



Australian  
Nursing &  
Midwifery  
Federation

# NATIONAL AGED CARE COVID-19 SURVEY 2022

March 2022



## Australian Nursing and Midwifery Federation National Aged Care COVID-19 Survey 2022

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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, almost half of all Australian nursing homes were experiencing an active COVID-19 outbreak.
- By mid-February 2022, most COVID-19 related deaths had occurred among nursing home residents who had not yet received a third dose of a COVID-19 vaccination. Almost half of all deaths in aged care have occurred since the start of the 'Omicron wave'.
- Third dose/booster vaccines are integral to protecting nursing home residents and staff from COVID-19 – particularly newer variants.
- The largest number of participants were from South Australia (45%), New South Wales (35%), and Victoria (10%) and were registered nurses (47%), enrolled nurses (27%), and personal care workers (25%).
- Most participants (62%/n=591) reported that they worked for a private not-for-profit aged care provider, 27% (n=257) worked for a private for-profit provider, while 9% (n=87) worked for an Australian Government provider.
- Around 21% (n=203) reported planning to leave their position within the next 12 months and approximately 39% (n=386) of participants reported plans to leave their job within 1-5 years. 16% (n=160) reported that they planned to leave their profession (e.g., nursing/aged care).
- Most participants reported accessing COVID-19 tests from multiple sources. While just over half of all participants reported solely using employer-provided COVID-19 tests, 17% had not received any tests from an employer and relied solely on mass testing sites or self-purchased kits.
- Around 15% of participants had been diagnosed with COVID-19, with 80% of that figure reporting that they had been diagnosed after 1 December 2021.
- Around half of those who reported being infected reported that they believed they had been infected at work.
- 59% (n=563) participants reported that their workplace had experienced a COVID-19 outbreak since December 2021.
- 13% (n=124) participants reported that they have had to go into isolation/quarantine because of COVID-19 since 1 December 2021 due to being diagnosed and 18% (n=177) 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 (47%/n=365) while 28% (n=217) participants reported that they have or would isolate at home but separate to their family.
- 61% of staff reported that their hours were 'a bit' or 'a lot' more than they would like. Only 2% of staff said their hours were less than they would like.
- 3% (n=17) participants reported that their Infection Prevention Control (IPC) Lead was an AIN/PCW/ACW despite this role needing to be an RN or EN.
- A quarter (25%/n=245) reported that their employer had asked them to cancel or delay planned leave or return to work from leave due to COVID-19.





- 22% (n=216) reported that their employer has a policy that asymptomatic workers can/should return to work before the end of their isolation period.
- 11% (n=87) reported that their employer had asked them to return to work during their COVID-19 isolation/quarantine period.
- 38% (n=371) reported that their employer did not provide leave with pay due to exposure COVID-19 and subsequent isolation.
- 75% (n=750) reported that their employer provided information regarding policies for testing and isolation.
- Most participants (78%/742) reported that their workplace had an up-to-date outbreak management plan in place since December 2021.
- While the largest group of participants (44%/n=416) reported that they always typically had enough personal protective equipment (PPE) at their workplace, around 20% of participants reported never, rarely, or only sometimes having enough PPE.
- While the largest group of participants (41%/391) reported that they always typically had the right types of PPE (e.g., gloves, gowns, masks, respirators) at their workplace, around a quarter of participants either never, rarely, or sometimes had the right types of PPE.
- Almost equal numbers of participants reported that their workplace's PPE policy did (42%/n=398) or did not (41%/n=393) include the need for both fit testing and checking.
- Most participants (36%/n=342) reported that their workplace often typically had the right size of PPE. 13% (n=119) of participants reported 'never' or 'rarely' having the right size of PPE and 24% (n=232) reported only sometimes having the right size. Only 27% (n=259) reported always having the right sized PPE.
- The largest group of participants (38%/n=361) reported that their employer had a policy for breaks while working in PPE while 31% (n=296) said their employer did not have a policy.
- From an analysis of open-ended responses, the main challenges identified by participants included; a severe and overwhelming lack of staff impacting on the ability to provide safe and adequate care. The inadequate provision of personal protective equipment, either unavailable or of an inappropriate fit, leaving staff and residents unprotected. Poor leadership with constantly shifting guidance and lack of communication. Insufficient pay, particularly for forced overtime and insecure work with workers required to use holiday pay when required to isolate, and an ongoing concern and anxiety for the safety of residents, colleagues, and family.
- From an analysis of open-ended responses, the main solutions to these challenges included overwhelmingly the need for more staff and improved remuneration. Improved leadership at all levels including better clinical governance was also recommended. Education, training for new staff and access to sufficient supplies of resources for providing care were also urgently called for by many staff. While not a 'solution' many participants reported apparent feelings of hopelessness and abandonment regarding the current and longstanding crisis in aged care.



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***“Twelve of the fifteen residents in our memory support unit have now been diagnosed with COVID-19. Our staff in that unit have been working short, therefore unable to provide the best quality care for our residents. Management have not provided any support for these amazing care workers who are at breaking point. I have worked in Aged Care for over 20 years and have never been so disheartened in this sector as I am at the moment. Things need to improve for the wellbeing of staff, but especially for the well-being and care of our elderly.”***

**Enrolled nurse, age 40, South Australia**

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## Acknowledgements

We would like to acknowledge and thank the nearly 1,000 nurses, midwives and personal care workers who donated time out of their very busy schedules to undertake the survey at a time when aged care is clearly in crisis. Your input is invaluable to ensuring that, collectively, the voice of the aged care community is heard regarding the challenges faced on the frontline of the COVID-19 pandemic response in Australia.

We would also like to acknowledge Kristy Male from the ANMF Federal Office for her work designing and laying out the final report.

### 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.



## Contents

Key Points .....	i
Acknowledgements.....	iii
Acknowledgement of country .....	iii
Foreword .....	1
Executive summary .....	2
Introduction.....	2
Methods.....	3
Results .....	3
Demographics .....	3
Intention to leave .....	3
COVID-19 vaccination and testing .....	4
COVID-19 infection.....	4
Workplace experiences .....	4
Managing COVID-19 in aged care.....	5
Workplace challenges and solutions .....	5
Considerations for policy and practice.....	6
Introduction .....	8
Background.....	9
People in Australian aged care.....	12
The Australian aged care workforce.....	12
COVID-19 and Australian aged care .....	13
Vaccine and third/dose rollout.....	18
Booster rollout in aged care .....	18
Methods .....	19
Results.....	20
Participant age.....	21
Employment .....	21
Intention to leave.....	22
COVID-19 vaccination and testing .....	24
COVID-19 testing.....	27
COVID-19 infection .....	30
Workplace .....	32
Work experiences .....	34
Managing COVID-19 in aged care.....	39
Personal protective equipment (PPE).....	39
Workplace challenges .....	42
Solutions to the challenges.....	48



Discussion .....	55
Nurses and care workers in aged care .....	55
Intention to leave.....	56
COVID-19 vaccination and testing .....	57
Workforce issues in aged care.....	58
Managing COVID-19 in aged care .....	59
Workplace challenges .....	60
Solutions to the challenges.....	61
Conclusion .....	62
Reference list.....	63







## Foreword

A year before this survey report was published, on 1 March 2021, the Morrison Government released the final report of the Royal Commission it had established to inquire into aged care quality and safety. The Commission's final report, *Care, Dignity and Respect*, detailed widespread, systemic failings across the aged care sector and outlined a system in crisis.

The Commissioners identified substandard care that is *unacceptable, deeply concerning and that has been known for many years*. They advised that there is no excuse for abdication of system governance responsibilities by the Australian Government and made critical recommendations to give the Government a road map for reform on a range of fundamental areas. The most critical of these was their recognition that the aged care sector's most precious resource is its dedicated and caring workforce, which, because of long standing systemic failings, has simply not been supported to do its job.

A year later, the aged care crisis has only deepened. In the year that has elapsed since the Royal Commission's final report, the Government has done nothing to ensure that every older Australian has access to the care they need and the dignity and respect they deserve. It has failed to act on the most critical actions needed, including a failure to protect older Australians from the COVID-19 pandemic.

What follows in this survey report is a heart breaking account of the consequences of the Government's inaction. It outlines the current situation in aged care from the perspective of dedicated aged care workers, who have not only suffered the disappointment of seeing nothing change in the last year but who have had to cope with the aftermath of the Government's insistence that the 'country must open up' and 'live with COVID'; who have had to bear witness to the devastation this strategy has caused in aged care.

The report explains how demoralising this has been for the aged care workforce. Nurses' and care-workers' experiences over the last few months have left them feeling abandoned, helpless and vulnerable – with many participants saying they have lost all hope. That no-one will fix aged care.

Aged care workers and older Australians deserve so much better.

Australians cannot stand by and watch them suffer any longer. There must be no more talking, no more 'taskforces', no more 'inquiries' or 'reviews', no more deferring responsibility – only action.

We can do it and we must.

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***We just “need a government with guts”***  
***Registered nurse, age 59, Tasmania***

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Annie Butler  
ANMF Federal Secretary



## Executive Summary

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***“We have had a breakout at work. Due to a wandering dementia resident, it spread like wildfire despite closing off the section. We just couldn’t stop it. Our workforce has been devastated. I have worked so hard - over 120hrs for the fortnight. I have no more to give.”***

**Registered nurse, age 49, Western Australia**

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## 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 aged care. The background section of this report provides details and analysis regarding the unfolding COVID-19 crisis in aged care.

There are over 310,000 ANMF members across the eight state and territory branches with around 40,000 working in aged care. This report is based on the data collected from participants who self-reported primarily working in aged care (residential and in-home/community).

Australia has faced immense challenges throughout the COVID-19 pandemic which began in Australia in January 2020, most particularly older Australians. Older people and especially those living in nursing homes are especially vulnerable to COVID-19 due to age, frailty, and multiple conditions. The fact that they are living in close quarters to others where health and personal care services must be regularly provided means that infection prevention and control can be challenging especially when there are not enough of the right kinds of staff to provide safe, effective, dignified care.

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 aged care sector throughout the period the survey was open. Understanding this background information is important for interpreting the context within which aged care workers were living in the lead up to and throughout the ‘omicron wave’.

This survey focussed on a range of 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 aged care during COVID-19.



## Methods

The online survey opened on 18 January and closed on 11 February 2022. The survey's 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.<sup>1</sup> The ANMF promoted the survey online via social media and websites. Data analyses in this report used descriptive quantitative and qualitative techniques.

## Results

### Demographics

985 participants answered at least one survey question with 938 participants making it to the end of the survey.\*

- The average age of participants was 48 years. The largest groups were people aged between 50 and 59 years (30%/n=261) followed by 60-69 years (21%/n=188), 40-49 years (21%/n=187), 30-39 years (19%/n=171), and 18-29 years (7%/n=63).
- Around 47% (n=443) of participants were registered nurses (RNs), 27% were enrolled nurses (n=257), and 25% (n=229) were care workers (i.e. assistants in nursing, personal care workers/aged care workers).
- The largest number of participants mainly worked in South Australia (45%/n=420), New South Wales (35%/n=327), Victoria (10%/n=94), and Queensland (5%/n=51).
- The majority of participants worked in residential aged care 91% (n=901) and 9% (n=87) worked in community/in-home aged care. 98% (n=968) had been employed since 1 December 2021, while 2% (n=19) participants reported that they had not been employed.
- Of 959 respondents most participants (62%/n=591) reported that they worked for a private not-for-profit aged care provider. 27% (n=257) worked for a private for-profit provider and 9% (n=87) worked for a public/government owned provider.

### Intention to leave

- While 39% (n=386) of participants reported that they did not intend on leaving their current position within the next five years, 37% (n=368) reported plans to leave within 1-5 years and 21% (n=203) reported planning to leave their position within the next 12 months.
- The largest group of participants (43%/n=428) reported that they did not plan on leaving their profession (E.g., nursing, aged care) to work in another field. 27% (n=266) reported that they were 'undecided' and 16% (n=160) reported that they planned to leave their profession. 13% (n=126) plan to retire.
- The age groups between 18-29 years (37%) and 70+ (40%) contained the largest proportion of people who reported intending to leave their current position within the next 12 months.
- Intention to leave a current role in the next 1-5 years ranged from 29% in the 18-29 age group to 48% in the 60-69 age group.

\* 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 (18%-20%) with the age groups over 60 years least likely to report intending to leave their profession but more likely to report plans to retire.
- Personal care workers are the employment category with the largest percentage of participants (24%) who reported intending to leave both their current position and profession (i.e. aged care) in comparison with other job categories.
- Registered nurses included the largest percentage of participants who reported intending to leave their role within the next five years (39%) and/or retiring (15%).

## COVID-19 vaccination and testing

- Most participants (72%/n=708) had received three doses of a COVID-19 vaccination while 27% (n=266) had received two doses.
- Most participants (79%/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. 73% (n=689) of respondents reported that their employer provided RAT kits.
- 109 (12%) participants reported solely relying on mass testing sites (no tests from employers or self-purchased) and 45 (5%) reported relying solely on self-purchased RAT kits.
- Most participants reported that their experiences of accessing COVID-19 testing was 'fair' (23%/n=218) or 'good' (26%/n=243). 25% (n=232) reported access to COVID-19 testing was 'very poor' or 'poor'.

## COVID-19 infection

- While most participants (83%/n=815) reported that they have not been diagnosed with COVID-19, 15% (n=145) reported having been diagnosed with COVID-19. 83% (n=135) of those infected reported being infected after 1 December 2021.
- 84 (52%) reported they believed they had been infected at work.
- Most participants (n=808/82%) reported that members of their immediate household had not tested positive for COVID-19 since 1 December 2021.
- 13% (n=124) participants reported that they have had to go into isolation/quarantine because of COVID-19 since 1 December 2021 due to being diagnosed. 18% (n=177) 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

- While 69% (n=616) reported that their workplace had an identified Infection Prevention Control Lead, 9% (n=77) of participants reported that their workplace did not have one. 23% (n=206) did not know if there was an IPC Lead at their workplace.
- 89% of participants reported that their workplace IPC Lead was a nurse, however 3% (n=17) of participants reported that their IPC was an AIN/PCW/ACW.
- Participants reported a diverse array of work experiences in terms of shift length, rostering, and overtime. Of the selection provided, the top five were: mainly 8-hour shifts (48%/n=450), long periods without sufficient breaks (42%/n=399), double shifts (40%/n=375), paid overtime (39%/n=363), and unpaid overtime (35%/n=325).
- 61% (n=584) participants reported that their working hours were 'a bit more' or 'a lot more' than they would like. (35%/n=334) of participants indicated that their working hours were 'about right'.



- A quarter of participants (25%/n=245) reported that their employer had asked them to cancel or delay planned leave or return to work from leave due to COVID-19.
- 22% (n=216) reported that their employer has a policy that asymptomatic workers can/should return to work before the end of their isolation period.
- While most participants (89%/n=725) reported that their employer had not asked them to return to work during their COVID-19 isolation/quarantine period while 11% (n=87) responded that they had been.
- While the largest group of participants (38%/n=371) reported that their employer did not provide leave with pay due to exposure COVID-19 and subsequent isolation, slightly smaller proportions did not know, or said that their employer did provide leave with pay.
- Most participants (77%/n=750) reported that their employer provided information regarding policies for testing and isolation.
- While the largest group of participants (31%/n=232) reported that their employer's information regarding policies for testing and isolation was 'very clear' a similar number reported that the policies were less than moderately clear to 'very unclear'.

### Managing COVID-19 in aged care

- Most (59%/n=563) participants reported that their workplace had experienced a COVID-19 outbreak since December 2021.
- Most participants (78%/742) reported that their workplace had an up-to-date outbreak management plan in place since December 2021.
- While the largest group of participants (44%/n=416) reported that they always typically had enough PPE at their workplace, around 20% of participants reported never, rarely, or only sometimes having enough PPE.
- While the largest group of participants (41%/391) reported that they always typically had the right types of PPE (e.g., gloves, gowns, masks, respirators) at their workplace, around a quarter of participants either never, rarely, or sometimes had the right types of PPE.
- Almost equal numbers of participants reported that their workplace's PPE policy did (42%/n=398) or did not (41%/n=393) include the need for both fit testing and checking.
- Most participants (36%/n=342) reported that their workplace often typically had the right size of PPE. Thirteen percent (n=119) of participants reported 'never' or 'rarely' having the right size of PPE and 24% (n=232) reported only sometimes having the right size. Only 27% (n=259) reported always having the right sized PPE.
- The largest group of participants (38%/n=361) reported that their employer had a policy for breaks while working in PPE while 31% (n=296) said their employer did not have a policy.

### Workplace challenges and solutions

- A lack of staff and agency and surge workforce was repeatedly mentioned as the most significant challenge faced by aged care workers when dealing with COVID-19 and was a fundamental contributor to the degree of crisis faced by the sector.
- Respondents reported a lack of availability of appropriate PPE, where PPE did not fit and was reportedly rationed by employers. Respondents also found it difficult to adhere to appropriate use of PPE when forced to work long days without adequate breaks.
- Respondents were fearful when considering how they would support themselves when required to isolate with no reimbursement from government or their employer and felt injustice when they were not appropriately compensated for working overtime and double shifts.





- Respondents were confused by the poor communication they received from management, which was compounded by the constantly changing guidelines and health directions received from the Government.
- Respondents were concerned for the wellbeing of residents and their families but were often met with verbal abuse from families frustrated in adhering to visitation and other restrictions. Respondents were also concerned for the welfare of their colleagues, and their own family who they felt they were placing at risk.
- While many responses suggested solutions to the challenges they faced, the collective voice of responses indicated that participants felt unseen, unvalued, and cast aside in dealing with the pandemic.
- Overwhelmingly responses called for increasing the number and availability of staff in aged care. More staff were required to cover shifts when regular workers could not attend due to isolation, sickness, or needing days off. More staff on shift was also called for to meet the increased care demands associated with the pandemic.
- Along with calls for more staff, respondents also called for improved pay and conditions, suggesting this was also a necessity to attracting and retaining staff in the sector. It was voiced that those who remain in aged care do so for the love and respect of the people they care for, and that the wages and conditions do not justify the risk and pressure of the conditions they are required to work under.
- Participant responses also included recommendations for better leadership at various levels of management. Participants demanded improved communication and guidance at the facility level and stronger support and immediate aid from the Australian Government.
- Responses from participants articulated the importance of being understood, communicated with, listened to, and appreciated by leaders, management, and the Government.
- Respondents highlighted the urgent need for improved education and training of especially new staff in aged care, which was often raised alongside other solutions including more staff and better wages and conditions. More educated staff were seen as being able to better support others in providing care and adequate infection prevention control to provide safe, effective care to residents.
- Many respondents stated a need for ready access to the necessary type and quantity of resources and policies and procedures to provide safe, effective care for residents. This included a need for adequate access to RAT kits, PPE, and other equipment necessary to provide adequate care.

## 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 aged care workforce.

- Interventions must be urgently deployed to address the attraction and retention of high-quality staff in the aged care sector. Significant improvements to staffing levels and skills mix, remuneration, clinical governance and leadership, and the education and training of surge workforces are required to alleviate a workforce that appears to be rapidly losing hope and strength to persevere due to longstanding systemic problems in aged care and feelings of being unvalued that have been greatly amplified by the ongoing pandemic and Omicron wave.
- The aged care workforce must grow significantly to ensure sustainable best practice care during and beyond the COVID-19 pandemic.



- The deployment of staff across the aged care sector 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 in aged care 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 and care of older people.
- High-quality clinical governance, improved communication and dialogue, and genuine understanding of the needs and experiences of staff providing direct care to people in aged care is required at all levels of aged care leadership including direct managers up to government.
- A stronger skills mix of direct care staff is required to provide safe, dignified, best-practice care to all residents. An increased proportion of registered nurses and enrolled nurses to provide leadership and clinical expertise is vital.
- Aged care 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 taken out of working hours.
- Workplaces must prioritise staff and resident health, wellbeing, and safety as a core business objective in policy and practice to ensure that staff and residents 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 that Infection Prevention Control Leads are either a registered or enrolled nurse in line with Government policy.
- Employers should ensure staffing levels are sufficient to ensure manageable workloads for staff, and that adequate and 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.

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***“...[W]e are chronically short-staffed always. Some staff have resigned, and more are about too. Makes me very sad for the residents that rely on us so much but there is only so much we can take.”***

***Care worker, age 64, Victoria***

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## 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. This report focusses solely on the participants who reported working in the aged care sector including residential aged care and in-home/community aged care.

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 40,000 working in aged care. This report is based on the data collected from participants who self-reported primarily working in aged care (residential and in-home/community).

Australia has faced immense challenges throughout the COVID-19 pandemic which began in Australia in January 2020, most particularly older Australians. Older people and especially those living in nursing homes are especially vulnerable to COVID-19 due to age, frailty, and multiple conditions. The fact that they are living in close quarters to others where health and personal care services must be regularly provided means that infection prevention and control can be challenging especially when there are not enough of the right kinds of staff to provide safe, effective, dignified care.

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***“Every single day, every shift we work short staffed. It is relentless, exhausting and distressing we can’t deliver appropriate care. Our managers now just tell us to work it out when we cannot find replacement staff.”***

***Registered nurse, age 50, Victoria***

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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 Australia and the aged care sector throughout the period the survey was open. Understanding this background information is important for interpreting the context within which aged care workers were living in the lead up to and throughout the ‘Omicron wave’.

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***“It’s tough at the moment! Lack of staffing due to exposure of COVID-19 or close contact! One area is on lockdown and it’s tough situations with PPE being worn, having to try and be there for the residents! You spend so much time at work that it sucks all your energy out, that it leaves you too tired and worn out when you get home! We feel isolated, it feels lack of support from the people at work we need it from the most! We also feel isolated! I know a lot of us want to leave because we feel unheard and not appreciated! But a part of me can’t, because I need to be there for the most vulnerable! I guess this COVID has made everyone see how important aged care is and deserves the most important care and appreciation for the staff.”***

***Enrolled Nurse, age 36, South Australia***

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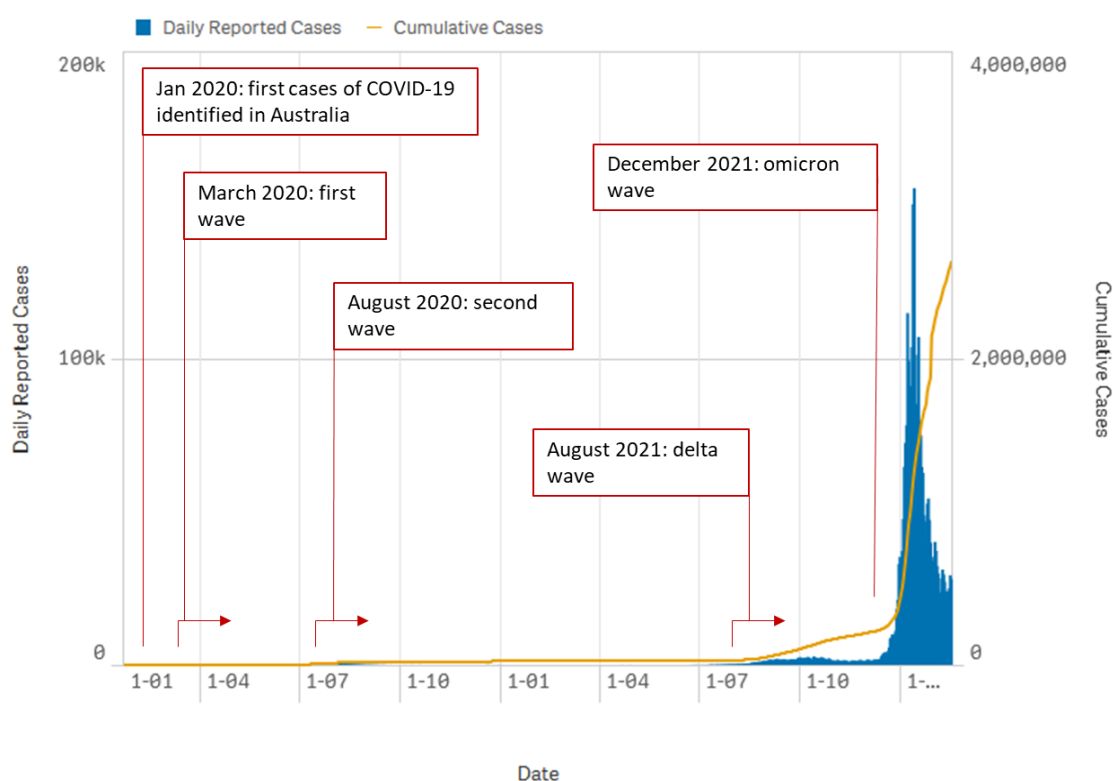
This survey focussed on a range of issues including: vaccination uptake, infection and exposure isolation and quarantine, work experiences with infection prevention and control including with personal protective equipment and workplace policies, challenges in the workplace, intention to leave, and staff-proposed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



## Background

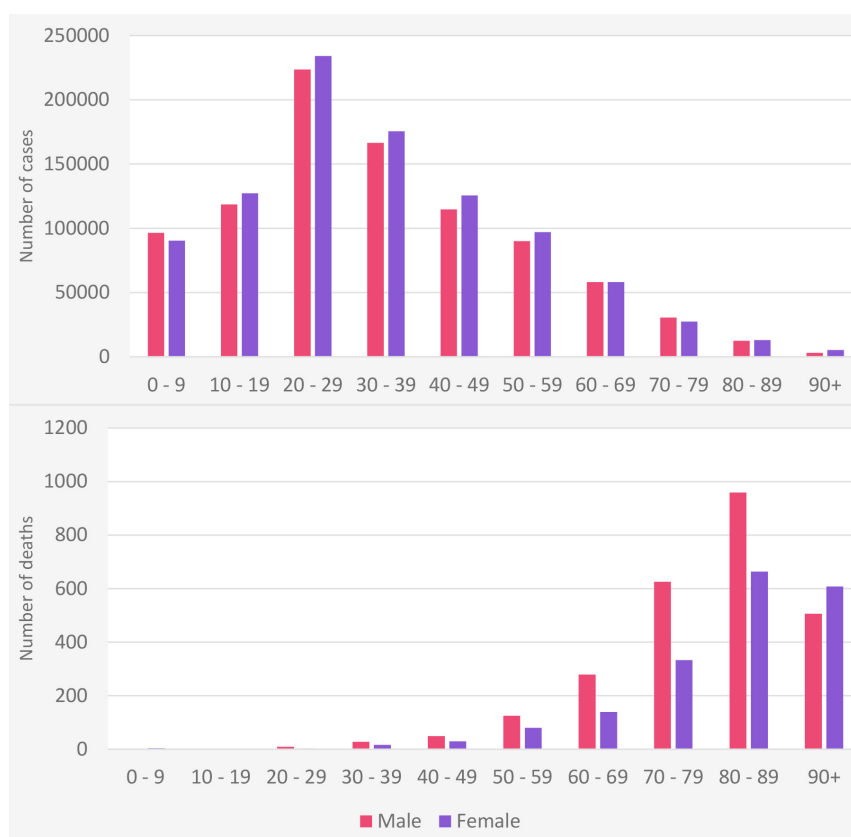
The background section of this report provides details and analysis regarding the unfolding COVID-19 crisis in Australia and in aged care.

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. 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](#)<sup>2</sup>

As has been well reported from the start of the pandemic, older people are much more vulnerable to COVID-19 than younger people. Government reported data indicating the number of COVID-19 cases by age group and sex, and number of deaths by age group and sex (**Figure 2**) show that although cases are more commonly reported in younger people, older people experience a higher mortality rate. For example, at 16 February 2022, of total cases reported in 20-29 year old females, the cohort with the highest number of recorded cases, 0.001% have died during the pandemic (9 people /234,023).



**Figure 2:** Government reported figures for COVID-19 cases by age group and sex, and COVID-19 deaths by age group and sex. Source: [Department of Health](#)<sup>2</sup> (16/02/22)

Conversely, of cases reported in males 80 to 89 years old, the cohort with the highest mortality, of those who contracted the disease 8% (959 people /12,437) have lost their life. That is, 8 in 100 males aged 80 to 89 years of age who contracted COVID-19 between the beginning of the pandemic and the 16th of February 2022 have died (**Table 1**).

**Table 1:** Government reported figures for COVID-19 cases by age group and sex, and number of deaths by age group and sex; and calculated proportion of deaths per number of cases by age group and sex. As reported at 16th of February 2022. Source: [Department of Health](#)<sup>2</sup> (16/02/22)

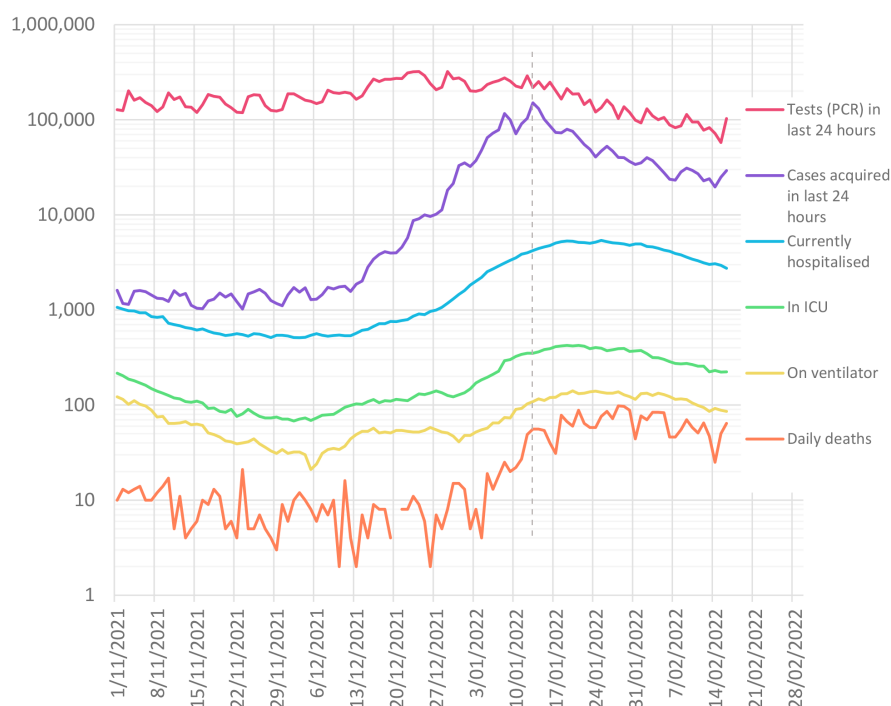
	Cases by age group and sex		Deaths by age group and sex		Deaths per number of cases (%)	
	Male	Female	Male	Female	Male	Female
0 to 9	96455	90450	1	4	0.0010%	0.0044%
10 to 19	118673	127242	1	1	0.0008%	0.0008%
20 to 29	223661	234023	9	3	0.0040%	0.0013%
30 to 39	166411	175438	28	16	0.0168%	0.0091%
40 to 49	114771	125637	49	30	0.0427%	0.0239%
50 to 59	89969	96947	125	80	0.1389%	0.0825%
60 to 69	58184	58098	279	139	0.4795%	0.2393%
70 to 79	30434	27466	626	333	2.0569%	1.2124%
80 to 89	12437	13048	959	664	7.7109%	5.0889%
90+	2971	5259	506	608	17.0313%	11.5611%

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 provides insight into the relationships between them.





**Figure 3** below is useful in that it provides an indication of the cross-sectional relationship between each variable and allows an understanding of how each variable has changed over time (from 1 Nov 2021, to 28 Feb 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 3:** 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. The COVID-19 data presented relates to all of Australia and is not aged care specific. Source: [covid19data.com.au](https://covid19data.com.au)

Understanding that the first cases of the Omicron variant were recorded in Australia on 27 November, **Figure 3** 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 conducted were met with 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 COVID-19 patients continues to require a significant number of hospital resources. This has significant bearing on the healthcare system's ability to cope with cases being transferred from nursing homes and in-home care.



## People in Australian aged care

The [Australian Institute of Health and Welfare](#) reports that over 1 million people use some form of aged care in Australia:<sup>3</sup>

- ~840,000 people used the Commonwealth Home Support Programme (home support).
- ~245,000 people lived permanently in a residential aged care facility at some point during 2019–20.
- ~175,000 people use Home Care Packages Program (home care).
- ~67,000 people use respite residential aged care.
- ~25,000 people use transition care.
- ~4,500 people use short-term restorative care.

## The Australian aged care workforce

The [2020 Aged Care Workforce Census Report](#) reported that there are 227,671 staff working in Residential Aged Care Facilities with 208,903 (129,151 FTE) of these staff being direct care workers.<sup>4</sup>

- 203 (163 FTE) **Nurse Practitioners** make up **0.13%** of direct care worker FTE
- 32,726 (20,154 FTE) **Registered Nurses** make up **15.6%** of direct care FTE
- 16,000 (9,919 FTE) **Enrolled Nurses** make up **7.68%** of direct care worker FTE
- 144,291 (91,893 FTE) **Personal Care Workers** make up **71.2%** of direct care worker FTE

The report finds that nurses (RN + EN) make up approximately 23-24% of the direct care workforce in residential aged care, and PCWs around 70%.

As many inquiries, reports, and experts have attested, the aged care workforce is at the centre of keeping older people as safe as possible from COVID-19. This workforce provides health and personal care services and is also integral to the vaccination and booster roll-out as well as testing for COVID-19. It is vital that the aged care workforce is supported, resourced, and appropriately recognised for their work.

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***“Working in nursing home very stressful, although lucky our nursing home has not had an outbreak yet. There is severe shortage of staff and I do extra shifts that I don’t want, getting very tired. No end in sight for this situation. We had almost 4 weeks of lockdown, very hard for residents, causing challenging behaviours. At present limited visiting allowed. All staff wearing masks and goggles or face shields, despite RAT before each shift (all visitors too) and all resident boosted. Goggles fog up because not using N95 masks yet and shields don’t fit well. Bloody nuisance and hard for residents with dementia. We are all so over it. Not enough support from head office or government. Promise of \$400 bonus for care workers is an insult and there is nothing in the pipeline for nurses, just endless hard work!!”***

**Registered nurse, age 66, South Australia**

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## COVID-19 and Australian aged care

Australia has faced immense challenges throughout the COVID-19 pandemic which began in Australia in January 2020. Older people and especially those living in nursing homes are especially vulnerable to COVID-19 due to age, frailty, multiple conditions, and the fact that living in close quarters to others where health and personal care services must be regularly provided means that infection prevention and control can be challenging especially when there are not enough of the right kinds of staff to provide safe, effective, dignified care.<sup>5</sup>

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*Since the COVID situation especially this year 2022, we have been working in short staffed shifts. Staff are being asked to extend or double their shifts as well, or staff are asked to work early to cover shifts. Since this situation, our management has had difficulty filling RN and personal care assistant shifts because of lack of applications in the aged care industry too. I feel like because of this current situation, people are not attracted to work in the private aged care industry. I hope that private aged care staff like me will also receive the same compensations/pay like the public aged care staff. I know there is still a big gap on this matter.*

*Registered nurse, age 31, Victoria*

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The tragic outcome of these challenges is well detailed in the [Royal Commission into Aged Care Quality and Safety's Special Report on COVID-19](#) and the [Independent Reviews of Outbreaks in Aged Care Facilities](#).<sup>6, 7</sup> Both of these important reports come to similar conclusions; the pandemic has exposed longstanding, widespread shortcomings and systemic weaknesses throughout the aged care system. Both reports highlight that over the past twenty years, many reviews and inquiries into the aged care sector have put forward countless recommendations which have not been heeded by governments, providers, and policy makers.

### ***Reporting on deaths, outbreaks, and cases in aged care***

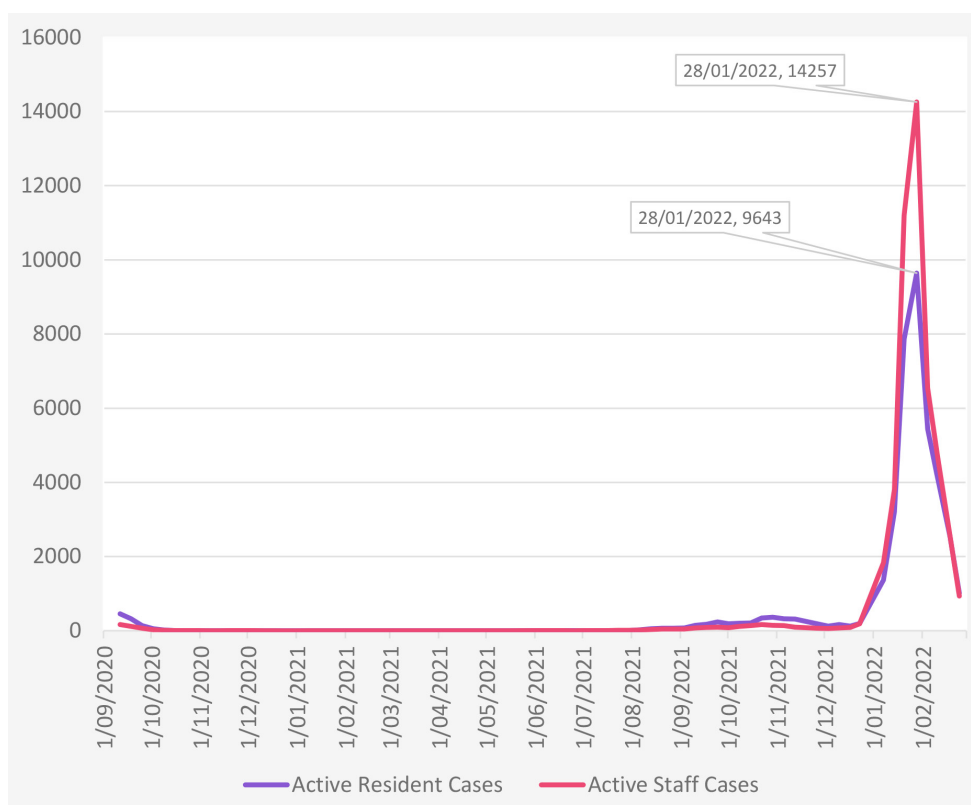
Each week on Friday evening, the Commonwealth Government releases a report on the current status of [COVID-19 outbreaks in aged care](#) (see **Table 2**).<sup>8</sup> To provide a picture of the situation at around the mid-point of when the survey was open, in the [report dated 28 January](#),<sup>9</sup> there were 23,900 active cases (staff and residents) of COVID-19 related to aged care across 1,261 residential aged care facilities including 63 new outbreaks since the previous week's report. This an increase of 4,840 new cases since the previous week including 9,643 active resident cases (an increase of 1,782/23% in one week) and 14,257 active staff cases (an increase of 3059/27% in one week). This shows that in January around half of all Australian nursing homes were experiencing an active COVID-19 outbreak.



**Table 2:** Active COVID-19 outbreaks, resident cases, and staff cases in Australian Nursing Homes – 5 November 2021-25 February 2022

Report Date	Nursing homes with active outbreak/s	Percent of total Australian nursing homes (N=2,722)	Active resident cases	Active staff cases
5 November '21	53	1.91%	323	137
12 November '21	34	1.22%	313	98
19 November '21	33	1.19%	253	84
26 November '21	29	1.04%	188	71
3 December '21	28	1.01%	127	64
10 December '21	36	1.29%	169	74
17 December '21	54	1.94%	125	88
24 December '21	105	3.78%	196	189
8 January '22	495	17.89%	1,370	1,835
14 January '22	1,107	39.93%	3,208	3,806
21 January '22	1,198	43.21%	7,861	11,198
28 January '22	1,261	45.49%	9,643	14,257
4 February '22	1,176	42.42%	5,439	6,541
11 February '22	987	35.60%	4,190	4,782
18 February '22	645	23.26%	2,550	2,572
25 February '22	286	10.5%	1,014	936

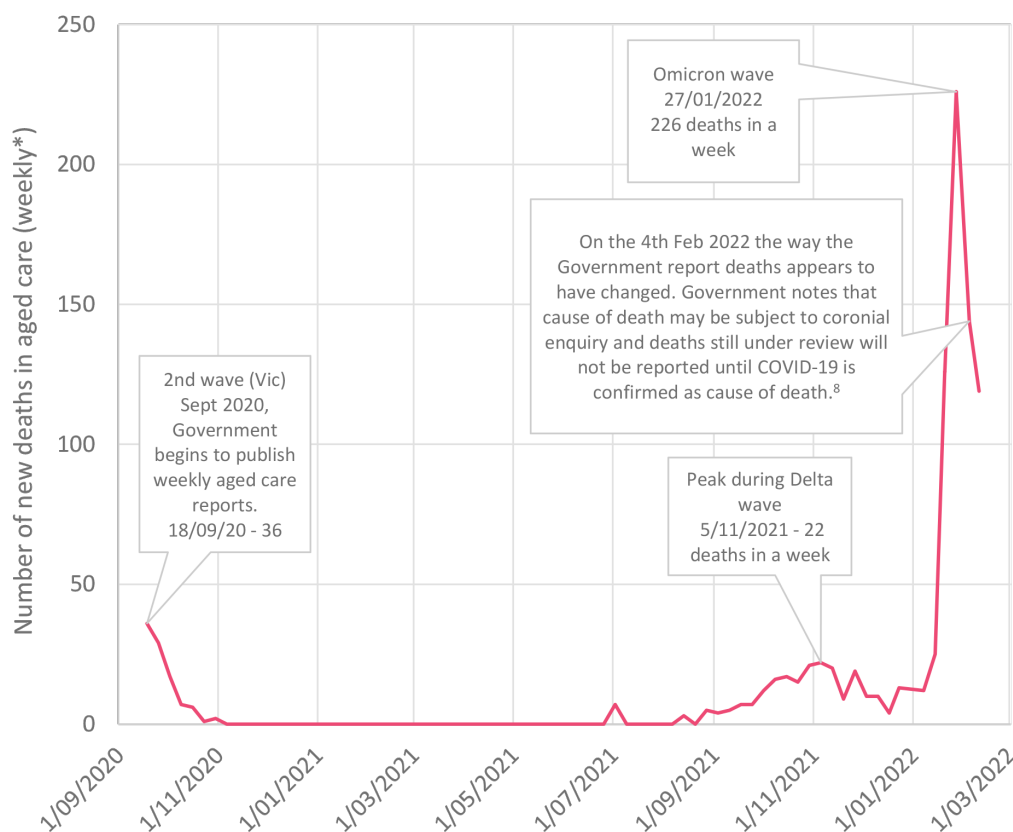
In the most recent Government report (25 February), the number of outbreaks and cases among aged care residents and staff had dropped significantly from the figures presented in previous reports (see **Figure 4**)<sup>10</sup> however as will be explained below, the impact of the pandemic on deaths are likely to persist for some time and the risk of another wave or variant of concern is still very real.



**Figure 4:** Active COVID-19 cases amongst nursing home residents and staff – 5 November 2021 - 25 February 2022



Using the Government reported data, **Figure 5** shows the disproportionate impact that the Omicron variant has had on mortality in aged care in comparison to the preceding waves of the pandemic. The graph shows how on 27 January 2022, the reported number of weekly deaths exceeded previous maximums by an approximate factor of 10.



\*Note: some 'weekly' reporting intervals may be slightly less than or exceed 7 days.

**Figure 5:** New deaths in aged care, reported from September 2020 to 11 February 2022. Aged care deaths are reported weekly and so 'number of new deaths' is the number of deaths that occurred between weekly reports.

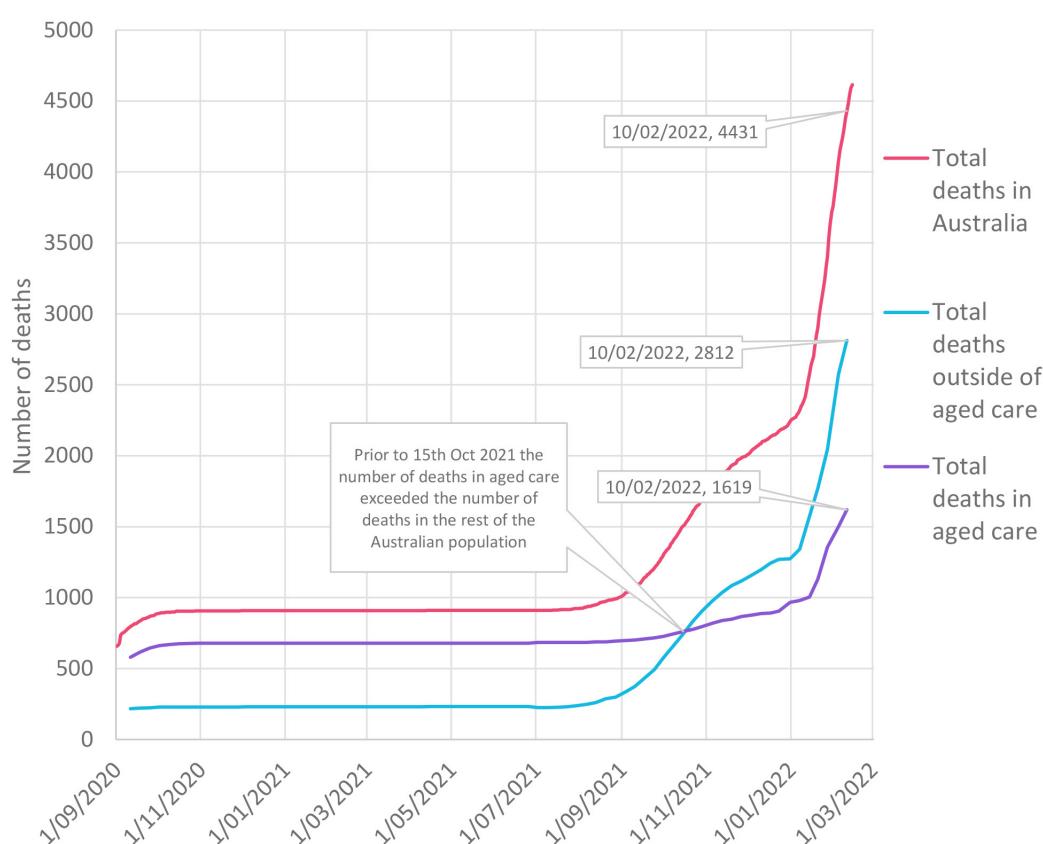
Source: [COVID-19 outbreaks in Australian residential aged care facilities](#).<sup>8</sup>

Apart from the weekly reports, deaths in aged care can also be calculated relatively accurately from [the daily figures released by the government](#).<sup>2</sup> At the time of writing, according to the daily figures, there have been 726 deaths in aged care in 2022 and about 1,008 deaths in aged care in the last 12 months. There has been a total of 4,798 deaths in Australia since start of pandemic including 1,693 deaths in aged care accounting for 35.3% of all deaths. The 726 deaths in aged care in 2022 account for 42.8% of all aged care deaths and 15.13% of Australia's total COVID-19 deaths to date. This highlights that in around 1.5 months in 2022 (~5% of the ~26-month pandemic), a disproportionately high number of people in aged care have died with the proportion of people dying in aged care still rising against all recorded aged care deaths prior to 2022 and generally in proportion to all deaths.





It can be useful to keep track of the daily figures due to the delays for the weekly reports. On 4 February 2022 the Government noted that weekly figures for number of deaths is dependent on reporting from facilities and subsequent validation by state and territories with confirmation of official COVID-19 related deaths in 2021 and 2022 still underway. They suggest that in many cases where a resident has comorbidities the confirmation of COVID-19 as a cause of death may be delayed until conclusion of the enquiry, and that figures for COVID-19 related deaths are subject to change. This indicates that with the high caseload and mortality experienced throughout the January period, the delays and changes (classification) in what is recorded as a COVID-19 related death have impacted on the number of reported figures. The impact of this shift can be seen in **Figure 5** when observing the significantly sharp decline in reported deaths across the period from 27 January to 10 February in relation to the sharp upward trend shown through late December – January.



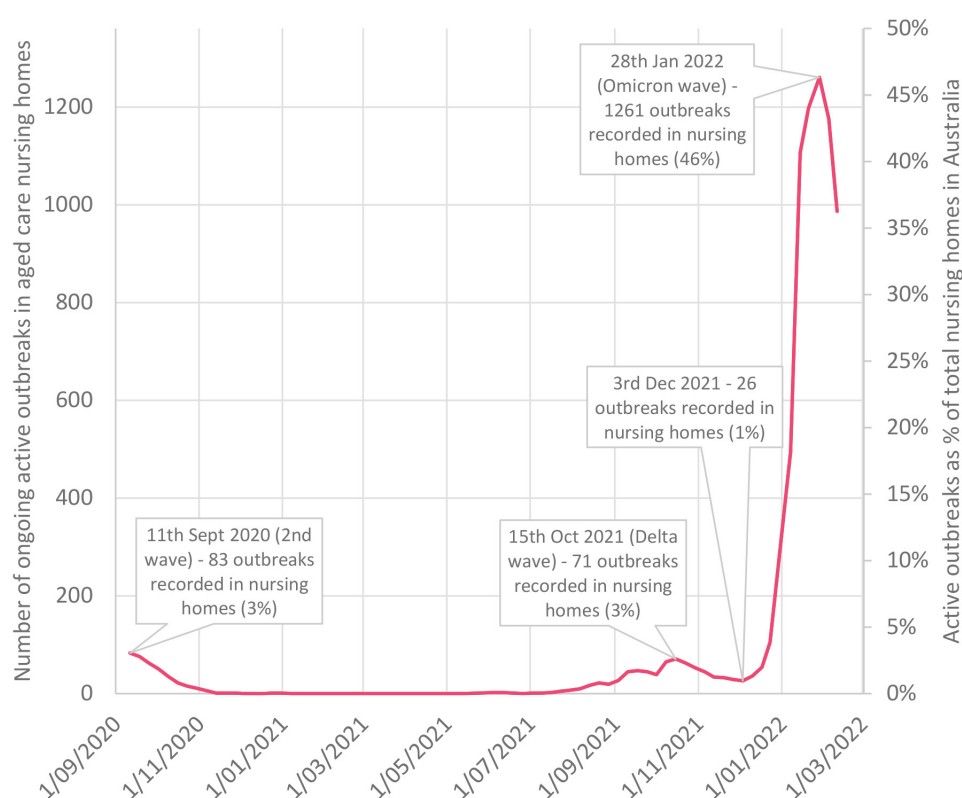
**Figure 6:** Number of COVID-19 related deaths in the total Australian population against total COVID-19 related deaths in aged care from September 2020 to the 11 February 2022. Source: 1) [COVID-19 outbreaks in Australian residential aged care facilities](#); [covid19data.com.au](#)

In **Figure 6** above, from September 2020 until August 2021 (the period following the second wave that occurred primarily in Victoria), deaths in aged care accounted for approximately 70% of total national deaths. This trend began to diverge with the onset of the Delta wave (where most cases were being reported primarily in NSW) and it was not until October 2021 that the number of COVID-19 related deaths occurring outside of aged care began to exceed those in aged care. Further, it is important to consider that the mortality rate of COVID-19 is significantly higher in older people and so it is likely this increase in deaths outside of aged care was largely occurring in Australia's older population.



Although deaths outside of aged care are seen here to shift and exceed those in aged care, COVID-19 is still having a disproportionate impact on the mortality of those living in nursing homes. At 30 June 2020 the [number of people residing in aged care facilities](#) represented approximately 1.3% of [Australia's population](#).<sup>11, 12</sup> On 28 January 2022 the number of deaths in aged care accounted for 37% of total national deaths. Further, on 10 February, 17,002 cases of COVID-19 are reported to have occurred in nursing home residents, this indicates that over the course of the pandemic to date approximately 1 in 10 people who reside in a nursing home and have contracted COVID-19 have died. This isn't just a statistic, this is the lives of mothers, fathers, grandparents, brothers, and sisters – friends and family.

To turn to the number and proportion of outbreaks in aged care, below in **Figure 7**, it can be seen that in September of 2022 during the second wave of the pandemic 3% of the total number of Australian nursing homes were reported as experiencing an outbreak. Similarly at the peak of the Delta wave, outbreaks were recorded in 71, or 3%, of facilities. This figure fell over the course of the next two months to 3 December 2021 to 26, or 1% of facilities, however at 28 January this figure had reached 1261, or 46% of all facilities in Australia. That is, over the course of 7 – 8 weeks COVID-19 outbreaks went from occurring in 1% of nursing homes, to occurring simultaneously in almost half of all facilities in Australia.



Source: [COVID-19 outbreaks in Australian residential aged care facilities](#).

**Figure 7:** Left-hand axis shows the number of ongoing COVID-19 outbreaks in aged care recorded between September 2020 and 31 January 2022. The right-hand axis shows this figure as a percentage of the [total number of registered aged care facilities in Australia](#).<sup>13</sup> Source: [COVID-19 outbreaks in Australian residential aged care facilities](#).



## Vaccine and third/dose rollout

Vaccination is one of the main protective factors that can keep older people safe from COVID-19 as being vaccinated reduces risk of infection, illness, severe illness, hospitalisation, intensive care unit admissions, and death. This protection is further amplified with the administration of a third dose/booster vaccine as two doses wane over time and are not as effective against the newer Delta and Omicron variants that are currently dominant in Australia. As such, vaccination and boosters are imperative for older people in aged care and aged care workers.

On 1 December 2021, the [Australian Government's Department of Health](#) reported that 82.7 percent of people aged 16 and over had received two doses of a COVID-19 vaccine and that 448,945 people had also received a third dose/booster.<sup>14</sup> In residential aged care, the report detailed that 99.3% of aged care workers had received two doses (fully vaccinated) and that just over 90% of residents had received at least two doses, with around 87% of residents having received one dose only. At this time, the [Australian Technical Advisory Group on Immunisation \(ATAGI\)](#) maintained their position that booster doses should only be administered to people aged 18 years or older who had received their last dose at least six months earlier. The ATAGI also advised that this interval could be shortened to five months for certain groups including patients with a greater risk of severe COVID-19 in outbreak settings and that anyone with an immunocompromising condition could receive a third dose at least two months after their second dose. By 24 December, the [ATAGI had updated their advice](#) and reduced the interval for most people to four months and recommended that as soon as capacity permits,<sup>15</sup> a three-month interval should be implemented which [came into effect from 24 January 2022](#).<sup>16</sup> At around this time also, many state and territory governments had also begun [implementing requirements for health and aged care workers to receive a third dose as soon they had become eligible](#).<sup>17</sup>

## Booster rollout in aged care

The [Australian Government](#) had committed to rolling out an efficient booster program in residential aged care including both workers and residents with a deadline of 31 January 2022 when all approved residential aged care facilities should have been visited by an [in-reach Commonwealth-coordinated booster clinic](#).<sup>18, 19</sup> On the [31 January](#) the Minister for Health and Aged Care stated that the booster program had concluded six weeks ahead of schedule with around 99 per cent of facilities were expected to have participated in the in-reach booster program with only providers that had experienced major outbreaks or where the vaccination provider had experienced an outbreak still to participate.<sup>20</sup> By the end of January it had become clear that while most nursing homes had received boosters, the [majority of deaths in Australia and Australian aged care were nursing home residents who had not received a third dose](#).<sup>21</sup>

The publication of [numbers regarding the aged care booster rollout](#) was expected to commence on 16 February 2022,<sup>22</sup> however at the time of writing, these figures still do not appear to be available. On 15 February, [Lieutenant General John Frewen](#) reported that over 83% of eligible residents have received a booster.<sup>23</sup> Facilities can now register for a [return booster clinic](#) where at least 10 per cent of residents at the facility require a COVID-19 vaccine dose (first, second or third/booster) and that this equates to 10 or more residents.<sup>22</sup>



## Methods

The online survey opened on 18 January and closed on 11 February 2022. The survey's 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 8**.

COVID-19 status and isolation	COVID-19 vaccinations and testing	Workplace experiences
<ul style="list-style-type: none"> <li>• COVID-19 infection/exposure</li> <li>• Isolation and quarantine</li> <li>• Leave from work due to COVID-19</li> </ul>	<ul style="list-style-type: none"> <li>• Vaccination access and experiences</li> <li>• Testing access and experiences</li> </ul>	<ul style="list-style-type: none"> <li>• Employment experiences</li> <li>• Intention to leave</li> <li>• Infection prevention</li> <li>• PPE</li> <li>• Challenges and solutions</li> </ul>

**Figure 8:** Domains assessed within the National COVID-19 Aged Care Survey 2022



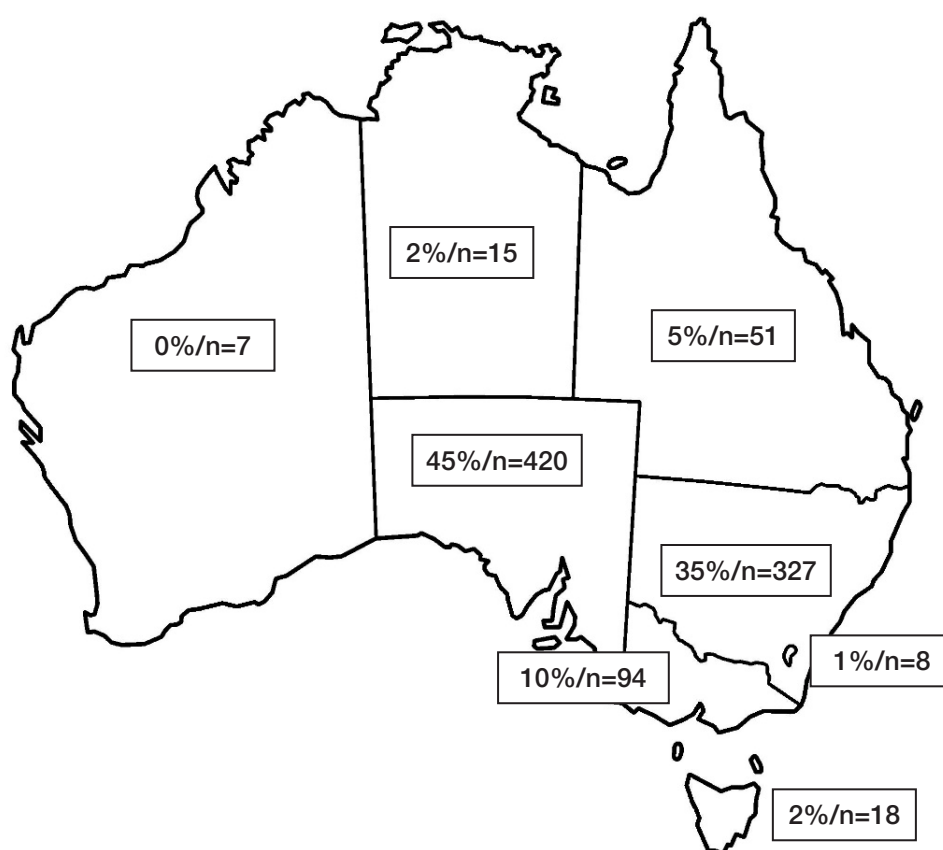
## Results

985 participants answered at least one survey question with 938 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 938 responses, 90% (n=778) were **ANMF/NSWNMA/QNMU** members, 9% (n=78) were not members, and 1% (n=8) were not sure.

Of 863 participants who responded to the question on **job classification**, 47% (n=443) were registered nurses (RN) including 5 dual-registered nurse/midwives, 27% were enrolled nurses (n=257), and 25% (n=229) were care workers (i.e., assistants in nursing, personal care workers/aged care workers). There were five nurse practitioners and three nursing students.

Most participants mainly worked in South Australia (45%/n=420), New South Wales (35%/n=327), Victoria (10%/n=94), and Queensland (5%/n=51). **Figure 9** shows the **breakdown of participants by the state or territory** they worked in.



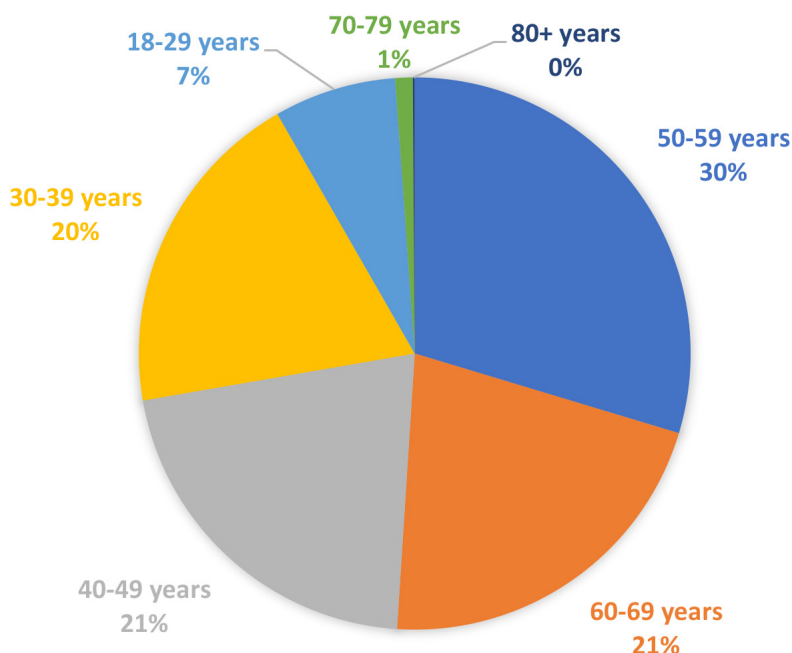
**Figure 9:** Participant distribution by state/territory





## Participant age

880 participants provided a valid response regarding their age. **The average age of participants was 48 years.** Of the valid responses, the largest groups were people aged between 50 and 59 years (30%/n=261) followed by 60-69 years (21%/n=188), 40-49 years (21%/n=187), 30-39 years (19%/n=171), and 18-29 years (7%/n=63). There were nine participants aged between 70 and 79 and one participant aged over 80 years. **Figure 10** shows the breakdown of **participants by age**.



**Figure 10:** Participant age groups

## Employment

All 988 participants who answered a question regarding where they worked most often since 1 December 2021 worked in aged care with 91% (n=901) working in residential aged care and 9% (n=87) working in community/in-home aged care.

Of 987 responses, most participants (98%/n=968) had been employed since 1 December 2021, while 2% (n=19) 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=3), retired (n=2), COVID-19 sick leave (n=1), non-COVID-19 sick leave (n=1), not receiving shifts (n=1), voluntarily left job (n=1), or undisclosed/ other (n=8).

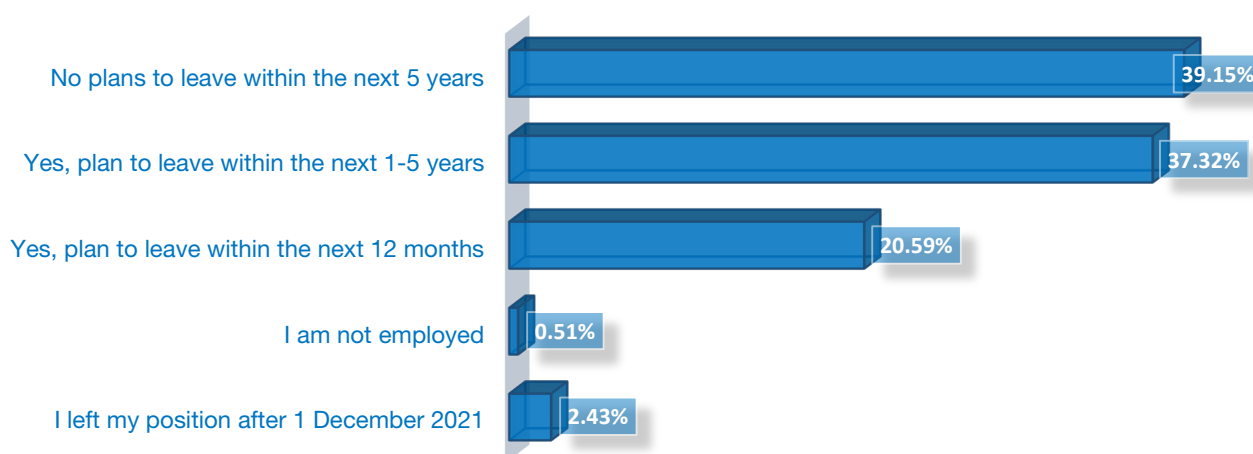


## Intention to leave

***“The workload in residential aged care is unmanageable. Staff are exhausted, frustrated, and leaving the industry. Care staff with minimal training are looking after COVID-19-positive residents and doing their very best. Residents deserve to be cared for and the staff deserve to be looked after also.”***

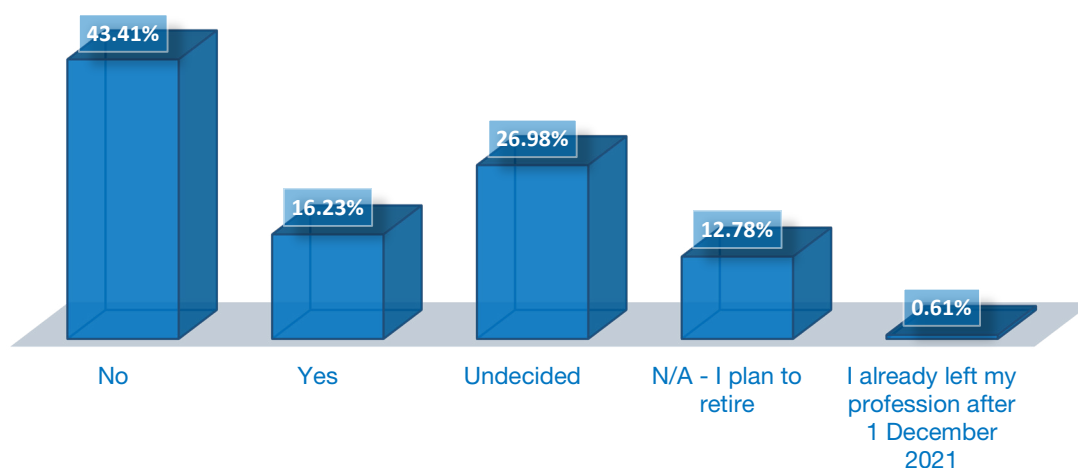
**Registered nurse, age 59, New South Wales**

Of 986 responses most participants (39%/n=386) reported that they did not intend on leaving their current position within the next five years, while 37% (n=368) reported plans to leave within 1-5 years. 21% (n=203) reported planning to leave their position within the next 12 months and 2% (n=24) reported leaving their job after 1 December 2021. **Figure 11** shows the **breakdown of participants’ responses regarding their intention to leave their current position.**



**Figure 11:** Do you plan to leave your current position?

Of 986 responses, most participants (43%/n=428) reported that they did not plan on leaving their profession (E.g., nursing, aged care) to work in another field. 27% (n=266) reported that they were ‘undecided’ and 16% (n=160) reported that they planned to leave their profession. 13% (n=126) plan to retire. **Figure 12** shows the **breakdown of participants’ responses regarding their intention to leave their current profession.**



**Figure 12:** 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 880 valid responses to allow categorisation of intention to leave by age. The age groups between 18-29 years (37%) and 70+ (40%) contained the largest proportion **of people who reported intending to leave their current position within the next 12 months. Intention to leave a current role in the next 1-5 years** ranged from 29% in the 18-29 age group to 48% in the 60-69 age group. **Intention to leave the profession** was relatively consistent across most age groups (18%-20%) with the age groups over 60 years least likely to report intending to leave their profession but more likely to report plans to retire. **Table 3** shows a breakdown of intention to leave by age group.

**Table 3:** *Intention to leave current position and profession by age group*

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	Not employed/ left work since 1 Dec 2021*
Age group	% / n	% / n	% / n	% / n	% / n	n
18-29 years (n=63)	37% / 23	29% / 19	33% / 21	19% / 12	-	1
30-39 years (n=171)	23% / 40	32% / 54	42% / 71	20% / 35	-	6
40-49 years (n=187)	20% / 38	30% / 65	44% / 82	19% / 35	1% / 2	3
50-59 years (n=261)	16% / 42	38% / 98	43% / 113	18% / 48	7% / 18	8
60-69 years (n=188)	18% / 34	48% / 90	30% / 56	7% / 14	46% / 87	6
70+ years (n=10)	40% / 4	40% / 4	-	10% / 1	50% / 5	2
<b>Total **</b>	21% / 181	38% / 330	40% / 343	16% / 145	13% 112	26

\*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.

In **Table 4** below, personal care worker is the employment category with the largest percentage of participants (24%) who reported intending to leave both their current position and profession (i.e. aged care) in comparison with other job categories. Registered nurses included the largest percentage of participants who reported intending to leave their role within the next five years (39%) and/or retiring (15%).

**Table 4:** *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	Not employed/ left work since 1 Dec 2021*
Employment category	% / n	% / n	% / n	% / n	% / n	n
Personal care worker (n=229)	24% / 54	37% / 84	38% / 86	22% / 50	9% / 21	5
Enrolled nurse (n=257)	20% / 52	35% / 90	43% / 110	18% / 48	14% / 37	4
Registered nurse** (n=443)	19% / 85	48% / 90	39% / 171	15% / 67	15% / 65	20
Nurse practitioner (n=5)	-	80% / 5	20% / 1	-	2	-

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

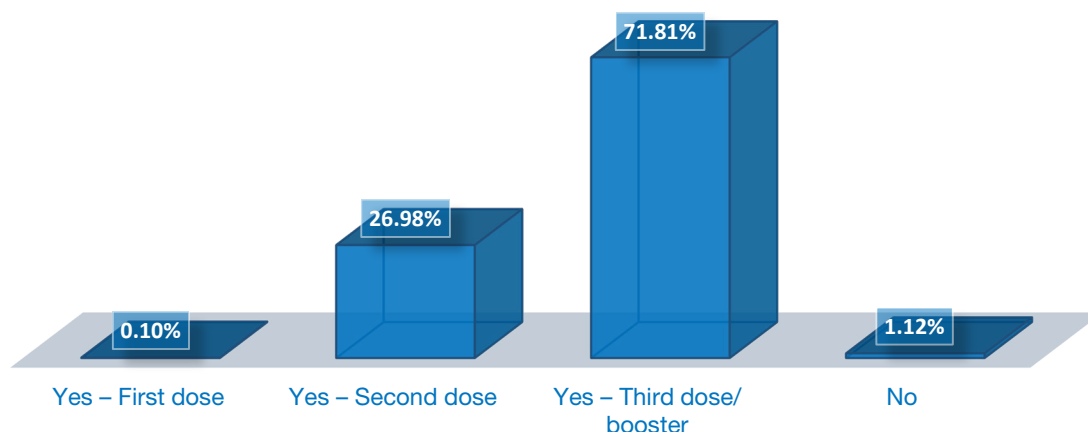
\*\*Including. dual registrants

***“It came to a point that I need to call the depression hotline because I am already mentally and physically exhausted with what is happening in the nursing home. It was so depressing to see your colleagues resign every week due to poor staffing, Increased workload, and the stress that brought by Covid 19 and yet we are still receiving small amount of salary. My colleagues resigned and applied to become a disability worker where they will have a better pay and less workload. Now, the RN’s needs to deal and guide new staff members day by day which makes our workload even harder because we also need to do the RAT test for all the residents every 3 days. Sometimes if you are short of staff you need to shoulder most of the workload alone. My mental and physical health was greatly impacted by this day-to-day situation.”***

**Registered nurse, age 41, New South Wales**

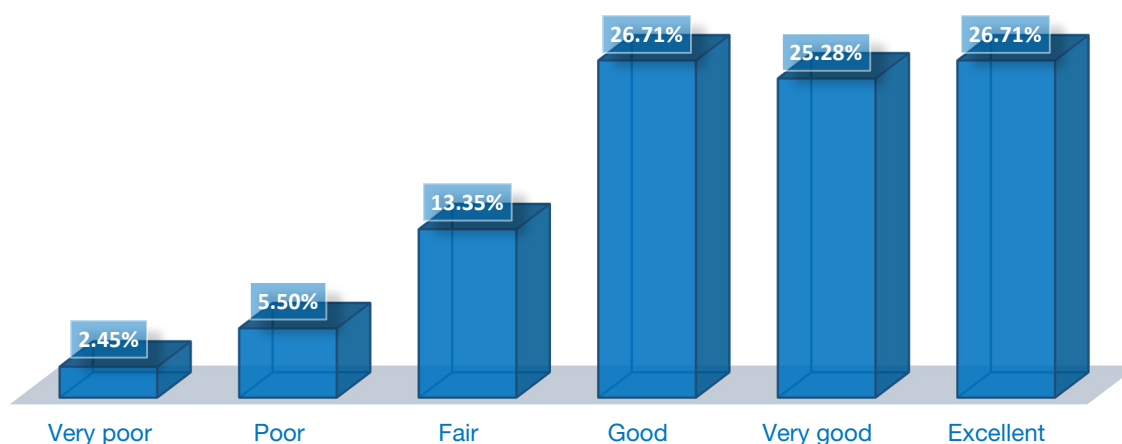
## COVID-19 vaccination and testing

Of 986 responses, most participants (72%/n=708) had received three doses of a COVID-19 vaccination while 27% (n=266) had received two doses. **Figure 13** shows the breakdown of **participants by vaccination status**. Participants who indicated not having received any COVID-19 vaccines (n=11) had worked in aged care previously but were not employed at the time of the survey.



**Figure 13:** Have you received a COVID-19 vaccination?

Of 981 responses, most participants (79%/n=772) reported that their experiences of accessing COVID-19 vaccines were 'good' to 'excellent'. 8% (n=78) of participants reported that their experiences of vaccine access were 'very poor' or 'poor'. **Figure 14** shows the breakdown of **participants' reported experience of accessing COVID-19 vaccines**.



**Figure 14:** What has been your experience regarding access to the COVID-19 vaccines?

Participants were asked 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. Some participants commented on the fact that changing eligibility requirements made organising and bringing forward doses was a challenge, while others reported challenges getting timely access to vaccines due to living and working in rural or regional areas or living in one state/territory and working in another. Some participants reported challenges accessing vaccines through in-reach clinics and that staff would only be given doses if there were left-overs from residents. Some participants reported that the information they had been provided by employers about when and where to receive vaccines and from the Government regarding availability and access was inaccurate. Some staff reported difficulties accessing the type of vaccine they wanted.



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*“Was a total schmozzle at the beginning; in-home care was phase 1b, even though visiting elderly people. Extremely difficult getting vax for clients who couldn’t leave their homes, which meant difficulties faced by staff was extra stressful due to worry about unwittingly infecting clients. My booster was due mid Feb until the time was shortened to 4 months, but I haven’t been able to bring my appointment forward.”*

Registered nurse, age 39, New South Wales

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*“Experience with first two vaccinations was very poor. Vaccination clinic for staff never eventuated. Vaccination was accessed via leftover doses once aged care residents had been vaccinated. Experience with booster was excellent as I self-arranged through my GP.”*

Care worker, age 62, New South Wales

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*“Regional areas had limited availability to begin with. As I am employed in ACT and live in NSW, once the vaccines became mandated, I was unable to access a vaccine where I am employed due to them excluding NSW residents (even with a border exemption).”*

Enrolled nurse, age 40, Australian Capital Territory/New South Wales

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*“The third or booster vaccination was not made available by the government until months after it was needed. Nobody seemed to be pushing for it during the Delta outbreak when those populations who were most at risk and most vulnerable were due the third vaccination as seen at the time by Israel’s third vaccination at a 5-month interval and evidenced today by the current 3-month interval.”*

Registered nurse, age 63, New South Wales

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*“Had difficulty obtaining initially and due to age was forced to get AZ although would have preferred Pfizer, I felt the government didn’t care about me despite the fact I worked in aged care. I was being penalised for being over 60 I didn’t get my first vaccination until the end of May so had to wait until August to be fully vaccinated.”*

Registered nurse, age 63, New South Wales

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*“I was lucky, we had spare doses of Pfizer because they were getting our residents vaccinated and staff on shift were offered the chance to have their first dose. I took it. My 2nd dose and the rest of our staff 1st dose was delayed due to government logistical error. The vaccines were sent to the wrong town and therefore had to be dumped.”*

Enrolled nurse, age 37, Queensland

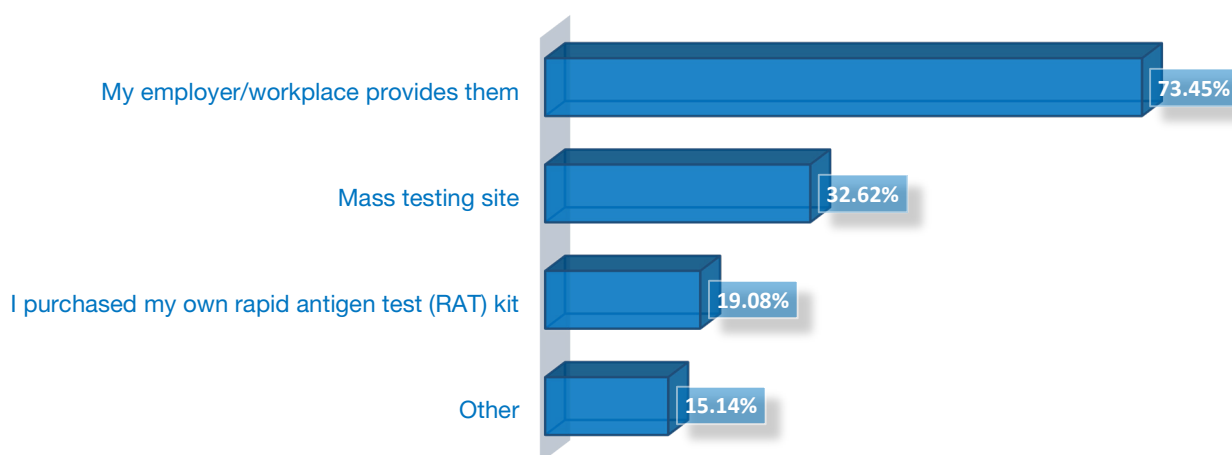
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## COVID-19 testing

Of 938 responses, many participants accessed COVID-19 tests from multiple sources as multiple responses were able to be selected for this question. 73% (n=689) of respondents reported that their employer provided RAT kits. 19% (n=179) participants reported buying their own tests and 33% (n=306) reported accessing a mass testing site. 19% (n=179) of participants reported buying their own tests and 33% (n=306) reported accessing a mass testing site. 109 (12%) participants reported solely relying on mass testing sites (no tests from employers or self-purchased) and 45 (5%) reported relying solely on self-purchased RAT kits. 475 (51%) participants reported only accessing employer-provided tests. **Figure 15** shows the breakdown of where **participants reported accessing COVID-19 tests (RAT and/or PCR).**



**Figure 15:** How did you access the test? (You can select more than one)

Participants were given the opportunity to explain further if they sourced tests through other means. Some participants reported various challenges gaining timely access to tests both for themselves and their residents including difficulties accessing the Government stockpile and needing to travelling long distances to purchase testing kits themselves.

***“My workplace had been an exposure site and then an outbreak site. The government has been slow in distributing rapid antigen testing from the stockpile. Within our community it is difficult to obtain rapid antigen testing this meant we had to travel to Adelaide to purchase enough to test all staff as recommended by the public health unit. The governments lack of response was disappointing, as the government stated they were ready to open the borders and we had good systems in place we as a facility. Felt let down by SA health and the government.”***

**Enrolled nurse, age 30, South Australia**

***“RAT tests were not readily available through work, which is appalling given I work in Aged Care. Shame on this government.”***

**Care worker, age 60, New South Wales**



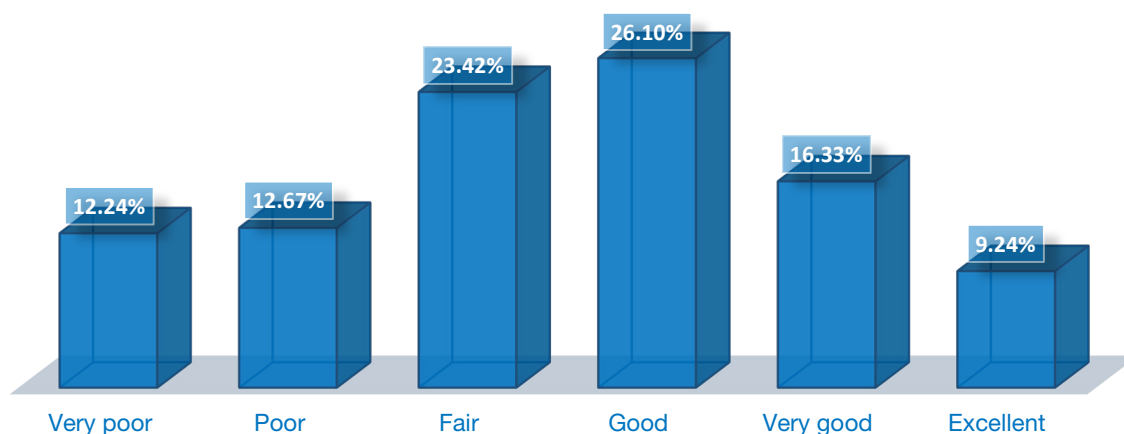
***“Stock had to be supplied from hospital to nursing home as the national stockpile promised to aged care still has not been provided.”***

**Registered nurse, age 33, New South Wales**

***“Workplace has very limited supplies. Only being used if absolutely necessary. Very expensive too.”***

**Registered Nurse, age 68, New South Wales**

Of 931 responses, most participants reported that their experiences of accessing COVID-19 testing was ‘fair’ (23%/n=218) or ‘good’ (26%/n=243). 25% (n=232) reported access to COVID-19 testing was ‘very poor’ or ‘poor’ and 9% (n=86) reported access was ‘excellent’. **Figure 16** shows the breakdown of participants’ reported experience of accessing COVID-19 testing.



**Figure 16:** What has been your experience regarding access to COVID-19 testing since 1 December 2021?

Participants were given the opportunity to provide comments on their responses to this question. While many participants were positive about their experiences accessing COVID-19 tests, many described the challenges they faced. Key challenges that were reported included; testing sites being closed and impacting on ability to work, long wait-times for tests and results, lack of availability of RATs, Challenges around ease of access and timeliness of results were particularly pronounced for people living in regional areas. The following quotes illustrate a number of the experiences described by participants regarding their experiences of accessing COVID-19 tests since 1 December 2021.



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***“I needed PCR testing as was a close contact but over Christmas/New Year it was very difficult to access due to holidays, many centres closed, or closed early. Made it very difficult as I couldn’t go back to work until I had them done.”***

**Registered nurse, age 63, New South Wales**

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***“Public test site: Queue is stopped suddenly with poor notification. Wasted 5 hours lining the queue ending up failed to get tested.”***

**Registered nurse, South Australia**

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***“No RATs anywhere to be found in December / early Jan. Very long waits at mass testing sites.”***

**Registered nurse, South Australia**

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***“I found it hard getting the 2nd testing due to higher number awaiting to get tested. I’d arrive to the testing centre at about 5am until 4pm, I and would be told that the centre is closing before I was seen.”***

**Enrolled nurse, age 29, Tasmania**

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***“Two main experiences stand out. First: I work in a small country town aged care facility, on days off I developed mild covid like symptoms. My workplace has a ‘no working when symptomatic’ policy, so I booked a PCR test for the next day (there is no local testing sites after 5pm). My results took FOUR days to come back, negative. They were delayed in transit to Adelaide and didn’t arrive until day 3. I’m a casual employee and missed 4 shifts. Second experience: the aged care facility, where I’m a nurse at, ordered RAT tests back at the start of December (both private orders and federal supplies); it is now the last day of January and we still haven’t received a single RAT test for staff yet.”***

**Enrolled nurse, age 34, South Australia**

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***“Long waiting lines for testing and long wait times for results has deterred some people from getting tested. Having to isolate for 5 days and not permitted to go to work till results are available is frustrating. Then to find out that those 5 days of waiting for results have to be taken as sick leave is not fair.”***

**Registered nurse and midwife, age 54, New South Wales**

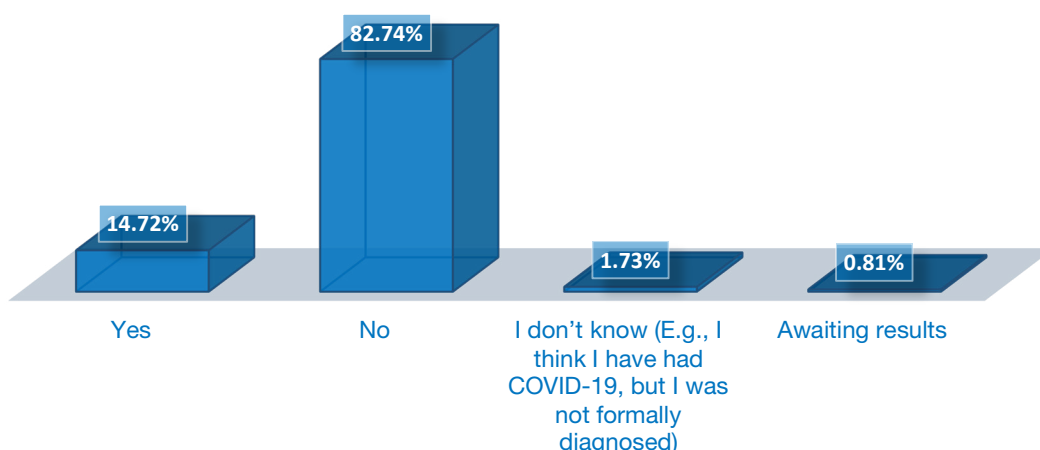
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## COVID-19 infection

Of 985 responses, most participants (83%/n=815) reported that they **have not been diagnosed with COVID-19**.

15% (n=145) reported having been diagnosed with COVID-19. **Figure 17** shows the breakdown of participant reports of COVID-19 diagnosis.

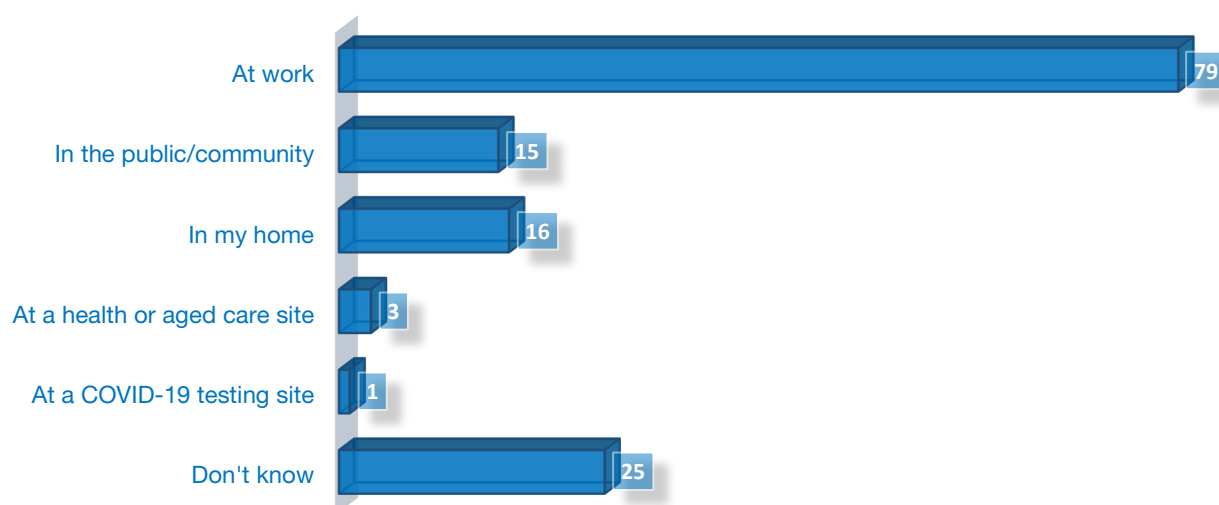


**Figure 17:** Participants that reported having been diagnosed with COVID-19.

Among the participants that had been diagnosed with COVID-19 (n=145) or were not sure if they had contracted COVID-19 (n=17), such as those that suspected infection but had no formal diagnosis, 83% (n=135) reported being **infected after 1 December 2021**. Only 15% (n=25) of respondents reported having been infected prior to 1 December 2021 and 4% (n=7) did not know when they had been infected.

Most participants (n=808/82%) reported that members of their **immediate household had not tested positive for COVID-19 since 1 December 2021**, while 18% (n=173) reported that a member of their immediate household had been infected since 1 December 2021.

While the largest group of participants (48%/n=390) had not been infected with COVID-19, of the 145 participants that reported having been infected with COVID-19 (n=145), 79 (54%) reported that they believed they had been infected at work. Twenty-five participants (17%) did not know where they had been infected, 16 (11%) reported being infected at home, 15 (10%) reported being infected in the community, three (2%) reported being infected at another health or aged care site that was not their work, and one participant reported being infected at a testing site. six participants (4%) did not report where they think they were infected. **Figure 18** shows the breakdown of **participant reports of where they believed they were infected with COVID-19 or became a close contact**.

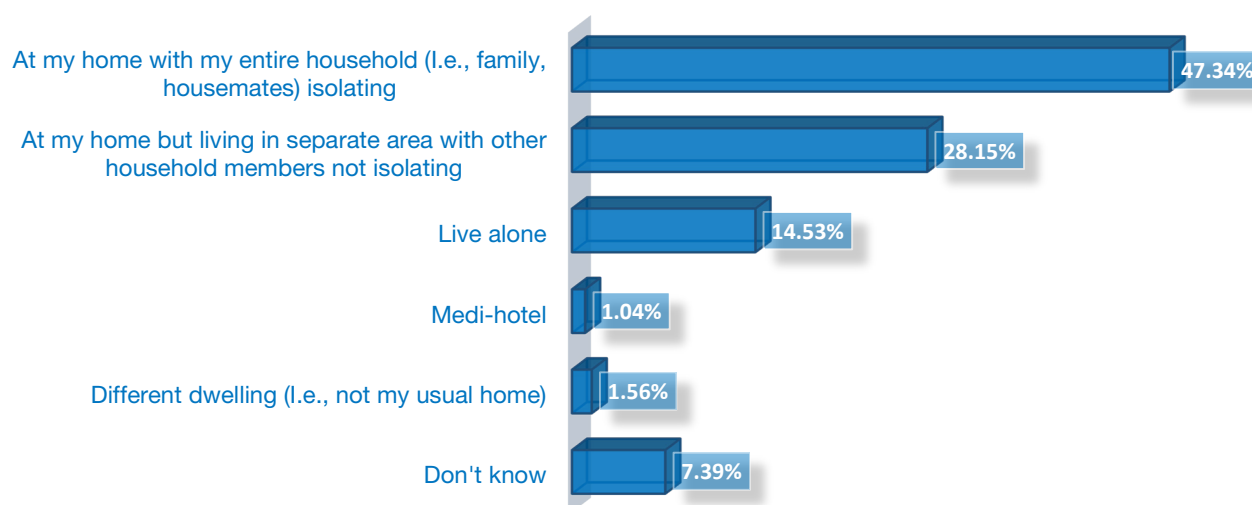


**Figure 18:** *Where do you think you were infected with COVID-19?*

Of 988 responses, 13% (n=124) of participants reported that they have had to go into **isolation/quarantine because of COVID-19 since 1 December 2021** due to being diagnosed. 18% (n=177) had to go into isolation/quarantine since 1 December 2021 because they were a close contact of a case. Most participants (70%/n=687) 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 771 responses, the most common place that participants reported isolating/quarantining was or would be in their own home with their entire household (47%/n=365). 28% (n=217) participants reported that they have or would isolate at home but separate to their family. **Figure 19** shows the breakdown of participant reports of where they had or would isolate due to COVID-19 diagnosis/close contact.



**Figure 19:** *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 difficulties of effectively isolating/quarantining in a house with family members due to concerns about infecting them, while others commented on the difficulties brought about by causing family members to need to isolate resulting in lost work and income during a particularly tough time. Some participants reported that employers would not allow them to take time off to isolate as a result of being a close contact. The following quotes have been chosen to illustrate the kinds of responses participants provided:

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***“As a healthcare worker I might get COVID while looking after patients, but I don’t want to come back home and risk my kid.”***

**Registered nurse, age 33, Northern Territory**

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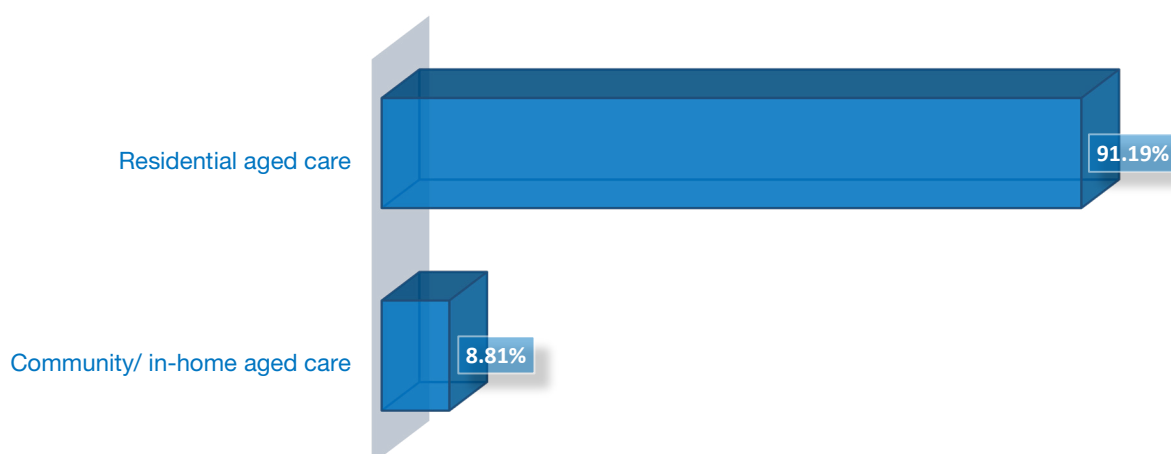
***“I was meant to isolate due to close contact, but my work didn’t allow me to take the time off. They said I had to continue working even before I had a test to ensure I was negative.”***

**Enrolled nurse, age 40, South Australia**

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## Workplace

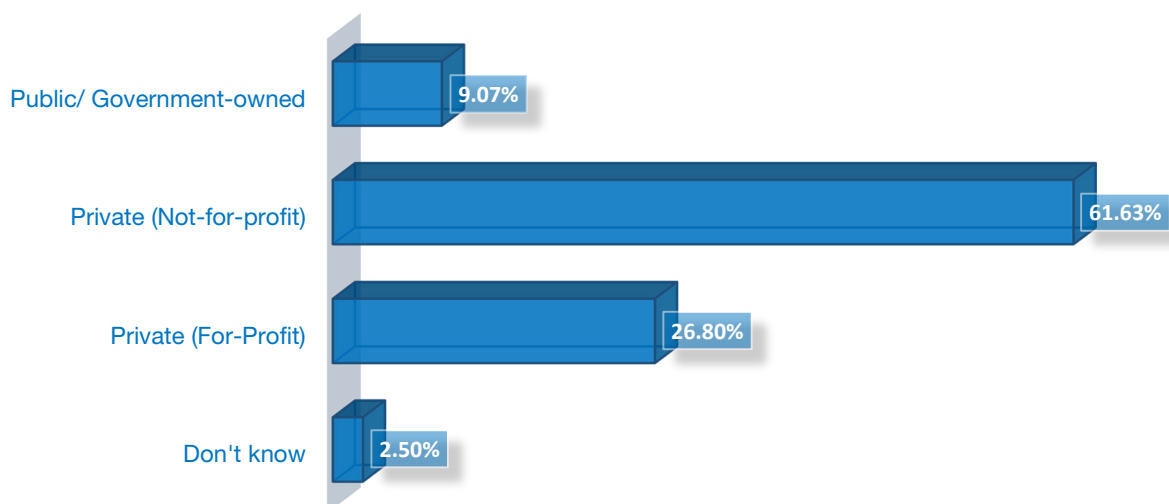
All participants reported that their main place of work was in aged care, with residential aged care accounting for 91% (n=901) participants. **Figure 20** shows the breakdown of **participants by aged care sub-sector**.



**Figure 20:** Since 1 December 2021, where do/did you work most often?

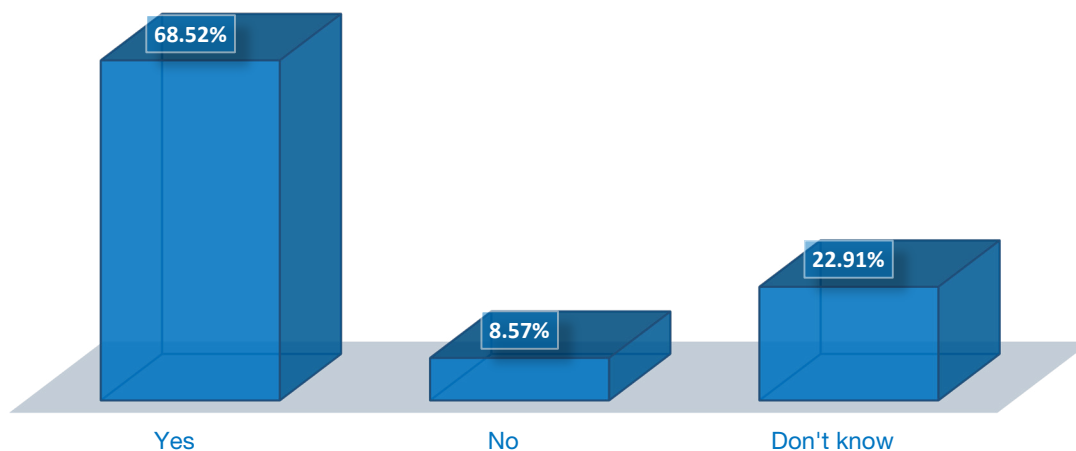
Of 959 respondents most participants (62%/n=591) reported that they worked for a private not-for-profit aged care provider. 27% (n=257) worked for a private for-profit provider and 9% (n=87) worked for a public/government owned provider. **Figure 21** shows the breakdown of **participants by aged care provider ownership**.





**Figure 21:** Employer type (public, not for profit, for profit, don't know).

Of 899 responses most participants (69%/n=616) reported that their workplace had an identified Infection Prevention Control Lead. Despite [Government requirements](#) that every aged care facility must have an [IPC Lead by 1 December 2020](#),<sup>24, 25</sup> 9% (n=77) of participants reported that their workplace did not have one while 23% (206) did not know if there was an IPC Lead at their workplace. **Figure 22** shows the breakdown of **participants reports of whether or not they had an IPC at their workplace**.



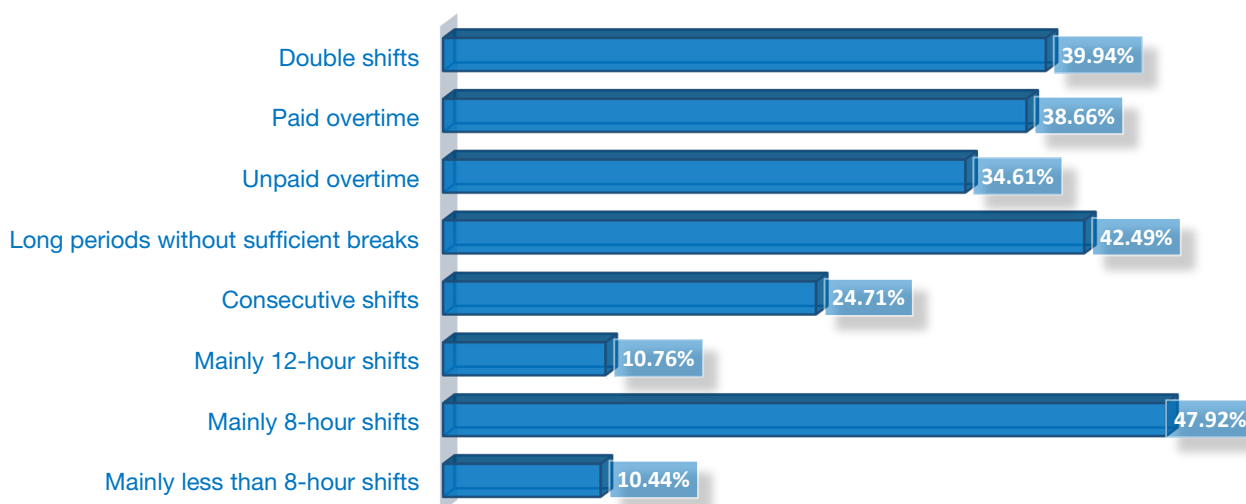
**Figure 22:** Since 1 December 2021, does your workplace have an Infection Prevention Control (IPC) Lead?

While the [Government requirements](#) state that the IPC lead must be a member of the nursing staff (RN or EN),<sup>24</sup> 3% (n=17) participants reported that their IPC was an AIN/PCW/ACW. 7% (n=47) of participants did not know what employment classification their IPC lead was. 77% (n=476) reported that their IPC lead was a RN while 12% (n=77) reported that the IPC was an EN.



## Work experiences

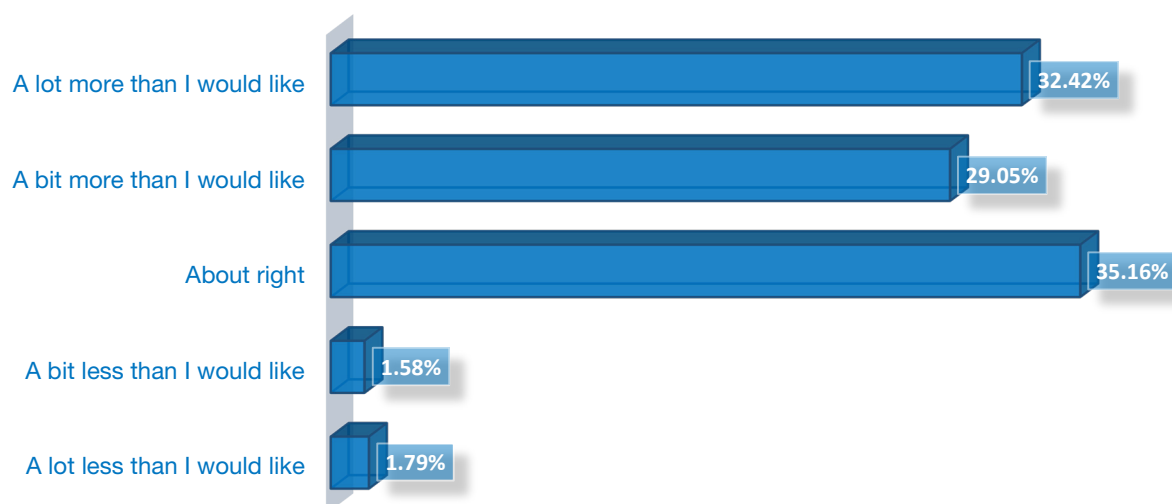
939 participants reported a diverse array of work experiences in terms of shift length, rostering, and overtime. Of the selection provided, the top five were: mainly 8-hour shifts (48%/n=450), long periods without sufficient breaks (42%/n=399), double shifts (40%/n=375), paid overtime (39%/n=363), and unpaid overtime (35%/n=325). **Figure 23** shows the breakdown of **participants reports of workplace experiences**.



**Figure 23:** Participants' reports of workplace experiences.

Of 950 responses, most participants indicated that their working hours were 'about right' (35%/n=334) followed by 'a lot more than I would like' (32%/n=308) and 'a bit more than I would like' (29%/n=276).

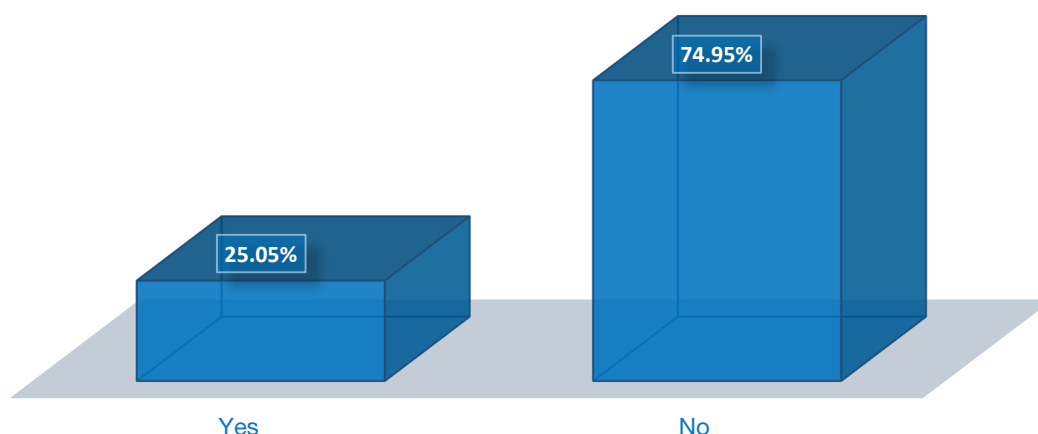
**Figure 24** shows the breakdown of **participants' satisfaction with working hours**.



**Figure 24:** Since 1 December 2021, are your working hours?

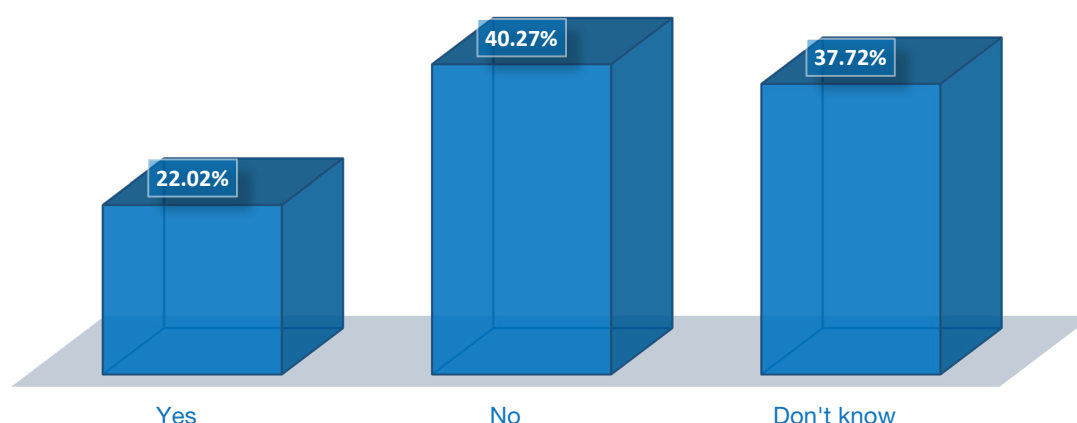


Of 978 responses, most participants (75%/n=733) reported that their employer had not asked them to cancel or delay planned leave or return to work from leave due to COVID-19 since 1 December 2021. A quarter (25%/n=245) reported that their employer had asked them to cancel or delay planned leave or return to work from leave due to COVID-19. **Figure 25** shows the breakdown of **participants' reports of delayed or cancelled leave since 1 December 2021 due to employer requests.**



**Figure 25:** 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?

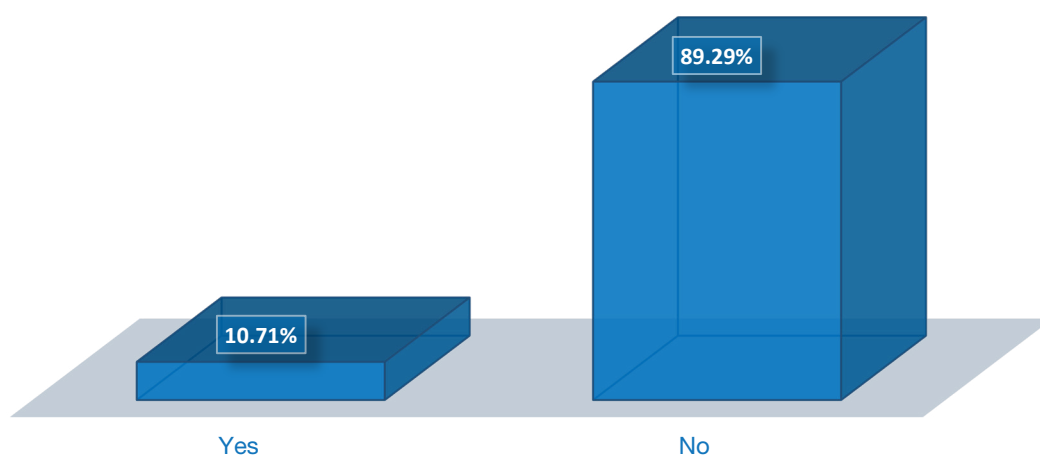
Of 904 responses, most participants (40%/n=395) reported that their employer did not have a policy that asymptomatic workers can/should return to work before the end of their isolation period or did not know (38%/n=370). 22% (n=216) reported that their employer has a policy that asymptomatic workers can/should return to work before the end of their isolation period. **Figure 26** shows the breakdown of **participants' reports of employer policies regarding return to work during a COVID-19 isolation period.**



**Figure 26:** Does your employer have a policy that asymptomatic workers can/should return to work before the end of their isolation period?



Of 812 responses, most participants (89%/n=725) reported that their employer had not asked them to return to work during their COVID-19 isolation/quarantine period while 11% (n=87) responded that they had been. **Figure 27** shows the breakdown of **participants' reports of employer requests to return to work during a COVID-19 isolation period**.



**Figure 27:** *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?*

Participants were asked to provide further comments on their response regarding whether their employer had asked them to return to work. Many participants reported that their employer had asked them to return to work during their isolation/quarantine period especially if they did not have symptoms or had not yet received a positive test result despite known risks of infection due to staff shortages. The following quotes have been chosen to illustrate the responses commonly provided by participants.

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***“Three days post-testing my result came negative, so because of staff shortages, they asked me to resume to work and do the 2nd and 3rd testing whilst attending work.”***

**Enrolled nurse, age 29, Tasmania**

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***“Worked up until result was received, even though my workplace knew that the chances were high to a positive result.”***

**Enrolled nurse, age 46, South Australia**

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***“There was a resident deemed close contact of a positive case. We were tested and expected to continue working whilst waiting the results.”***

**Care worker, age 55, South Australia**

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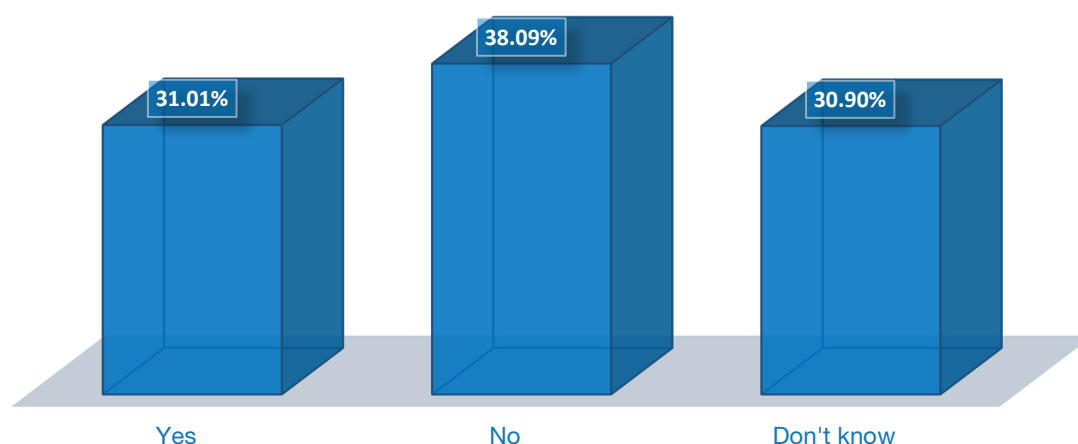
***“The family had to isolate when our son was furloughed from his workplace. I had to fight to stay at home and isolate due to being a close contact. At that stage there were no vaccines. Now we are encouraged to do the right thing and stay at home.”***

**Care worker, age 53, Victoria**

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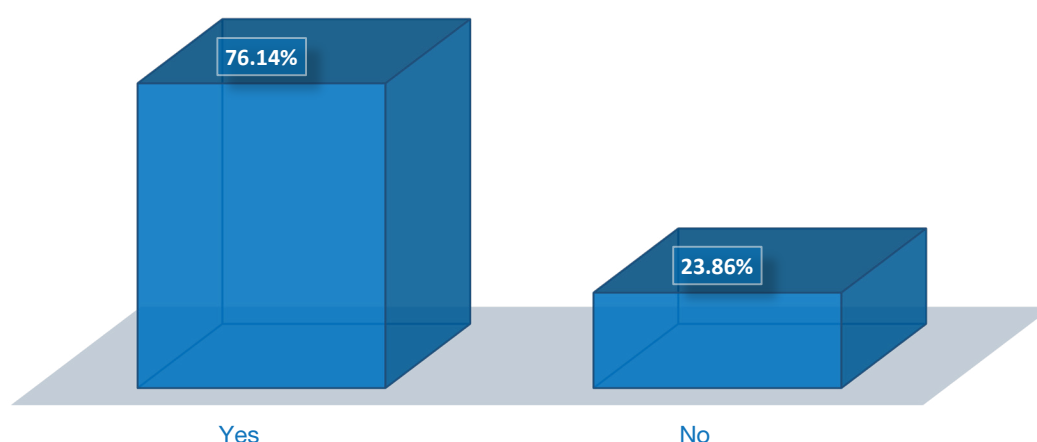
Of 974 responses most participants (38%/n=371) reported that their employer did not provide leave with pay due to exposure COVID-19 and subsequent isolation. **Figure 28** shows the breakdown of participants' reports of employer provision of leave with pay during a COVID-19 isolation period.



**Figure 28:** Does your employer provide leave with pay if you need to isolate due to exposure to COVID-19?

Participants were asked to provide further comments on their response regarding whether their employer provided leave with pay if they needed to isolate. The majority of participants' comments indicated that employers would require staff to use up the balance of their sick leave and personal/recreation leave before any further paid leave would be provided. Many participants reported that even if all other leave entitlements had been used, many employers still did not offer leave with pay. Some participants reported that leave with pay would only be provided if they had been infected at work which was difficult if not impossible to prove especially with COVID-19 circulating in the community during December-January. Other participants reported that leave would only be paid for partial periods of isolation/quarantine or only if a sick certificate could be produced.

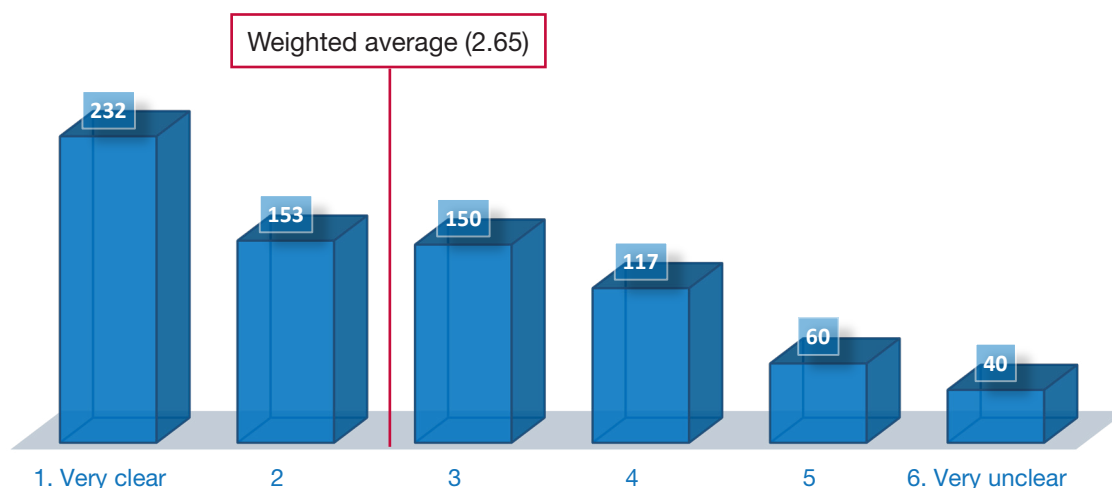
Of 985 responses, most participants (76%/n=750) reported that their employer provided information regarding policies for testing and isolation. **Figure 29** shows the breakdown of participants' reports of employer provision of information regarding policies for testing and isolation.



**Figure 29:** Since 1 December 2021, has your employer provided you with information regarding policies for testing and isolation?



Of 752 responses most participants (31%/n=232) reported that their employer's **information regarding policies for testing and isolation** was 'very clear'. The weighted average of all results was 2.65, indicating that most participants felt that the information was more clear than unclear. **Figure 30** shows the breakdown of **participants' reports of the clarity of employer information regarding policies for testing and isolation**.



**Figure 30:** 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?

Participants were asked to provide further comments on their response regarding their employer's information regarding policies for testing and isolation. While many participants were pleased with the clarity of information and the fact that information was kept up to date and communicated effectively in an individualised manner to staff across multiple channels, many participants who reported that the information was not clear reported that information and policies were often hard to interpret due to frequent changes. Information could be confusing especially for staff working in locations that had not needed to deal with COVID-19 until the Omicron wave. Some participants reported that the information was often changed or updated and that employers would try to use the policies to enforce staff to return to work sooner to manage staff shortages. The following quotes have been chosen to illustrate the responses commonly provided by participants.

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***"The policy has been very changeable. We've gone from having twice weekly asymptomatic PCRs to no formal asymptomatic testing. There was a period where my employer wanted asymptomatic COVID positive people to work due to staff shortages, but collectively we declined to adhere to this, so our management did not ultimately enforce it, and went with the guideline to isolate for a week minimum."***

**Registered nurse, age 29, Victoria**

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***"Written simply, shared in print and recorded video. Relevant information is sent to individuals according to their situation and followed up with phone calls."***

**Registered nurse, age 68, New South Wales**

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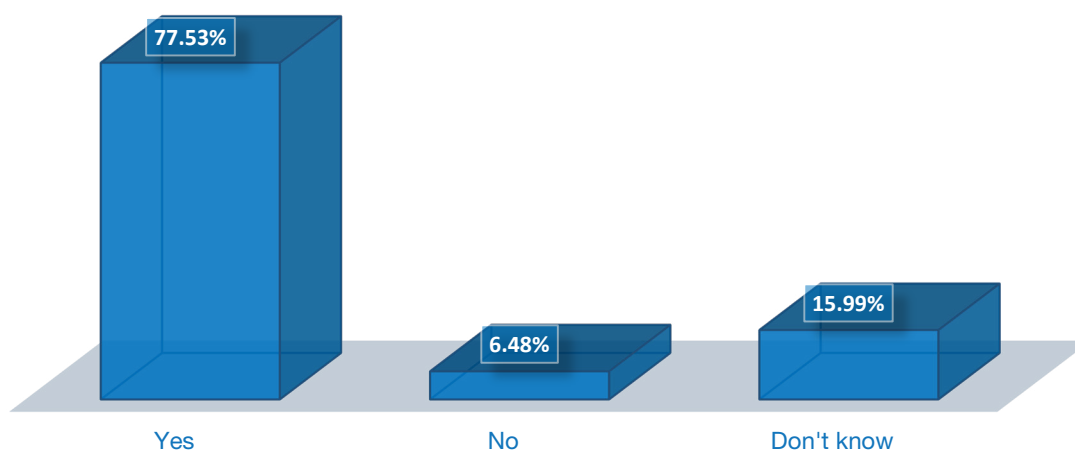
*“I think they are trying their best. We’re a small regional facility with very minimal exposure to covid until recently, so filtering the information to staff about the constant changes is confusing and overwhelming for both sides.”*

Enrolled nurse, age 35, Victoria

## Managing COVID-19 in aged care

59% (n=563) participants reported that their **workplace had experienced a COVID-19 outbreak since December 2021** while 36% (n=345) reported not having experienced an outbreak at work.

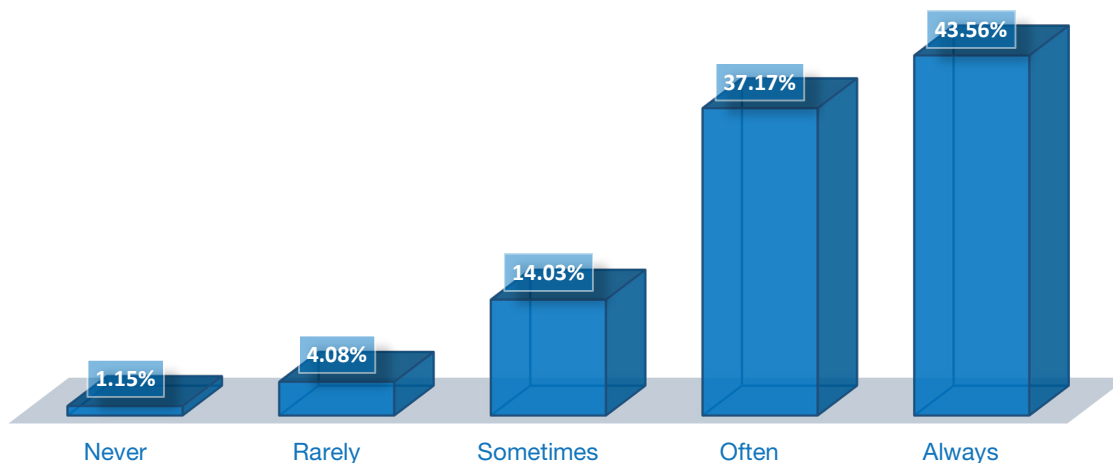
Most participants (78%/742) reported that their workplace had an up-to-date outbreak management plan in place since December 2021. **Figure 31** shows the breakdown of **participants’ reports of workplace outbreak management plans**.



**Figure 31:** Since 1 December 2021, does your workplace have an up-to-date outbreak management plan?

## Personal protective equipment (PPE)

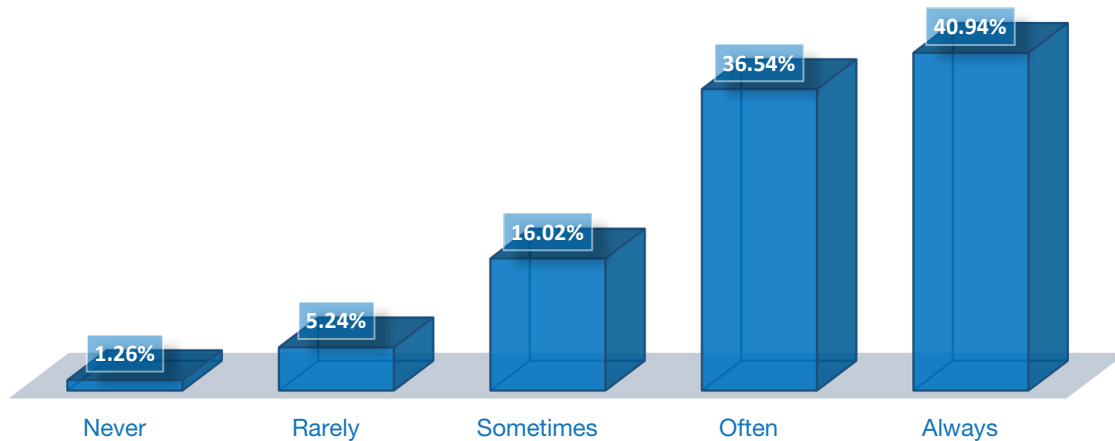
Most participants (44%/n=416) reported that they always typically had enough PPE at their workplace while 5% (n=50) reported never or rarely having enough PPE. **Figure 32** shows the breakdown of **participants’ reports of workplace availability of PPE**.



**Figure 32:** Since 1 December 2021, at your primary workplace, how often do you typically have a sufficient amount of PPE?

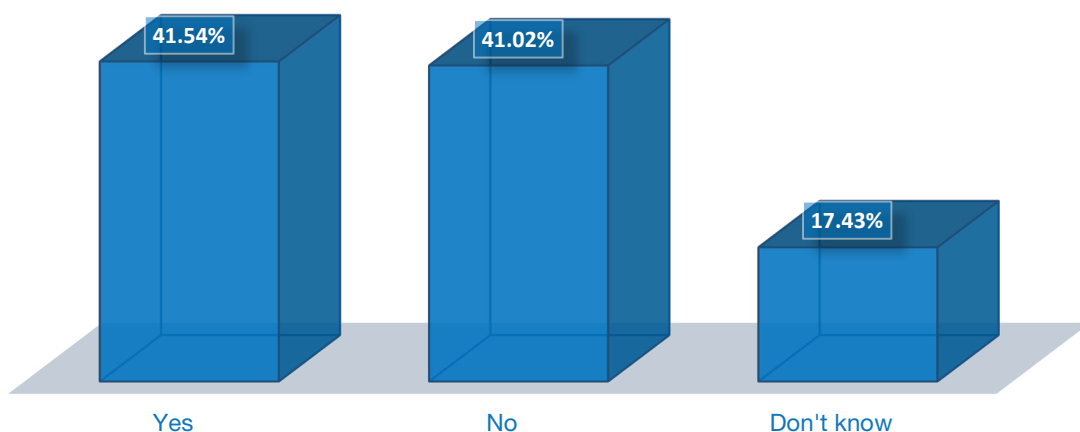


Most participants (41%/391) reported that they always typically had the right types of PPE (e.g., gloves, gowns, masks, respirators) at their workplace. 7% (n=52) of participants reported 'never' or 'rarely' having the right types of PPE. **Figure 33** shows the breakdown of **participants' reports of workplace suitability of PPE**.



**Figure 33:** *Since 1 December 2021, at your primary workplace, how often do you typically have the right types of PPE?*

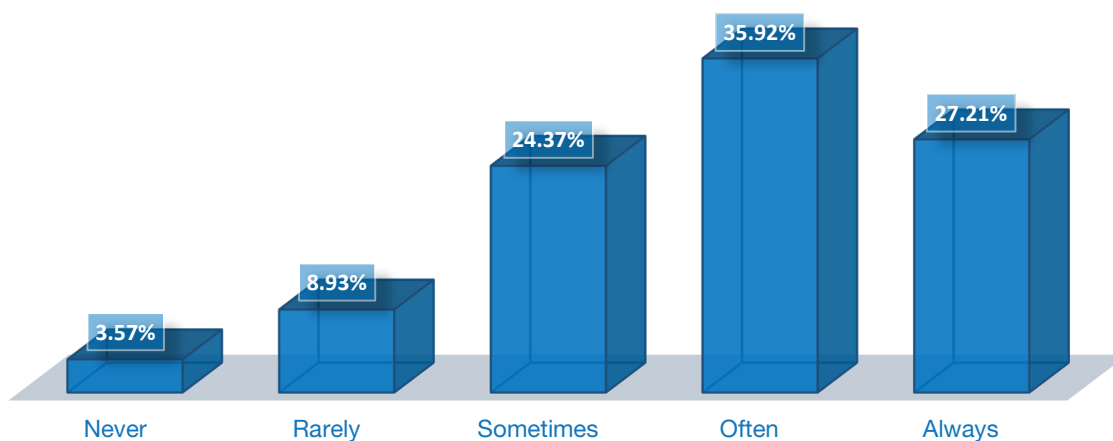
[Australian Government](#) advice includes recommendations that fit testing and checking of respirators should be part of standard PPE use for health and aged care workers.<sup>26</sup> Almost equal numbers of participants reported that their workplace's PPE policy did (42%/n=398) or did not (41%/n=393) include the need for both fit testing and checking. **Figure 34** shows the breakdown of **participants' reports of workplace policy regarding PPE fit testing and checking**.



**Figure 34:** *Does your employer's current PPE policy include the need for both fit testing and fit checking?*

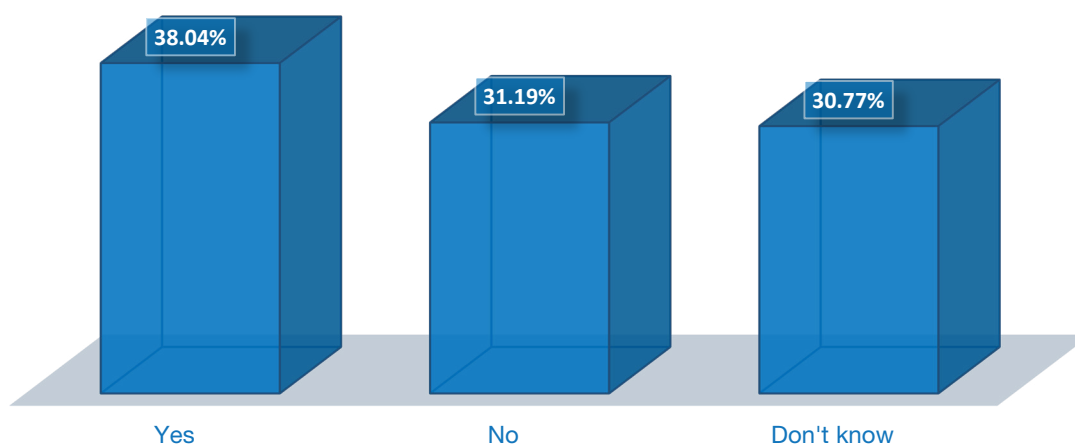


Fit testing and checking are vital to ensure that staff can select the right type and size of respirator that is safe for them to use. Most participants (36%/n=342) reported that their workplace often typically had the right size of PPE. 13% (n=119) of participants reported 'never' or 'rarely' having the right size of PPE and 24% (n=232) reported only sometimes having the right size. Only 27% (n=259) reported always having the right sized PPE. **Figure 35** shows the breakdown of **participants' reports of workplace availability of suitably sized PPE**.



**Figure 35:** 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. Most participants (38%/n=361) reported that their employer had a policy for breaks while working in PPE while 31% (n=296) said their employer did not have a policy. **Figure 36** shows the breakdown of **participants' reports of workplace policies for breaks when working in full PPE**.



**Figure 36:** Since 1 December 2021, does your workplace have a policy for breaks while working in full PPE?



## 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 808 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 indicated that lack of sufficient staff was the most significant challenge that they encountered in dealing with COVID-19. Not only was this issue raised most frequently in the vast majority of responses, but it was also conveyed consistently across by participants from all around Australia very bluntly and directly:

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***“Under staffing” - Care worker, age 36, South Australia***

***“No staff” - Registered nurse, age 55, Western Australia***

***“Staff shortages” - Registered nurse, age 62, New South Wales***

***“Not enough staff” - Enrolled nurse, age 38, Tasmania***

***“Not enough staff” - Registered nurse, age 49, Australian capital Territory***

***“Short staffed” - Enrolled nurse, age 31, South Australia***

***“Short of staff” - Registered nurse, age 33, Northern Territory***

***“Short staffed” - Care worker, age 55, Queensland***

***“Under staffed” - Enrolled nurse, age 43, Victoria***

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Respondents found that with staff being furloughed due to infection with COVID-19 or designation as a close contact, there were no other staff available to fill shifts or cover them. With shifts unable to be covered, respondents then felt pressure from their employer, sometimes via an outwardly stated expectation, to work harder and continue to provide care even when at breaking point.

Respondents demonstrated a significant level of resilience in meeting these challenges with many responses indicating staff were rising to the need by repeatedly working significant amounts of paid and unpaid overtime or double shifts, with minimal or no days off. Respondents did not feel this was fair however, and although they were rising to the challenge, they felt overwhelmed and frustrated, with frequent calls for support and backup which often went unheard. These issues were also exacerbated in rural and regional areas where the availability of support staff was even more limited.



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*“Lack of staff! We have a wonderful team of staff that are trying their absolute hardest. On average we are having 2 people per day testing positive prior to their shift. We have mandatory RAT testing for all entrants to our facility. Our workforce is severely depleted. Our CEO has contacted agencies, the government and local hospitals to source staff and has been told there is no one to help us. Of particular concern is our lack of registered nurses. We have actively tried to source staff, but no one responds. We severely lack senior management and rely on lower level staff to keep the place running. They deserve more support.”*

Enrolled nurse, age 36, Victoria

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*“Management that doesn’t give flexibility or a bit of understanding towards overworked staff, wouldn’t listen to reasons. Getting a sick leave is like having a gun on your head to convince reason.”*

Care worker, age 50, New South Wales

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*“Today’s 29th January 2022. My last day off was 29th December 2021. I have made myself unavailable 31 and 1st. I need to look after me.”*

Registered nurse, age 63, South Australia

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*“Short staffed but high expectations from employer remain putting undue stress on staff”*

Enrolled nurse, 43, Queensland

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*“Staffing - single site rules have impacted plus staff needing to isolate or any potential staff being off awaiting PCR result as we are encouraged to be cautious. Also some staff limited on hours - students, carers for family. Many shifts short staffed as no one else available. Exhaustion - physical, mental & emotional. No chance to take leave as no replacement staff. Often having only 1 day off each week so shifts are better covered - many staff are doing this. Meeting emotional & psychologically needs of elderly residents with limited / no outside contact. We are coping a lot of negative interactions & vocalisation of their despair despite a lot of great effort from our team to make everyday enjoyable and regular family contact facilitated which is very draining & upsetting. Balancing child care with shifts especially public holidays & weekends as my spouse is also in healthcare.”*

Enrolled nurse, age 43, Victoria

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Overall, respondents felt a heavy burden in meeting expectations to work longer hours to cover shifts and continue to provide care to residents they loved and cared about where other staff were unavailable. Around Australia, staff have risen to the challenge but have been left feeling unsupported, with no indication of a reprieve or backup.



## ***Limited PPE and no breaks.***

On top of a lack of staff, respondents also vented frustrations relating to the availability and use of PPE. Respondents reported issues in gaining access to PPE, where a lack of availability, particularly from Commonwealth stockpiles forced many to source supplies from the community. Where PPE was available, respondents commented on frequent rationing by employers, e.g., allocating a single mask per shift, and noted that the PPE that was sourced often did not fit. This resulted in increased risk of infection and sickness. Respondents frequently noted the difficulty in wearing PPE for full shifts, in hot Australian summer conditions, with limited or no breaks due to a lack of staff. Further, infection control requirements dictated the frequent need to don and doff PPE when moving between various areas of the facility – an unavoidable necessity perpetuated by a lack of staff to attend to the needs of residents. The inadequate supply of PPE in combination with hot, long working conditions, and a lack of breaks also saw staff struggling to appropriately use PPE, with respondents noting concern about meeting the requirements of proper infection prevention control procedures that could put them, their residents, and colleagues at risk.

Not the only ones impacted by difficulties associated with PPE, respondents also noted their frustration and hopelessness in attending to the needs of residents who felt isolated and ‘imprisoned’ when unable to see the face of the people caring for them. These feelings were further exacerbated with residents struggling to understand staff wearing PPE because of problems seeing and hearing staff speaking to them. This led to increased distress and stress for both residents and staff.

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***“No surge work force. No access to PPE from Commonwealth when needed had to source from community. RAT-negative staff but have covid without symptoms. Masks should have been mandatory before Xmas”***

**Registered nurse, age 49, New South Wales**

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***“Not enough PPE giving one mask only for an 8-10hr shift have to take off for break and place back on does not meet IC”***

**Registered nurse, New South Wales**

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***“Staff were exhausted wearing full PPE with face shields and N95 mask. Residents were confused and depressed due to lockdown”***

**Registered nurse, age 37, South Australia**

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***Performing 12-18-hour shifts. With no appropriate staff or breaks. PPE got removed once they got clearance from SA HEALTH while some clients are still symptomatic. Not even appropriate size gloves.***

**Registered nurse, age 30, South Australia**

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Overall, responses that reported the availability and use of PPE as a critical challenge depicted an exhausted, demoralised, and resigned workforce that was being forced to work in an occupationally unsafe environment with a clear lack of adequate or appropriate protection for both them and the vulnerable people they care for.





### ***Insecure employment and inadequate pay***

While working longer hours, in increasingly difficult conditions, without appropriate PPE; issues relating to employment and pay were also frequently raised by respondents. Most often these issues related to a lack of adequate pay and financial security perpetuated by isolation and single-worksite requirements. Respondents were fearful and at a loss when describing how they could be expected to pay for bills, food, and care for children when required to isolate at home following a positive COVID-19 result. With no reimbursement from the government or their employers, many respondents stated they had often been required to use annual and long service leave to make ends meet. This of course was not an option for casual employees, many of whom expressed the challenges of working in high-pressure, high-risk environments with no entitlements to paid leave.

Issues relating to pay were not limited to covering the cost of isolation and lack of work following exposure to COVID-19 however, respondents also raised issues relating to their pay in conjunction with the expectation to work longer hours in the absence of other staff. Many participants expressed a sense of disdain and injustice when describing the pressure to work overtime and double shifts, which when worked, were not met with extra or penalty pay. That is; respondents reported working overtime without any penalty rate or other compensation for their increased commitment. This left many feeling unvalued, taken advantage of, and expendable.

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***“Working at single site location was a distinct disadvantage having to use my annual and long service leave. This has nearly been exhausted.”***

**Care worker, age 72, New South Wales**

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***“Being a casual employee, with no entitlements. Then the possibility of having to isolate due to coming into contact with a Covid positive individual, and having to isolate with no financial support.”***

**Enrolled nurse, age 51, South Australia**

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***“Working in a building with COVID and losing my other employment with no compensation for not being able to work both jobs”***

**Enrolled nurse, age 52, South Australia**

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Although rising to meet the challenge and fill staffing gaps by working longer hours under more trying conditions, it was clear that many aged care staff felt that they were not being duly compensated. Responses conveyed feelings of frustration, anxiety, fear, and injustice in the way their increased efforts in providing care had been met and not rewarded or valued.

### ***Poor management and changing health directions***

With ongoing pressure to work harder for longer in the absence of adequate staff, fair reimbursement, or access to appropriate PPE, respondents were also frustrated at having to deal with poor and sometimes inappropriate communication from those in management roles. This poor communication and lack of clear direction was coupled with ongoing uncertainty and challenges of dealing with the changes to directions from government and the threat and experience of repeated lockdowns of both nursing homes and the wider community.



When communication was provided, participants found the guidance provided to be either inconsistent or largely unclear, with constant changes to management of COVID-19 causing confusion in the workplace. Other respondents stated there was either no, or minimal, communication from management, finding they often did not know who had tested positive for COVID-19, and in one case only discovered their facility had gone into lockdown via social media. This confusion and frustration was echoed by others who indicated that with no established means of communication both management and staff were reliant on social media to send and receive facility updates.

Further, with health directions constantly changing, respondents also voiced concerns regarding the reactive nature their management had taken in response to the pandemic. They found that management would either do the minimum, adhering only to mandates, or would take no proactive action and wait for direction from government before implementing safety plans and procedures. Some respondents reported that their facility then failed to adequately execute contingency plans after detection of positive cases, leading to further spread of the virus.

These frustrations however were not all directed at management. Respondents also noted the constantly changing directions and guidance from government and variable support from local health networks as challenges. Several respondents mentioned difficulty in meeting the increased administrative workload of changing reporting requirements and voiced frustration at needing to report the same information across multiple government departments.

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***“We have recently changed the program that we use for work and there is no establish line of communication the current app does not have the ability for staff to send or receive a personal or group message. Work group in Facebook is being used for same but not everyone has it and still lacking since we can’t use it to communicate with our staff appropriately and efficiently it is mostly used by CEO to update us.”***

**Registered nurse, age 34, New South Wales**

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***“No communication, staff weren’t even contacted when facility went into lockdown, read it on Facebook”***

**Care worker, age 51, Queensland**

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***“Not enough protection, employer refused to tell staff regarding the truth of the outbreak. Didn’t tell staff how many staff been confirmed as positive. Often tell us every one will get it, don’t panic.”***

**Registered nurse, age 38, South Australia**

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***“Lack of response from PHU. Working past 10days straight of 12-14hr days. Being management and not provided the financial support for excessive work time during outbreak.”***

**Registered nurse, age 33, New South Wales**

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***“Staffing and keeping up with all of the changes in advice and regulations changes from NSW Health. Changes in reporting criteria is time consuming and NDIS and other government departments need to stop demanding that facilities report to the same information to multiple departments.”***

**Registered nurse, age 54, New South Wales**

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With the rapid pace at which the pandemic situation developed, the sentiment of respondents echoed frustration and disdain towards the constant and unclear changes in guidance which often left them unclear as to how to proceed in their roles. This frustration was not just directed within their work environment but towards health networks and governments.

### ***Concern for residents, colleagues, and family***

Following the challenges associated with understaffing, lack of PPE, inadequate reimbursement, and unclear guidance from management, respondents also felt anxious and concerned for residents and their families, as well as for colleagues, and their own family who they felt were being placed under threat as a result of their exposure to the high COVID-19 risk environment.

Respondents expressed their sadness when seeing the health and wellbeing of residents being impacted by ongoing lockdowns, inability to see family and friends, and difficulties in communicating with carers wearing PPE. Respondents also noted it was not just the residents who were struggling but also families as well, whose frustration in not being able to visit was vented through verbal abusive directed towards staff.

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***“Watching people die from loneliness”***

**Care worker, age 58, Victoria**

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***“No extra staff rostered on, expectation to cover the workload of others without increased pay or even acknowledgment. Working like this means I get verbally abused frequently from clients and families who think I’m doing this on purpose to make things harder for them. It’s very stressful and upsetting.”***

**Registered nurse, age 38, Victoria**

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Respondents did not feel it was only their efforts which were above and beyond, many comments stated the effort of their co-workers noting that all were working hard to protect everyone, but also found that in the face of constant challenges teamwork in some regards had broken down. Respondents also feel anxious when returning home. Respondents were concerned that contracting the virus was inevitable and that after being exposed at work, there was a significant risk they would pass it onto family members.

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***“Management changing rules and processes with no communication. Staff working double shifts. Management taking credit for all the great things we are doing to make the facility safe. Staff taking abusive phone calls from families.”***

**Enrolled nurse, age 52, New South Wales**

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***“I am at risk and hubby is immunocompromised. I have informed my employer but I am still required to attend covid positive client. At this point I am on stress leave. I do not want to return to my career”***

**Enrolled nurse, age 45, South Australia**

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***“The stress of expecting to become infected and spread to my grandchildren”***

**Care worker, age 58, New South Wales**

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Workers in aged care have risen to the challenges that the pandemic has presented with them, however in meeting this challenge they have been met with a lack of support and leadership, undue abuse, forced into compromising situations, and feel a sadness that in working hard the people they are caring for are still being left behind.

## **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. 746 participants provided a response. 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 six themes were developed and presented below with illustrative quotes from participants.

### ***No hope in aged care***

While many participants proposed two or more solutions, a large number of others expressed a sense of hopelessness and dejection, commenting that nothing could be done or that they simply did not know what could fix the crises they have experienced while working in aged care. While most of these sorts of responses consisted of one or a few words (“nothing”, “no idea”, “not much”) others conveyed the feelings of abandonment, helplessness, and vulnerability that appeared to pervade many of the direct participant quotes collected in this study. While other themes below comprised a significantly larger number of findings, the sense of despair so apparent in the findings in this theme pervaded a distressing majority of all responses despite the question asking participants to offer solutions.

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***“Nothing I suggest will make a difference. There is no hope in aged care.”***

**Care worker, age 38, Victoria**

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***“Nothing. NO-ONE seems to listen.”***

**Care worker, age 54, South Australia**

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***“I don’t think it can be fixed. No-one wants to come out and work in the regional areas. Employees rather retire from the health system completely. Or resign and look for other employment not in the health system.”***

**Enrolled nurse, age 66, South Australia**

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***“Too late now. Nothing can be done.”***

**Registered nurse, age 38, Northern Territory**

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It was clear from these types of responses that many participants felt unseen, unvalued, and cast aside to deal with the unfolding pandemic around them. While individually, many of the findings that contributed to this theme contained little to no detail, brought together, they carry a similar sentiment as the title of the Royal Commission’s Interim Report – *Neglect*.

***The lynchpin of reform is: we need more staff NOW!***

An overwhelmingly majority of the responses contained clear recommendations for increasing the number and availability of staff. While many of these responses were stark demands; “we need more staff”, “staffing ratios”, “provide more nurses”, others provided additional 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 simply needing to have a day off. Without a sufficient number of staff, many participants described long hours, double shifts, overtime, burnout, and missing breaks because there were not enough staff to provide safe, effective, dignified care to residents.

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***“In an ideal world, more staff would be great. However aged care was struggling to keep/seek staff even before COVID. The Aged Care Award needs updating, and aged care staff need to be paid the equivalent wages as the acute sector to attract and retain suitable aged care workers. In my opinion employers should provide one more nurse to work in the area or house with COVID-19 cases to prevent spreading it.”***

**Registered nurse, age 54, New South Wales**

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***“There is no incentive for registered nurses and staff in general to work in aged care. We are paid poorly and have no ratios. I have just finished my Bachelor of Nursing and placements on severely understaffed wards were a relaxing break compared to what we are suffering in aged care! I’d be very surprised if I wasn’t the only person graduating that wishes to work in aged care.”***

**Enrolled nurse, age 36, Victoria**

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***“We need a set staffing methodology residential care must abide by to accommodate the true needs of our residents. At least 4 hours per resident per day with [an] increased amount of hours for sick or palliating residents.”***

**Registered nurse, age 51, South Australia**

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***“Instead of employing several new managers full time and only two nurse supports part time, at least employ an Infection Control Nurse who could support us with COVID challenges. Introduction of more breaks in between scheduled tea breaks. Rostering more float staffs in case anyone calls sick to cover or help and support other staff.”***

**Registered nurse, age 59, Victoria**

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***“The realisation that aged care is suffering because there are very limited incentives for people to choose to work in aged care. The government needs to provide incentives for people to choose to work in aged care and support to retain the current aged care workforce. Better coordination of government departments. Some consideration to the amount of work that their demands are placing on a very understaffed work force would be beneficial.”***

**Registered nurse and registered midwife, age 54, New South Wales**

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In many instances, appeals for more staff were made along with recommendations regarding increased pay, better working conditions, improved support, enhanced education and training, and being more highly valued. This highlights that many participants have a strong appreciation of the fact that while improving staffing levels and skills mix is almost universally and utterly necessary to reform aged care, increasing the number of staff is the keystone in a range of actions that must be implemented and sustained to both attract and retain the size and type of workers that are needed. The quotes above each contain reference to solutions grouped together within other themes. Many participants also noted increasing the number of staff would be linked to making the sector more attractive both to new recruits who could be better supported and to retaining existing staff who currently are struggling to cope with extreme workloads.

### ***Improved pay to reward, retain, and attract staff***

The number of responses that contained reference to improved pay was almost as high if not equal to the number that proposed increased staffing as many responses calling for better staffing also noted that better pay was just as vital. As with improved staffing levels, improved pay was linked by many participants to the need to attract and retain staff. These participants highlighted that for many prospective and current staff, the stress and burden of working in aged care was simply not worth the substandard pay that many could receive in comparison to working in healthcare or another industry entirely.

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***“I feel there needs to be better pay, more government support, and funding. We all do this work for the love of our residents, but new nurses or care staff only see the short shifts, working more, and becoming burnt out. This burnout is also affecting management as well. We need to have some surge work force to reduce burnout. Even in a non-COVID world. More support is needed for management from the government and instead of sending in the Commission to audit us, send someone to help us.”***

**Enrolled nurse, age 30, South Australia**

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***“Equal pay across all facets of nursing to help attract/ retain nurses. Address staffing shortages.”***

**Registered Nurse, age 47, South Australia**

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***“Make aged care facilities inviting and pay very well for people to work in aged care. Staff are leaving as they get more pay elsewhere, no or a lot less stress, and their work is appreciated.”***

**Enrolled Nurse, age 59, South Australia**

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Many participants explained that while the pay was inadequate, they remained in the sector caring for older people out of love and a sense of responsibility. Many however stressed that without fair remuneration that would help staff feel valued and that their work was respected and worthwhile, even the extra pay from working double shifts, overtime, and coming in on days off would often not make much of a difference to their take home pay. It was clear from many participants responses that sustained and significant pay increases to equal the acute health sector would be required and that temporary incentives and bonuses neither acknowledge nor repay the workloads and stress many staff are under both during and prior to the pandemic.

### ***Improved leadership and understanding at all levels***

Many participant's responses contained recommendations for better leadership from various levels of management, from improved communication and guidance from direct supervisors in the facility to the need for the Australian Government to provide stronger support and immediate aid to a sector in turmoil. These findings conveyed a sense of abandonment and feelings that managers and executives were dislocated, removed, and above workers and thus did not understand or appreciate the experience and pressure of working in aged care during or even before a pandemic. Debriefing, feedback, and the opportunity for genuine communication and accessibility to managers and leaders was key for many participants. The quotes from participants, as with the other themes, could often be brief, but these contained the essence of many of the longer reports; *"Management telling the truth and being transparent"*, *"management to be better informed and relay information to staff"*, *"Government help as they stating in their email"*, *"More consistency from Government"*.

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***"Sufficient time to ready for potential outbreak, and yet sourcing of supplies was not done. The facility has relied on agency staff for too long without recruitment of regular staff. Now cannot source enough agency."***

**Enrolled nurse, age 53, Queensland**

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***"Review rules. Ask people actually working in these situations what rules work and don't. Bureaucrats and politicians simply don't understand."***

**Registered nurse, age 49, New South Wales**

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***"Management positions, DOC [Director of Care/Facility Manager], clinical coordinators, and clinical nurses need to have people with minimal 5 years clinical experience including hospital experience not just hospital placements in their RN training."***

**Enrolled Nurse, age 68, South Australia**

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***"Some management could come out of their offices and assist staff for more than an hour in the day. It would be more appreciated than being offered a chocolate or drink to say thanks for working short-staffed and being expected to do regular duties."***

**Enrolled Nurse, age 47, South Australia**

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Participant quotes often conveyed the importance of simply being understood, communicated with listened to, and genuinely appreciated by leaders, managers, and government. The importance of managers that had relevant hands-on experience, clinical governance expertise, and that hear and respond effectively to staff when issues are raised was clear in many quotes. Others highlighted the belief that policy makers, bureaucrats, and politicians could not appreciate the crisis unfolding in aged care and that experts with experience and knowledge in health and aged care were needed to guide decision making and effective action in aged care. Issues of a lack of planning, foresight, and preparation were also evident in many quotes that raised the importance of good leadership.

## ***Education and training to provide safe, best practice care***

Many participants said that there was an urgent need for improved education and training of staff in aged care. As with the above themes, this was often raised in tandem with other solutions (i.e., more staff with better training) and the observation that better training and education of staff would be necessary to attract and retain staff in the sector as more highly skilled staff could help support others provide care to residents. Education and training needs were identified by and for staff of all levels, highlighting that registered nurses, enrolled nurses, and personal care workers all need to be of a suitably high skill level and possess sufficient education and qualifications to work in a sector where many residents have complex care needs. Along with the need for education and training, familiarity with residents and care plans was also called for in a several quotes, highlighting that agency staff may not be able to provide the same quality of care to residents due to lack of specific training and knowledge of resident's specific care needs and preferences. Some participants also linked the need for higher levels of skill and training to managers and those in leadership positions who did not have adequate hands-on experience or clinical training and skills.

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***“Good, trained staff. Not trained from paperwork. Hands-on is the main job. It is rare to find staff who have great levels of skill and knowledge in aged care. This is not pushed enough in training before employment. Over the years I’ve seen a massive drop in skills which is scary and becoming unsafe and placing RNs, ENs, and management on sites to be placed in uncomfortable, stressed and fear of losing their registration in the job [sic]. It’s not easy when you have care staff who have poor time management and lazy skills. I’m annoyed for the good care staff who care what they do and have great levels of skills.”***

**Enrolled Nurse, age 59, South Australia**

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***“Train managers to be knowledgeable and be reliable in terms of outbreaks. Have proper, physical training for staff not just let the staff watch from computers. Have the educators and Trainers know what they are doing. Acknowledge, plan, info share, and execute what’s on the Outbreak Plan. STAFF STAFF STAFF STAFF... we need more people on the floor during outbreak.”***

**Care worker, age 41, New South Wales**

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***“Challenge was unprecedented. Much better training by agencies. Some are better than others. Defence force could have been called in a long time ago to help out.”***

**Registered nurse, age 66, South Australia**

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***“Every day is a new challenge. Overall things are fixed as we move along. I believe trained staff that could be deployed (we are a remote community). Someone to answer and run the phones to residents. Training in communication during a lockdown and how we can better speak to each other and operate as a cohesive team. Somewhere to put our wandering residents away from the facility.”***

**Registered nurse, age 49, Western Australia**

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***“Make the industry more attractive to join, also to retain staff. Ensure agency staff are well trained. I often have to train them whilst working on night duty. To be honest I feel sorry for them; It's not their fault they are not trained properly. We must have mandated ratios. We are a 70 bed facility and some nights it's all agency bar 1 regular staff member who knows the residents well and their care plans.”***

**Care worker, age 53, Victoria**

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The need for education and training covered both COVID-19/infection prevention and control related issues and more general needs for skills and expertise that were necessary in aged care prior to the pandemic, especially for agency staff called in to cover absences and furloughed staff. The need for trained and educated staff in regional, rural, and remote areas was also apparent in many quotes. This highlighted as with many of the themes and quotes above, that the pandemic has increased pressure and burden onto a workforce that was already struggling prior to COVID-19 as identified by the Royal Commission and other key reports and inquiries into aged care over the years.

### ***Satisfactory access to required and appropriate resources***

Having ready access to the necessary type and quantity of resources and policies and procedures to provide safe, effective care for residents during the COVID-19 pandemic was put forward by many residents. The need for resources covered access to RAT kits, PPE, and other equipment necessary for ensuring that residents and staff could be safe and protected from the risks of infection. Many participants noted that requirements to source their own RATs or access mass testing sites could have been addressed if better planning and provision of resources via employers had taken place. Ensuring that nursing homes were adequately fitted out and equipped to care for both residents with COVID-19 and those who had not been infected was raised, particularly with regard to residents who have dementia and wander or those who may leave and return to the facility. Many participants highlighted considerable problems sourcing and accessing sufficient PPE of the right kind, required quality, and sizes as well as issues regarding policies not ensuring that fit testing and checking both had to occur.

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***“Planning. When borders opened and Omicron was known to be around, more thought should have been put into staffing and how it has impact hospital and especially aged care. There is very little you can do when an outbreak occurs except hope that it ends soon, that there is enough PPE, that you don't lose residents and that the impact on the staff working though the outbreak isn't too bad.”***

**Registered nurse, age 56, South Australia**

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***“Provide staff with RAT [kits] to do at home rather than sending them to testing sites and await hours and hours to be tested then await days for the results.”***

**Enrolled nurse, age 32, South Australia**

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***“The government need to realise how extremely difficult it is to quarantine/ isolate residents to stop the spread of infection in residential homes whether we are fully staffed or understaffed. We aren’t like hospitals with specific COVID-19 wards and with nurses assigned to only work in that ward for the shift. I don’t think aged care residents should be moved to hospital if they don’t need to be, but we need to be able to send positive residents offsite to be cared for so staff don’t have to care for both positive and negative residents on the one shift. We should be paid an allowance for having to care for covid results as nurses do.”***

**Care worker, age 43, Victoria**

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***“Allow businesses to organise their own vaccinations clinics like they do with the flu, much more efficient. RAT testing kits, ours are still on back order. N95 mask fitting has only just been done, should have been done 2 years ago. Aged care is left behind, yet, we are essential.”***

**Enrolled nurse, age 59, South Australia**

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***“Fit testing and checking for P2 masks for aged care workers looking after COVID-positive resident/s.”***

**Registered nurse, 50, New South Wales**

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***“Provide sufficient staff, right PPE, especially good quality gloves and mask all the time.”***

**Care worker, age 42, South Australia**

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***“Ensure that there is PPE to fit everyone. More comfortable face shields should be made available. Extra pay would make coming to work a little bit easier.”***

**Care worker, age 31, Queensland**

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***“Find a place for all residents [with COVID-19] in one place where they can wander, but are contained so they aren’t infecting staff and other residents.”***

**Care worker, age 56, New South Wales**

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The importance of planning and preparing was evident in many responses. A number of participants noted that they were surprised and disappointed that despite being around two years into the pandemic, their facility or the government had not properly equipped them to work safely and effectively in terms of resources, policies, or staffing. Some participants noted that access to vaccines and boosters could have been improved had nursing homes been able to organise their own.



## Discussion

This report has presented the results of a national survey of 985 nurses and care workers in Australian aged care 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, almost half of all nursing homes were embroiled in the fight against active COVID-19 infections among both residents and staff while the Government endeavoured to promote community-wide vaccines and booster doses for eligible recipients including an [in-reach booster clinic program for nursing homes](#).<sup>19</sup>

As at 16 February, there are around 4,190 active (infected) resident cases of COVID-19 associated with the 987 active outbreaks in nursing homes. Overall, since the beginning of the pandemic there have been 17,002 cases of COVID-19 in nursing homes; around 7% of all nursing home residents. By 16 February 2022, there had been [691 deaths in aged care in 2022](#) from a total of 2,901 outbreaks across 2,033 individual nursing homes.<sup>2</sup> This follows the 685 reported deaths in 2020 and 282 deaths in 2021 – all of which occurred after 1 July. As at 16 February, just over 4% of nursing home residents who have been infected with COVID-19 have died.

With a total of 4,669 deaths in Australia since start of pandemic including 1,658 deaths in aged care, aged care deaths account for 35.5% of all reported deaths from COVID-19. Reflecting the severity of the outbreak over the summer of 2022, the 691 deaths in aged care in 2022 account for 41.6% of all aged care deaths; a percentage that is slowly but consistently rising each day. These 2022 aged care deaths account for 14.8% of Australia's total COVID-19 deaths to date, which is also rising. Overall, this highlights that in the approximately 1.5 months in 2022 (~5% of the pandemic), a disproportionately high number of people in aged care have died.

### Nurses and care workers in aged care

Almost all (90%) participants in this survey were ANMF members with the main participant groups coming from South Australia, New South Wales, and Victoria. Most participants were registered nurses followed by enrolled nurses and care workers. This profile is somewhat inverse to the composition of [Australia's current direct aged care workforce](#) which is mostly made up of almost 16 percent registered nurses, 8 percent enrolled nurses, and 72 percent personal care workers.<sup>4</sup> These workers have been integral to operation of Australia's aged care sector that cares for approximately one million older people. Almost all (91%) participants worked in residential aged care while 9 percent worked in in-home/community care settings.

Our survey participants had an average age of 48 years, which is consistent with previous findings from [Australian workforce censuses](#) but with slightly higher representation of older participants aged 50 and above and lower representation of younger participants aged under 30.<sup>4</sup> Most participants reported working in private not-for-profit aged care followed by private for-profit aged care, and then public/government-owned homes. This is consistent with the [ownership profile of aged care in Australia](#).<sup>13</sup>





## Intention to leave

Intention to leave one's current position or the profession/sector to work elsewhere is a pressing topic in Australian aged care as there are numerous reports over many years highlighting the need to both grow and retain a larger aged care workforce to manage the impact of an aging population.

When considering the results of this 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 and personal care workers are increasingly reporting intention to leave their position or the profession. This poses a significant risk to the health and wellbeing of older people in aged care as well as to the urgently needed reforms that are required to support a safe, effective, high quality aged care sector.

The results of the present study are similar to earlier Australian findings. A [national workforce survey conducted by the Rosemary Bryant AO Research Centre and the ANMF in 2020](#),<sup>27</sup> found that intention to leave one's current position within 12 months was highest in aged care (n= 259/ 20%) in comparison to 21% in the present study. Results regarding intention to leave a current role within one to five years were also similar with 507 participants (39%) reporting intention to leave in 2020 in comparison to around 40% in the present study.

In the 2020 study, intention to leave one's profession for another sector was highest in aged care (n = 141/ 18%) in comparison with the present study's 16% (n=145). In terms of intention to retire, in 2020, 29% (n=226) participants reported an intention to retire while in 2021 only 13% did.

The [2020 Aged Care Workforce Census](#) reported on provider-reported (as opposed to the staff themselves) workforce attrition from 1,329 (49%) of Australia's 2,716 nursing homes and found that 29% (n = 52,588) of all workers at November 2019 had left their job before November 2020.<sup>4</sup> This figure is almost 10% higher than the self-reported intention to leave within 12 months from the two ANMF surveys. Interpreting difference between these findings may be informed by the fact that workers reported as leaving their role in the census who left may have taken up or retained roles at other aged care providers which may be understandable as in 2020, many providers required employees to work at one facility only.

The present study found that personal care workers included the largest percentage (24%) of workers who reported intending to leave their current position within the next 12 months. In contrast, 20% of enrolled nurses planned on leaving, and 19% of registered nurses. From the 2020 census, the largest groups to leave their jobs over this period were registered nurses (n=10,206/ 37%) and nurse practitioners (n=185/ 37%) followed by enrolled nurses (n= 4,200/28%) and personal care workers (n=36,039/ 28%). The difference between these findings may be partially explained through the influence of retrospective data used in the 2020 workforce census in comparison to the self-reported and prospective intentions of participants.





Looking back further, in comparison to the previous [2016 aged care workforce census](#),<sup>27</sup> 10.2 % of workers were actively seeking work. The largest proportion of these people were registered nurses, enrolled nurses, and personal care workers who had been in their current role for 12 months or less. The 2016 report highlighted that a large proportion of workers (43%) – particularly nurses – appear to move jobs within the aged care sector rather than leaving aged care completely (71% of registered nurses and 60% of enrolled nurses). Another finding from the 2016 census report was that around a quarter of aged care workers and a third of nurses planned on leaving the aged care sector within the next five years with retirement being the main reason put forward by nurses and taking up or finishing nursing education and moving into another sector being the most common reason among other workers.<sup>28</sup>

The 2016 report also highlighted that 18% of the aged care workforce intended to leave their current employer after 12 months including 4% intending to leave the sector altogether. This figure of 18% annual attrition has also been referred to in 2021's [Committee for Economic Development of Australia's \(CEDA\) report](#) as the generally acknowledged and research-based assumed aged care sector attrition.<sup>29</sup>

CEDA's report also contains modelling based on reported sector attrition rates and projected workforce requirements that would be needed to meet the [Royal Commission's recommendations regarding increasing the minimum staff time standards for resident care](#).<sup>30</sup> Their report highlights that significant reforms are necessary to find the 17,000 direct care workers per year that will be imperative for meeting the Royal Commission's recommendations. These reforms would need to include reducing sector attrition to 12 percent, increasing the number of workers trained every year, ensuring migrant workers are attracted and retained in aged care, and increasing the attractiveness of the sector to workers from other sectors including especially healthcare and social services. These actions are consistent with the [ANMF's recommendations for sector-wide reform in aged care](#) which explain how the Australian Government must go further than simply meeting the first of the Royal Commission's recommendations regarding staffing minimum time standards and commit to growing and sustaining a workforce of the size and composition that could provide best practice care to every resident.<sup>31</sup>

## 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 aged care staff are accepting of the need to be vaccinated against COVID-19 to protect themselves, their residents, their families, and the wider community. Most participants reported that their experience of accessing vaccines was good to excellent.

Despite this high level of vaccine coverage, as of 16 February there have been 19,067 reported cases in aged care staff with 10,174 cases associated with the current 987 active outbreaks in Australian nursing homes; 4,782 are still active (infected). Fortunately, and accenting the effectiveness and necessity of vaccines, according to government figures there have been no reported deaths of staff members due to COVID-19 to date. This survey found that around 15% of participants had been diagnosed with COVID-19, with 80% 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 aged care due to the Omicron and Delta outbreaks. Around half 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 1 December 2021, which is positive as earlier [Australian national surveys](#) have reported that concern for family members is a source of worry for many health and aged care workers who were found to mainly be isolating/quarantining either with their entire household or in a separate living area.<sup>1</sup> Twenty two percent of participants reported that their employer had a policy that asymptomatic workers can/should return to work before the end of their isolation period, with 11 percent being asked to return to work which would have been challenging for participants who were worried about working with colleagues and residents during a period where they may still have been infectious. Another challenge that would have been experienced by many participants was the fact that most participants (38%) reported that their employer did not provide leave with pay due to exposure COVID-19 and subsequent isolation. 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 three quarters of 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 to very clear.

Due to the risk posed by working while infectious, many aged care 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 just over half of all participants reported solely using employer-provided COVID-19 tests, 17% had not received any tests from an employer and relied solely on mass testing sites or self-purchased kits. This highlights that many aged care 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 was 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.

## Workforce issues in aged care

The survey included many questions regarding issues around current workplace practices and experiences relating to managing care and activities during the COVID-19 pandemic. Despite [Government requirements](#) that every aged care facility must have an [Infection Prevention and Control Lead by 1 December 2020](#),<sup>24, 25</sup> 9% (n=77) of participants reported that their workplace did not have one while 23% (206) did not know if there was an IPC Lead at their workplace. This was a particularly disturbing finding in light of the Omicron outbreak occurring across approximately half of all homes in mid-January.

While 35% of participants indicated that their working hours were 'about right', participants reported a diverse array of work experiences in terms of shift length, rostering, and overtime. Around half of the participants reported working mainly 8-hour shifts and long periods without sufficient breaks. Almost half of all participants (35-40%) reported working double shifts as well as paid and unpaid overtime. These challenging working conditions almost certainly contributed to almost 60% of participants reporting 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, a quarter of participants reported that their employer had asked them to cancel, delay, or return to work from planned leave.



## Managing COVID-19 in aged care

COVID-19 is known to be a greater risk to older people who are often frailer, have more underlying and chronic conditions, and typically more vulnerable immune systems. While 2.6% of people in nursing homes are aged under 65 years these people also have underlying conditions or weakened immune systems. Around [two thirds of women in nursing homes and almost half of men are aged 85 years and older](#).<sup>3</sup> Because nursing home residents are so vulnerable to infectious diseases including COVID-19, infection prevention and control measures including restrictions on visitors, care processes, and protocols to minimise infection risk and care for older people with and without COVID-19 have been in place for much of the pandemic. Almost 80 percent of participants reported that their workplace had an up-to-date outbreak management plan in place since December 2021. The vaccine and booster rollouts have also been a great part of protecting residents against COVID-19, particularly through endeavouring to ensure high vaccine coverage for residents and mandates for vaccinations and more recently boosters among staff.

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 of participants (44%/n=416) reported that they always typically had enough PPE at their workplace and just under 30% reported often having the right type, around 20% 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 unsafe 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, equal numbers of participants reported that their workplace did or did not have a PPE policy that included the need for both fit testing and checking. [Australian Government](#) advice includes recommendations that fit testing and checking of respirators should be part of standard PPE use for health and aged care workers.<sup>26</sup> 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 (36%/n=342) reported that their workplace often typically had the right size of PPE, 13% (n=119) of participants reported 'never' or 'rarely' having the right size of PPE and 24% (n=232) reported only sometimes having the right size. 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. While most participants (38%/n=361) reported that their employer had a policy for breaks while working in PPE while 31% (n=296) said their employer did not have a policy and a similar proportion did not know.



## Workplace challenges

The challenges described by participants revealed a workforce at breaking point, stuck between intense commitment to caring for their residents during a frightening and lonely crisis and feeling crushed under the weight of unrelenting pressure, untenable workloads, and promises of support and relief that rarely if ever eventuated. A lack of staff and agency and surge workforce was repeatedly and overwhelmingly mentioned as the most significant challenge faced by aged care workers when dealing with COVID-19 and was a fundamental contributor to the degree of crisis faced by the sector. This echoes findings of many reports even prior to the COVID-19 pandemic and highlights how little has been done to alleviate pressures on the aged care workforce that have been intensifying for years if not decades.

Despite two years of preparation for the Omicron wave, respondents reported a lack of availability of appropriate PPE, where PPE did not fit and was reportedly rationed by employers. Respondents also found it difficult to adhere to appropriate use of PPE when forced to work long days without adequate breaks, demonstrating the harshness of the working conditions in many nursing homes during the pandemic.

Respondents were fearful when considering how they would support themselves when required to isolate with no reimbursement from government or their employer and felt a sense of injustice and being undervalued when they were not appropriately compensated for working overtime and double shifts. This lack of value often felt by aged care staff also pervades reports throughout and prior to the pandemic.

Clear, frequent, and consistent communication is vital in health and aged care and at no time more importantly than during an outbreak of a severe, infectious disease. Respondents were confused by the poor communication they received from management, which was compounded by the constantly changing guidelines and health directions received from government. Sometimes social media was the only way participants would receive up to date communication about vital information such as outbreaks in their workplace.

Despite the horrifying working conditions and sheer weight of the pressure and stain of working while understaffed and with little support and few resources, nurses and carers were deeply concerned for the wellbeing of residents and their families who were also frightened, lonely, and in pain. Participants however were often met with verbal abuse from families frustrated in adhering to visitation and other restrictions. Respondents were also concerned for the welfare of their colleagues, and their own family whom they felt they were placing at risk highlighting that while many were putting their all into protecting Australia's older and most vulnerable people from COVID-19, these staff are vulnerable themselves, are frightened, and need greater support urgently.



## Solutions to the challenges

While many responses suggested solutions to the challenges they faced, the collective voice of responses indicated that participants felt unseen, unvalued, and cast aside in dealing with the pandemic. Many participants felt a complete lack of hope; while they could articulate challenges and speak of their experiences working under high pressure in frightening, lonely conditions, many found it impossible to imagine any solutions or that any relief would be forthcoming.

Overwhelmingly responses called for increasing the number and availability of staff in aged care. More staff were required to cover shifts when regular workers could not attend due to isolation, sickness, or needing days off. More staff on shift was also called for to meet the increased care demands associated with the pandemic. Along with calls for more staff, respondents also called for improved pay and conditions, suggesting this was also a necessity to attracting and retaining staff in the sector. It was voiced that those who remain in aged care do so for the love and respect of the people they care for, and that the wages and conditions do not justify the risk and pressure of the conditions they are required to work under.

Participant responses also included recommendations for better leadership at various levels of management. Participants demanded improved communication and guidance at the facility level and stronger support and immediate aid from the Australian Government. Responses from participants articulated the importance of being understood, communicated with, listened to and appreciated by leaders, management, and government.

Respondents highlighted the urgent need for improved education and training of especially new staff in aged care, which was often raised alongside other solutions including more staff and better wages and conditions. More educated staff were seen as being able to better support others in providing care and adequate infection prevention control to provide safe, effective care to residents. Participants were also concerned that continuity of care was not able to be provided to residents when agency or surge workforces were called in (if available) who did not know residents' care needs, may not have necessary skills, and who were not familiar with residents.

Many respondents stated a need for ready access to the necessary type and quantity of resources and policies and procedures to provide safe, effective care for residents and expressed shock that two years into a pandemic, many supplies were still hard to source. This included a need for adequate access to RAT kits, PPE, and other equipment necessary to provide adequate care which participants felt they should not need to pay for themselves or spend hours sourcing.

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***“Aged care has become a very difficult industry to work in since COVID-19 has arrived. We have lost so many good nurses due to the massive workloads and staff to resident ratio. A lot of residents that enter aged care facilities have significant complex care needs and are more demanding on an already stretched work force. We need staff to resident ratios changed to help provide the appropriate care our aged care people deserve or I fear that in years to come, no one will want to work in aged care due to the copious, extreme workloads.”***

**Enrolled nurse, age 38, South Australia**

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## Conclusion

It is anticipated that this report will enhance understanding of the impacts of the COVID-19 omicron wave pandemic on aged care workforce of Australia, as well as the demographics, working environments, and experiences of this vital workforce.

The survey's findings revealed a dedicated workforce of nurses and care workers striving under immense pressure to provide safe, dignified care to residents they genuinely love and care for during what can only be described as a crisis. This crisis was not unforeseeable but occurred after around two years of the COVID-19 pandemic and significantly contributed to feelings of being unvalued, unheard, and hopelessness. Many of the experiences and stressors revealed by this study were not new and are consistent with reports from the aged care workforce and ANMF members from previous research during the early months of the COVID-19 pandemic as well as surveys, reviews, and inquiries into aged care that began or even concluded prior to the pandemic beginning. This highlights the systemic and widespread problems throughout Australia's aged care sector and points to many years of government inattention and inaction to fix a range of well-known, well researched failures.

The Omicron wave is steadily becoming the most damaging and fatal onslaught on aged care of the COVID-19 pandemic to date, with almost half of all COVID-19 deaths occurring in the almost three months since the start of December 2021. This survey revealed that during this time, it is likely that the high vaccination and booster rate among aged care staff has provided many protections despite rising infections among workers during this time.

While Australia is entering its third year of the pandemic, policies and processes regarding management of COVID-19 in aged care 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 residents and keep themselves, families, and colleagues safe.

This survey reveals a workforce under immense pressure and strain compounded by feelings that their ongoing struggle is going unheard and unappreciated by those in power. With many of the recommendations of the Royal Commission yet to be implemented or not even planned, many participants would rather leave the sector than continue to suffer.

It is vital that employers and government work to prioritise the safety and wellbeing of the aged care workforce 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, engaging in genuine dialogue, and working to prioritise their safety and wellbeing. It is hoped that the results of this study will provide the data to support improved policies and practices and enable organisations to advocate for real change in aged care.





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