended responses that this was not always applied consistently. Australian Government advice includes recommendations that fit testing and checking of respirators should be part of standard PPE use for healthcare workers.[9] Fit testing and checking are vital to ensure that staff can select the right type and size of respirator that is safe for them to use. While most participants (39%/n=300) reported that their workplace 'often' typically had the right size of PPE, Almost 10% (n=75) of participants reported either 'rarely' (7%/n=52) or 'never' (3%/n=23) having the right size of PPE. Working for long periods of time in PPE without a break is dangerous and negatively impacts on workplace health and safety and infection prevention and control-related outcomes.

Policies for breaks when using PPE is important to ensure the health and safety of staff and residents/ clients. The largest number of participants (40%/n=311) reported that they did not know if their employer had a policy for breaks while working in PPE, while similar numbers reported that their employer's policy did (~30%/n=228) or did not (~30%/n=234) include a policy for breaks while working in full PPE.

"Staffing levels have been abysmal. On a ward which to have a safe staffing ratio would need 5 medicating nurses on morning and afternoon shift, we were often left with 3, and 2 of these medicating staff were often new grads."

Enrolled nurse, age 28, New South Wales

Workplace challenges

Most frequently, respondents raised a lack of available staff as the main challenge they faced when dealing with COVID-19. Issues related to a lack of staffing were already prevalent prior to the pandemic however as staff have been required to isolate after testing positive to COVID-19, otherwise furloughed, or walked out, respondents found there was an expectation and pressure to cover shifts. Not only were available staff covering shifts however, but they were also required to do more with less, citing the extra patient load where shifts were unable to be covered, and the extra requirement in meeting COVID-19 infection prevention and control requirements and other protective measures. Staff rose to meet this need however the increased levels of overtime and expectation placed on them by government, employers and community left them feeling stressed, anxious and exhausted. Staff reported concerns that working under these conditions left them unable to provide best quality patient care, and impacted on their ability to practise safely.

Not only were staff required to meet the requirements of an increased workload, including working longer hours; they were also required to work these hours under gruelling conditions. Although it was acknowledged as important in protecting the health and safety of themselves, patients, and colleagues, staff were required to work long hours in hot, sweaty PPE. Working day after day under these conditions with less staff, in full PPE, further compounded the exhaustion felt by covering the increased patient load. The gruelling nature of these long days however was not just a result of working in PPE, but were exacerbated by an apparent lack of PPE, and correctly fitting PPE. With a sense that PPE was in short supply, respondents felt anxious about the amount of PPE they were consuming and described efforts to ration or reserve it for use on their ward or facility. Respondents also found it difficult to do their job and adhere to infection prevention and control measures with PPE that didn't fit correctly.

Staff also reported working long periods of time without breaks, sometimes without being able to take a break for the entirety of their shift. This was due both in part to the increased workload, but also in an effort to reduce the use of PPE. Concerningly, respondents frequently reported being unable to take breaks for water when they needed it, citing a lack of staff to cover them, and not always having time to go the bathroom after hydrating when they might need to. Many staff reported suffering headaches, skin irritation, dehydration, UTIs and body aches as a result of the conditions they were expected to work under.

Further to exhaustion, staff were also frustrated at the lack of appropriate planning and confusing directions they received from management. This wasn't only directed at the facility level, but also at governments. Respondents were also frustrated at the lack of support available to them where they were required to take leave as a result of contracting COVID-19 or being a close contact. Further, as a result of a severe lack of staff and unclear direction, staff reported anxiety at being redeployed in other parts of their facility, or anticipating being asked to provide support in other areas.

While working under these difficult conditions however, one of the main concerns for staff was towards the impact of COVID-19 on their patients, colleagues, families, and themselves. Respondents were distressed at the lack of access for patients to visit family, and at the hardship they could see their colleagues facing. They were also concerned that the high-risk environment they worked in might compromise the safety of their family.

"We are required to wear N95 masks at work at all times to protect staff from exposure. It is also part of the rationale that is given so staff may return to work under the "rapid" model post exposure or illness. However, NO fit testing has been offered at any point to my team AND there are only 2 masks supplied to us, which genuinely do not fit me (and others in my team). This leaves me feeling very uncomfortable and vulnerable, as I cannot create a seal, get headaches and pressure wounds on my nose from the ill-fitting masks. When I spoke up, I was told you get what you are given as there are supply issues. I have noted that executive management staff all have access to duckbill n95 masks which are not offered to clinical staff."

Registered nurse, age 42, Victoria

Solutions to the challenges

Overwhelmingly, participants demanded more staff and better skills mix to care for their patients, each other, and themselves. Most of the responses called for increasing the number, skills mix, and availability of staff in hospitals both to care for people with COVID-19 and others. Participants explained that more staff were necessary to cover shifts and that without a sufficient number of staff, high workloads and large numbers of patients made providing safe, effective care to patients difficult and dangerous.

Many participants provided suggestions for improving staffing including increased pay, better working conditions, improved support, enhanced education and training, and ensuring that staff feel more highly valued. Participants suggested that improved placement of student nurses, paid employment models for Registered Undergraduate Students of Nursing (RUSON), and employment of graduate nurses and agency staff would improve workloads for nurses. It was clear from many responses that these problems with staffing predated the pandemic and had been exacerbated by it.

Within many responses were exhortations that leaders, government, employers, and decision makers needed to actually listen to nurses' and midwives' feedback and calls for change and more importantly act upon them. Here, clearly many participants felt that they had been overlooked and their expertise and hands-on experiences and knowledge ignored. These feelings were expressed in response to a range of issues and directed at a number of stakeholders; from management, to employers, through to government and policy decision-makers.

With the high workloads, stress, and burden of working throughout the 'Omicron wave' Many participants highlighted the need for better policies and processes for taking breaks at work and leave from work. Policies and processes as well as the spaces provided to staff to take breaks at work – especially when using full PPE and taking care of patients with COVID-19 or with colleagues who did were focussed on by many participants. Many participants wrote of the difficulty accessing sufficiently long breaks to account for having to put on and take off PPE safely. As with other themes, many expressed that leaders and managers did not understand the situation and felt isolated and removed from leaders who did not have first-hand experience at the coal face of the wards.

It was clear from many participants' responses that the challenges they were dealing with now during the pandemic would have been much more manageable with greater forethought and planning. Participants demanded that preparations for ensuring evidence-based policy and access to best practice PPE should have been in place before the Omicron wave. In terms of workforce planning, many highlighted that the staffing deficiencies, workloads, and poor skills mixes were longstanding prior to the pandemic. Issues such as ensuring hospitals and staff were better prepared to handle both COVID-19 and non-COVID-19 patients were also raised.

Many participants raised issued with the inadequacy of local policy and resources, noting that things like PPE supplies, policies, and processes for accessing and using PPE and taking breaks needed significant improvement. Some expressed frustration that employers, government, and decision-makers should have been much better prepared for a new wave of infections caused by a variant of concern.

"It is insulting being asked to cancel annual leave when we are working doubles and extras and not getting to spend time with our families. The workload is untenable and very few other professionals would tolerate what is being asked of nurses."

Registered nurse and midwife, age 33, Victoria

Conclusion

This study reports on findings of a large national survey of hospital-based nurses, midwives, and care workers. It is hoped that this report will improve understanding of the impacts of the COVID-19 Omicron wave on the Australian hospital workforce as well as their demographics, working environments, and experiences during this time.

The survey's findings revealed a steadfast workforce striving under immense pressure and patient loads to provide safe, effective care during a global and local crisis. This crisis was not unanticipated but occurred after around two years of the COVID-19 pandemic and significantly contributed to feelings of being unheard and overlooked. This highlights the systemic and widespread tensions and stressors in healthcare and points to many years of government inattention, lack of funding, and inaction to fix a range of well-known, well researched failures. The picture that is painted is one of gruelling workloads and lack of sufficient staff to provide best practice care to all patients.

The Omicron wave is steadily becoming the most damaging and fatal onslaught of the COVID-19 pandemic to date. While Australia is entering its third year of the pandemic, policies and processes regarding management of COVID-19 in hospitals and access to resources are still wanting, with too many participants highlighting a lack of clarity in policies as well as inability to access the necessary resources to care for patients and keep themselves, families, and colleagues safe. This survey reveals a workforce under immense pressure and strain compounded by feelings that this work will be unrelenting and unlikely to diminish soon.

The gruelling and relentless picture of work in Australian hospitals during the pandemic means that it is imperative that employers, decision-makers, and government work to prioritise the safety and wellbeing of Australia's nursing and midwifery workforces by ensuring effective, evidence-based plans, policies, and procedures for major health crises such as COVID-19 are implemented as a matter of urgency. It is imperative that employers actively engage with their workforces, especially during such extreme events, by seeking their feedback and concerns, engaging in genuine dialogue, and working to prioritise their safety and wellbeing. Beyond listening however, real action is needed. Nurses, midwives, and care workers don't need to be simply heard, they need decision makers to act decisively and immediately to address the challenges and pressures that this workforce knows all too well.

"I'm tired and burnt out."

Enrolled nurse, age 63, New South Wales

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