



Australian  
Nursing &  
Midwifery  
Federation

# **National COVID-19 in Aged Care Survey - Final Report**



**June 2020**



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

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## Key Messages

- The majority of the 1,513 participants were from New South Wales, Queensland, and Victoria, were AIN/PCWs, women, and worked part-time.
- 23 participants reported having a COVID-19 case in their workplace and 76 were not sure.
- Most participants who reported a COVID-19 case in the workplace felt that it was handled adequately.
- Almost half (43%) of all participants did not feel prepared for a COVID-19 outbreak in their workplace; 19 percent were not sure. These results were similar by sector and employment classification. Lack of PPE, information, support from employers, and sufficient staffing appeared to be critical issues.
- Just over a quarter (28%) of participants reported their employer had not provided them with a reviewed or updated plan regarding COVID-19 or were not sure. These results were similar by sector and employment classification. Some participants reported that plans and information were not always of suitable quality or were not implemented well by the employer.
- Almost half (46%) of participants reported not having adequate supplies of PPE. A quarter of participants (25%) were not sure. These results were similar by sector and employment classification. Access to supplies of appropriate PPE was a major concern for many participants who reported a range of difficulties in stocking and support for using PPE.
- A quarter (25%) of participants reported not receiving recent information or training regarding correct use of PPE or were not sure if they had received it. Information and training was often described as being insufficient, unclear, inconsistent or not helpful.
- Almost 30 percent of participants reported that their facility had not undertaken or provided infection control education as part of meeting the aged care quality standards or did not know. These results were similar by sector and employment classification. While infection control procedures were positively regarded by some participants, inconsistent implementation and lack of PPE interfered with application.
- Almost 80 percent of participants reported that their employer had recently updated infection control procedures for staff. These results were similar by sector and employment classification. Participants commonly reported screening practices but also that some employers did not support staff to take sick leave even when unwell.
- Almost 90 percent of participants reported that their employer had recently updated infection control procedures for visitors. These results were similar by sector and employment classification. Lock downs were the most commonly reported approach as well as screening for visitors. Some respondents reported that this was inconsistent and poorly implemented.
- Over three quarters of participants (76%) reported that staffing of nursing and care staff had not increased for dealing with COVID-19. Eight percent did not know. Low staffing levels were reported to predate the COVID-19 outbreak and led to unreasonable workloads and expectations on staff.



- Almost half of the participants who reported staff increases were not sure (22%) or did not think that the increase would be sufficient to meet resident/client needs (22%). Some participants reported that new hires had been made but that the new staff had not started work. Others noted that they would still be understaffed.
- Sixty four percent of participants reported staff cuts since the beginning of March and 18 percent were not sure if staff cuts had occurred. Staffing cuts were reported to often impact casual workers who were forced to choose between employers as they would only be able to work at one. Agency staff were also reported to be particularly impacted by cuts.
- Participants in for-profit providers included the largest proportion (19%) of participants who reported staff cuts in residential aged care. Participants reported that the prioritisation of profits over residents and staff led to lack of support and focus on staffing and care.
- Almost 60 percent of participants reported that kitchen, cleaning, and other staff had not been increased or were unsure (17%). Participants in for-profit providers included the largest proportion (22%) of participants who reported no increase. Participants reported having to take on cleaning and kitchen tasks that they did not used to have to do.
- Just over 80 percent of participants reported having a registered nurse rostered on all shifts. These results were similar by sector and employment classification. Many participants reported that while nurses may be rostered on, if they did not come into work or called in sick they would not be replaced. Participants also reported that having only one RN was often not enough for the number of residents.
- Over half of all participants (53%) were willing to take on additional hours or shifts during the COVID-19 outbreak. Participants reported a willingness to work but many reported that the hours/shifts were not being made available.
- Almost half of all participants (42%) reported that their employer had not made arrangements regarding special COVID-19 leave, 30 percent were unsure. The largest groups reporting lack of arrangements were for-profit aged care (46%) and not for profit (45%). Participants often reported that they would be required by their employer to take sick leave, annual leave, or leave without pay if they needed to self-isolate.
- Just over 80 percent of participants reported that their employer had not discussed the aged care worker retention bonus with them. Many participants reported that they were not aware of the funding details or what it could be used for.
- Just over 90 percent of participants reported that their employer had not discussed how they were spending funding from the government with them. Some participants reported that their employer would not spend this on staffing or did not discuss such funding matters with them.





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## Executive Summary

### Background

The SARS-CoV-2 virus was declared a pandemic by the World Health Organization (WHO) on 30 January 2020, five days after the first cases were reported in Australia.<sup>1</sup> Those most at-risk of infection are people in close, regular, and/or prolonged contact with others carrying the SARS-CoV-2 virus. Available national and international figures indicate that hospitalisations, intensive care unit admissions, and deaths associated with COVID-19 are significantly higher amongst older people especially those with pre-existing medical conditions which account for a large proportion of older people – particularly those receiving care in social and residential care settings.

For older people, even what would be a mild infection such as a cold or common influenza for a younger and/or healthier person can be serious and life-threatening. The close proximity of people in residential aged care and need for staff to provide care for multiple people often in the context of relatively low numbers and skills mix of staff also increases their risk of infection and harm. Additionally, depletion of the number of more highly qualified staff in aged care (e.g. registered and enrolled nurses) as well as often less than optimal interfaces with the healthcare sector (e.g. general practice, primary care, and tertiary hospitals) may mean that infection control and response in aged care could be lacking.

There is currently no vaccination nor a specific treatment for COVID-19, so infection prevention and control are currently our first and only line of defence against the virus.

As of the fourth of June,<sup>2</sup> there have been 7,229 cases of COVID-19 recorded in Australia, 102 COVID-19 related deaths, and 6,640 recovered cases. Five people were in intensive care units and 25 in hospital. In Australia, there have been 67 people in residential aged care with confirmed COVID-19 infection, 36 of whom have recovered and 27 who have died. In in-home aged care, 31 confirmed cases have occurred with 27 recoveries and three deaths. More than a quarter of all COVID-19 related deaths in Australia occurred in residential aged care.

### Methods

The survey was developed by senior members of the ANMF Federal Office staff to be focussed on selected issues facing staff working in Australia's aged care sector. The survey was open to participation between the 15th of April and the 6th of May 2020. Descriptive statistics were used to analyse and present the results in tabular and diagrammatic form together with narrative descriptions of results. Simple qualitative analysis of the comments provided by participants was conducted in relation to several of the questions.



## Results

One thousand nine hundred and eighty-one individuals began the survey. Some participants were excluded (468) as they worked in public or private hospitals, were retired, or responded to demographic questions only and answered no additional questions. Of the included participants 1,513 individuals responded to at least one survey question beyond the demographic data. Of these, 893 (59%) were ANMF members. Participants worked in every state and territory with the greatest numbers from New South Wales, Victoria, Queensland, and South Australia. Staff of private, not-for-profit residential aged care facilities (RACFs) represented the largest group followed by private for-profit, and public/government staff. Aged care workers (AIN/PCWs) made up the largest group followed by registered nurses and enrolled nurses. A number of other staff also participated and listed their job classification under 'other'.

The typical respondent appeared to be an AIN/PCW, EN or RN, female, aged between 35 and 64, working part-time in a nursing home and located in one of the Eastern states. Whilst slightly biased towards aged care workers from NSW, VIC, and QLD, this demographic can otherwise be considered representative of healthcare workers within the aged care sector.

Only 23 individuals reported a positive diagnosis of COVID-19 in their workplace, 76 others were not sure. Of the 23 participants who reported positive diagnoses, 14 said that the employer's handling had been adequate, five said it was not adequate, and four were not sure. Some participants provided comments on problems regarding how suspected and confirmed COVID-19 cases were being handled by their employer.

### *Planning, preparation, and management*

Of those who responded to questions in regard to planning, preparation, and management in the face of COVID-19, just under half (43%) did not feel prepared for an outbreak of COVID-19 at their workplace and a fifth (20%) suggested their employers had not provided them with a reviewed or updated COVID-19 plan. While there were some positive comments highlighting that some staff felt well prepared and supported by their employer to manage an outbreak with extra training and clear, regular communication, the vast majority of comments focussed upon specific concerns that may be linked to feeling unprepared for an outbreak. While some respondents provided positive comments regarding their employer's provision of plans around COVID-19, most respondents remarked on the lack of sufficient planning and communication with staff. These comments often noted that communication was either absent, infrequent, or uninformative. Even where participants reported the existence of suitable planning, other factors limited their confidence in the plans being effective including poor implementation or lack of consistency in contents or application.

### *Personal protective equipment*

Potentially contributing to concerns of preparedness was an apparent lack of PPE. Of those who responded to PPE questions, nearly half (46%) suggested they did not have access to adequate supplies of PPE and approximately one in five (21%) suggested they had not received recent information or training on how to appropriately use PPE. Issues regarding PPE was one of the most frequently cited concerns by participants throughout the survey. These concerns included worries about supply, accessibility, and suitability of equipment, management preventing access, and lack of sufficient education and training regarding PPE and infection control.



While only a small number of participants who reported having enough appropriate PPE provided comments, most of these comments indicated that while sufficient supply had been achieved this had either only just occurred, or may only be temporary. While PPE training was commonly provided across aged care settings, the quality, detail/ comprehensiveness, accessibility, and applicability for staff was often found to be quite limited.

### *Infection control and staffing*

Responses from those who had answered questions in regard to infection control and staffing suggested aged care providers had generally provided infection control education in line with requirements of the Aged Care Quality Standards (71%), as well as updated or implemented infection control procedures for both staff (79%) and visitors (86%). Many participants reported in their comments that infection control information and education had only been provided online, or not in a way that supported staff to learn effectively. Some participants expressed concerns regarding the quality, usefulness, consistency, and application/implementation of infection control resources and information. While most participants reported that lockdowns had occurred to restrict visitor access to nursing homes as a means of preventing potential infection, many noted that there were delays, inconsistencies, and confusion regarding implementation and that these lockdowns resulted in greater distress for residents and higher workloads for staff.

An apparent lack of willingness to support the implementation of these infection control measures was exhibited, however where three of every four respondents (76%) suggested there had been no increase to nursing and care staff, and over half (58%) suggested there had been no increase to kitchen, cleaning or other staff. Nearly a fifth of respondents (19%) indicated their facility had in fact made cuts to staff hours in response to the COVID-19 outbreak. Comments regarding staffing highlighted the immense workloads faced by many participants often within the context of poor staffing levels and skills mix which often appeared to be a general and pre-existing feature of many nursing homes – particularly where employers had reduced staffing even further. Unpaid overtime and high expectations from providers were frequently noted, with many participants left feeling unrecognised and unsupported by their employer. Some participants did however note that staffing had been increased (16%) which led to more positive appraisals of preparedness and ability of the staff to provide safe quality care in the context of the pandemic. In some instances, staffing had been increased but not enough to guarantee quality care or workers had been hired but not yet deployed (22%). Some participants also reported that staff cuts had been made during the COVID-19 outbreak (19%) and focussed on the significant impact that the pandemic has had on casual workers who have had shifts cut or been required by provider policy to choose one workplace only. Others highlighted problems with not replacing staff who resigned or cannot come to work due to sickness. While the majority of participants reported that an RN was rostered on for every shift (83%), this may not always be described to be adequate. Many participants noted that while an RN may be rostered on, it was often still only one RN responsible for a large number of residents and other staff members, particularly overnight. Many participants also noted that while an RN may be rostered on for every shift, often if that nurse could not come to work (e.g. sick) they would not be replaced.





### *Staff leave, work hours, and funding*

In support of aged care, residents, and their employers, over half (53%) of those who provided a response to questions of leave, hours, and funding subsidies indicated they were ready and willing to take on additional work hours/shifts in response to COVID-19. Notably this response was consistent across all roles and was inclusive of those of those already working full-time. Many participants reported that they were already working additional hours, while others reported that while they would be willing to work, they didn't believe that their employer would make more shifts/hours available. A number of participants felt responsible for working additional shifts and cited wanting to provide care for their residents and support for their overworked colleagues.

Employers however did not appear to extend similar supports to their workers, as nearly three quarters indicated their employer either had no arrangements in place for additional or special leave in the event a worker was required to self-isolate (42%) or they were unsure of any arrangement (30%). While some participants noted that they would be able to access paid special leave, many participants commented on their employers requiring them to take annual leave, sick leave, long service leave, or unpaid leave if they became ill or were suspected of having COVID-19.

Four in five respondents (81%) indicated their employer had not discussed the Federal Government's aged care worker retention bonus with them, and most respondents (92%) indicated their employer had not discussed how they were spending funding received from the Federal Government in response to COVID-19.

### *Overall comments regarding the COVID-19 outbreak*

Five hundred and sixty-eight participants provided comments when asked the final open-ended question of the survey "do you have any other comments?". This question allowed participants to provide comments about anything they wished. The main themes derived from these comments were:

- Proactive, regular, and informative communication with staff supports safety and wellbeing of staff and residents.
- Staff feel undervalued and unrecognised – especially AIN/PCWs
- Lack of planning and policy, slow and inconsistent uptake of precautions
- Doing our best in a changing environment
- Ongoing lack of sufficient staffing, staff cuts compounding existing problems
- Lack of PPE, inconsistent information and messaging, inability to access or use existing PPE
- Significantly increased workloads
- Concern for the residents' wellbeing



## Conclusion

*“I care a lot about my residents. It pains me knowing there is not enough staff to efficiently care for them, so I step up when need be.”*

As of the 4th of June 2020, it appears the peak of the COVID-19 pandemic has passed.<sup>2</sup> Due to the generally effective and efficient action and preparation on the part of governments, healthcare providers, the community, and some aged care providers the potential for an unmanageable surge of patients with COVID-19 has thankfully been avoided to date. This does not diminish the loss and sadness felt by those who have lost loved ones and family members to the outbreak. For the families, friends, and health and aged care staff of the 102 individuals who have died – many of whom who were vulnerable older Australians – the scale and scope of protections and preparations were sadly not enough. At a population level, Australia, its healthcare and aged care system, and the patients, residents, and clients who are cared for there have largely been spared. This is in stark contrast to several other nations, many of which are large well-developed economies like our own.

*“I am passionate about what I do. if the time comes and those residents need me, I would happily to do so.”*

The lessons we can learn from the ongoing COVID-19 pandemic and outbreak in Australia are valuable and should be carefully considered and reflected upon by decision-makers across government, health, and aged care. Many have known for decades of the potential for a global pandemic and how this might impact health and aged care and while previous warnings tended to focus on the threat of viral influenza and other diseases such as Ebola, COVID-19 did follow similar transmission pathways to viral influenza and could be argued to have had a similar impact to a highly contagious and virulent strain.

*“We have done a huge amount of work to try and prevent COVID-19 entering our facility, but if it does, we will have extreme difficulty managing care.”*

While this report cannot directly compare the response in health and aged care, what we have found is that many of the conditions, brought to the attention of the public prior to the pandemic through the Royal Commission into Aged Care Quality and Safety and other studies, have persisted.<sup>3,4</sup> Australia's aged care sector is indisputably understaffed and the workers who are there are in many cases doing the best they can with little support, few resources, and limited recognition by providers and more broadly within the public domain. While only isolated outbreaks of COVID-19 appear to have occurred in residential aged care, and further more specific evidence and inquiry is needed to examine these instances further, a number of issues are clear:

- Many aged care providers need to increase their staffing levels and skills mix to deliver safe quality care for vulnerable residents and clients.
- Higher levels of staffing and better skills mix with greater numbers of registered nurses and enrolled nurses would provide better infection control and health care as well as greater support to nurses, care workers, and other staff.
- Workloads in aged care are often unmanageable and were intensified by the COVID-19 pandemic across the sector.
- Many aged care providers were prepared for an outbreak, but many were also unprepared. High quality communication, information, resources, education, and training, and safe staffing levels all appear to be critical features of better preparedness.



- Personal protective equipment was a major concern for many staff. There needs to be greater investment and preparation to ensure adequate supply, stocks, training, and information regarding use.
- Infection control policies and procedures could be improved and implemented better across many areas in aged care in a consistent and evidence-based manner.
- Staffing levels and responsibilities of auxiliary staff (e.g. cooking, cleaning, and other staff) are vital and may require further examination regarding how these roles contribute to aged care's ability to respond to infectious disease outbreaks.
- Aged care providers may not utilise funding to support the delivery of safe and quality care for residents as use of funding to ensure an adequately sized, appropriately supported workforce appears to be limited.
- Registered nurses may be rostered on but this appears to occur in such low numbers that they may not be present on every shift or able to do their jobs effectively.
- Aged care workers feel undervalued and unrecognised for the important work they do to care for residents.
- Many aged care staff were willing to work extra hours or shifts during the COVID-19 outbreak but this willingness to work does not appear to have been taken up by employers.
- Many providers did not provide special leave for staff who may have needed to self-isolate due to potential COVID-19 infection.

The results of this survey, as well as the overall low number of cases and deaths in the Australian aged care sector, highlight the clear willingness and commitment held by aged care staff towards the protection and safety of those in their care. The hardworking people who go to work - often with little recognition and little reward, even during a global pandemic which has placed them, their loved ones, and their jobs at risk, should be thanked and recognised for their passion and dedication to caring for Australia's most vulnerable population. In contrast to the impact felt by many other nations globally, COVID-19 has so far been contained across most of Australia and this is in no small part due to the integrity and professional conduct of the aged care workers, nurses, doctors, specialists, and staff who have borne the responsibility and risk required in achieving a result of which our nation can truly be proud.

*“Please help Australian aged care show the good work that is being done each and every day. Stop only showing how bad, because when you look at the rest of the world, we did not abandon our posts and leave people to die. We did not have inadequate policies and procedures and measures to allow our residents to suffer.*

*We have provided safety, security, love, and extreme resourcefulness and quality of life in the most difficult of circumstances that we as an industry have ever had to face and we are tired of being seen as substandard and all rogues because we are most certainly not.*

*Our residents matter and we are on the job each and every day to provide the very best love and care to them as we possibly can. Tell that story. Is that newsworthy? I hope yes. Then show the contrasts of the rest of the world. We should be able to hold our heads high and not hang in shame. Thank you.”*



## Background

### *The COVID-19 pandemic and aged care*

COVID-19 (from ‘severe acute respiratory syndrome coronavirus 2’ (or ‘SARS-CoV-2’) is a newly discovered (novel) coronavirus first identified in Wuhan, Hubei province, China in 2019 as the cause of a cluster of pneumonia cases.<sup>5</sup> Coronaviruses are similar to a number of human and animal pathogens including some of those which cause the common cold as well as more serious illnesses including severe acute respiratory syndrome (SARS/ SARS-CoV-1) and Middle East respiratory syndrome (MERS). Since discovery, the SARS-CoV-2 virus has spread to many countries and was declared a pandemic by the World Health Organization (WHO) on 30 January 2020, five days after the first cases were reported in Australia.<sup>1</sup>

Risk of exposure to SARS-CoV-2 and potential infection occurs through close contact with infected people and/or objects, droplet transmission, and contact with surfaces contaminated by droplets containing viable SARS-CoV-2 virus particles. There is ongoing debate regarding the potential for the virus to be transmitted via smaller aerosolised droplets (airborne transmission),<sup>6</sup> but it is currently unknown whether these smaller particles pose an infection risk.<sup>7</sup>

Based on current evidence, those most at-risk of infection are people in close, regular, and/or prolonged contact with others carrying the SARS-CoV-2 virus. While respiratory symptoms increase the risk of transmitting the virus via saliva and mucus expressed by coughing and sneezing – particularly when hand hygiene, proper cough/sneeze etiquette, and environmental cleaning/decontamination is not followed – people not displaying respiratory symptoms may also be infectious and transmit the virus potentially without even knowing they themselves had been infected.<sup>8</sup>

Available national and international figures indicate that hospitalisations, intensive care unit admissions, and deaths associated with COVID-19 are significantly higher amongst older people especially those with pre-existing medical conditions which account for a large proportion of older people – particularly those receiving care in social and residential care settings.

Over 1.3 million people received some form of aged care in the year 2017-18, most receiving home-based care and support, with relatively few living in residential care.<sup>9</sup> Residential aged care provides permanent accommodation and care for around 241,723 people who cannot continue to live at home due to increased care needs as well as short-term/respite accommodation and care for around 61,993 people who (or whose carers) need a break from their normal living arrangements. In 2016-17, almost all (97%) people in either type of residential aged care were aged 65 and over.<sup>10</sup> There are also many Australians who use in-home aged care services in the community with 116,843 people receiving home care packages, 64,491 people receiving support through the Commonwealth-State HACC program in Western Australia, and 783,043 people receiving home support through the Commonwealth Home Support Program.



For older people, even what would be a mild infection such as a cold or common influenza for a younger and/or healthier person can be serious and life-threatening. The close proximity of people in residential aged care and need for staff to provide care for multiple people often in the context of relatively low numbers and skills mix of staff also increases their risk of infection and harm. Additionally, depletion of the number of more highly qualified staff in aged care (e.g. registered and enrolled nurses) as well as often less than optimal interfaces with the healthcare sector (e.g. general practice, primary care, and tertiary hospitals) may mean that infection control and response in aged care could be lacking.

In Australia, hospitalisations and deaths due to influenza are consistently higher amongst older people despite the existence of effective vaccinations and treatments. In the case of COVID-19 however, no such vaccination nor treatments exist, so while vaccination may be an effective intervention for known viral illnesses, for COVID-19, infection prevention and control are currently our first and only line of defence.

In the effort to reduce the spread of disease, infection control measures are of paramount importance and methods such as frequent handwashing and surface disinfection have been consistently and widely recommended throughout the course of the COVID-19 pandemic. Controlling the spread of disease is particularly important in aged care facilities where frequent close contact between carers, residents, and visitors creates many opportunities for disease transmission.

Sadly, where COVID-19 has spread throughout aged care facilities, infection, and casualty rates have been significant. This has been particularly concerning in international settings and some isolated outbreaks in Australia.

As of the fourth of June,<sup>2</sup> there have been 7,229 cases of COVID-19 recorded in Australia, 102 COVID-19 related deaths, and 6,640 recovered cases. Five people were in intensive care units and 25 in hospital. In Australia, there have been 67 people in residential aged care with confirmed COVID-19 infection, 36 of whom have recovered and 27 who have died. In in-home aged care, 31 confirmed cases have occurred with 27 recoveries and three deaths. More than a quarter of all COVID-19 related deaths in Australia occurred in residential aged care.

This survey aimed to gather information from staff working across different settings in the aged care sector in Australia, focusing on preparedness for dealing with the COVID-19 outbreak in their facility/ employer, staffing issues in the context of COVID-19, access to and information/education about PPE, infection control policies and procedures, willingness to work during the COVID-19 pandemic, leave arrangements, and funding.





## Methods

The survey was developed by senior members of the ANMF Federal Office staff to be focussed on selected issues facing staff working in the aged care sector. The survey was open to participation between the 15th of April and the 6th of May 2020. The survey was promoted nationally on the ANMF website, through ANMF social media, direct email promotion to individuals who have signed up to the ANMF aged care campaign list. The State and Territory Branches also promoted the survey through their own social media and various member communications.

Descriptive statistics have been used to analyse and present the results in tabular and diagrammatic form together with narrative descriptions of results. Simple qualitative analysis of the comments provided by participants has been conducted in relation to several of the questions. This involved reading and re-reading the comments to achieve a familiarity with the feedback and then grouping the longer comments with richer more descriptive information (as opposed to answers where only a few words had been provided) into basic categories. Comments were selected for inclusion in the report based on the assessment that they had provided a representative sample of the overall topics, themes, and issues raised by all comments for that particular question.

## Results

Because we sought to report solely on the results reported by people working in aged care sector, some participants ( $n = 468$ ) have been excluded from this report including those who reported working in public or private hospitals, retired participants, and participants who responded to demographic questions only but no additional questions (Figure 1). Because of the way the survey was promoted and disseminated to potential participants it is not possible to determine whether the number of respondents are representative of all of those who could have potentially responded.

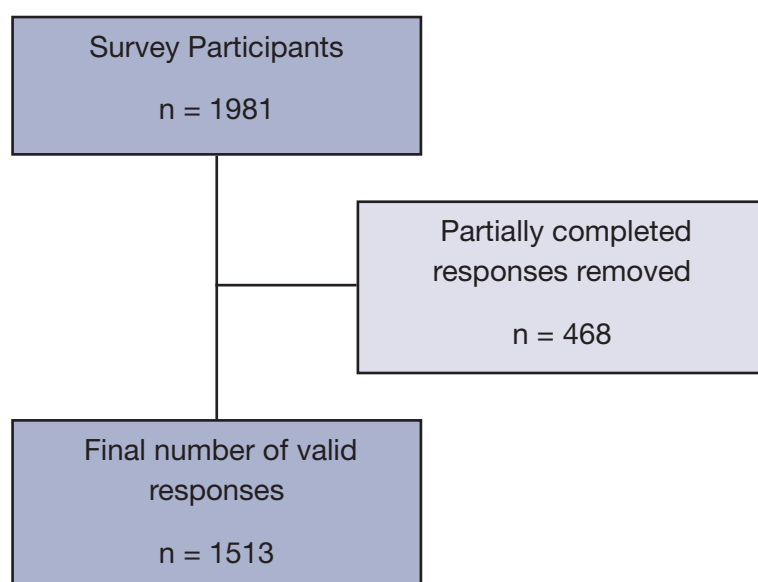


Figure 1: Inclusion/ exclusion of participants



## Participants demographics

Of the included participants 1,513 individuals responded to at least one survey question beyond the demographic data. Of these, 893 (59%) were ANMF members.

Participants worked in every state and territory (Table 1) with the greatest numbers from New South Wales (NSW), Victoria (VIC), Queensland (QLD), and South Australia (SA). One participant did not provide their state/territory. Map 1 shows the number of participants by State and Territory and provides a heat map of the 1,464 participants who provided their postcode.

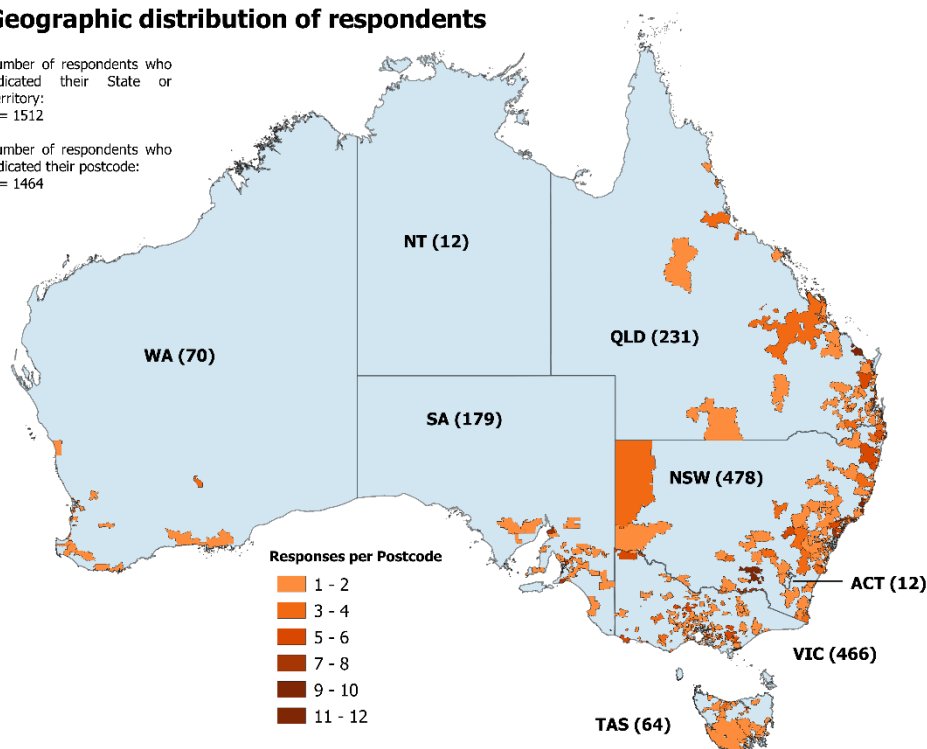
ACT	NSW	NT	QLD	SA	TAS	VIC	WA
12	478	12	231	179	64	466	70

Table 1: Participants by state and territory

### Geographic distribution of respondents

Number of respondents who indicated their State or Territory:  
n = 1512

Number of respondents who indicated their postcode:  
n = 1464



Map 1: Heat map of participants by postcode

Participants worked across a variety of sectors in aged care with 1,504 indicating where they worked (Table 2). Staff of private, not-for-profit residential aged care facilities (RACFs) represented the largest group followed by private for-profit, and public/government staff.

RACF - Public	RACF Private - for-profit	RACF Private - Not-for-profit	In-home care	Multipurpose health facility	Other
171	490	687	84	27	45

Table 2: Participants by employment sector



Forty-five participants reported working in an ‘other’ setting. This group was made up of agency staff (n = 23), participants who were not sure of their sector (n = 17), those working across multiple sectors but not identified as agency (n = 3), and undefined RACFs (n = 2).

Participants represented several job classifications, with 1,508 reporting theirs (Table 3). Aged care workers (referred to in the figures as assistants in nursing (AIN)/ personal care workers (PCW) made up the largest group followed by registered nurses and enrolled nurses. A number of other staff also participated and listed their job classification under ‘other’ including; ‘hotel’ staff (n = 13), allied health/ therapy (n = 9), administration (n = 6), consultant (n = 3), other/unspecified (n = 3), and Aged Care Funding Instrument (ACFI) officer (n = 1).

AIN/PCW	EN	RN	Lifestyle officer	Manager	Other
721	302	396	30	19	40

Table 3: Participants by job classification

Participants aged between 45 and 54 years were the largest participant group of those who provided age and gender information (Figure 2). This was followed by participants aged between 55 and 64. Of the 1,504 participants who reported their age and gender, 1,380 were female and 93 were male. Two participants did not identify as male or female and 29 participants did not report their gender.

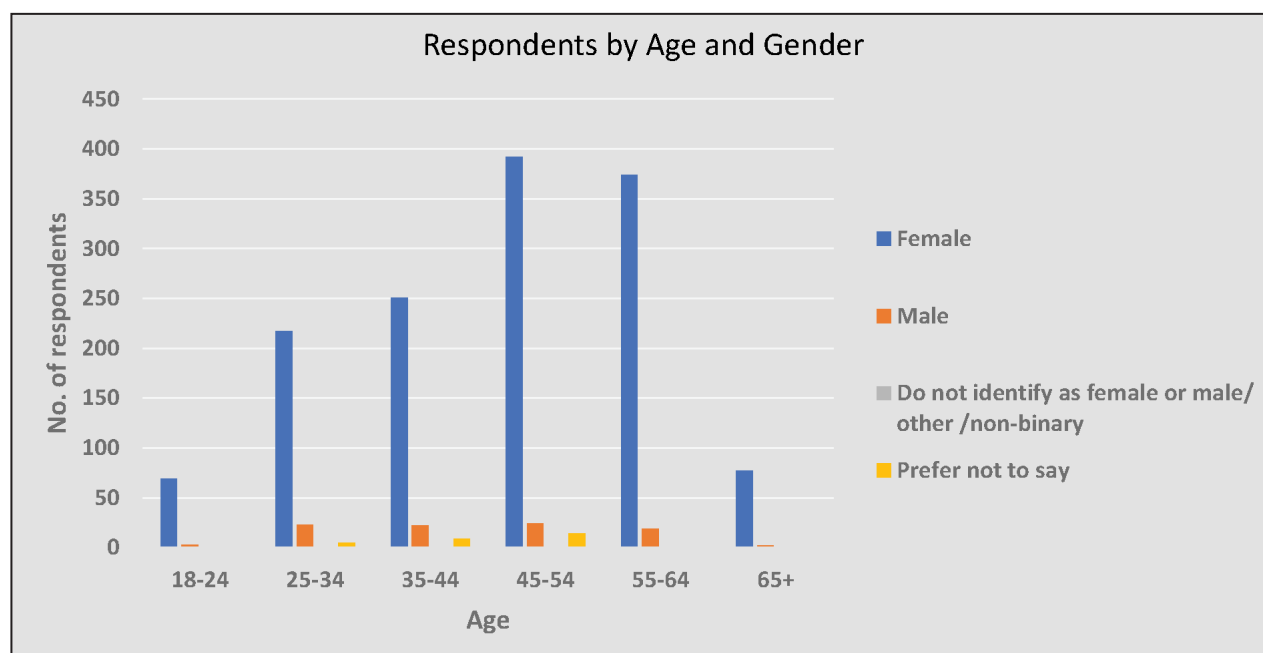


Figure 2: Participants by age and gender



# NATIONAL COVID-19 IN AGED CARE SURVEY - FINAL REPORT

Participants reported their work hours. This is presented by employment sector (Table 4) and job classification (Table 5).

Work Hours	Employment Sector						
		RACF - Public	RACF Private - for-profit	RACF Private – Not-for-profit	In-home care	Multi-purpose health facility	Other
	Full time	32	113	140	15	8	4
	Part time	118	331	476	40	16	16
	Casual	21	40	71	28	3	25
	Other	0	3	0	1	0	0
	Total	171	487	687	84	27	45

Table 4: Participants by work hours and employment sector

Job Classification	Employment Sector						
		RACF - Public	RACF Private - for-profit	RACF Private – Not-for-profit	In-home care	Multi-purpose health facility	Other
	AIN/PCW	68	244	318	63	4	20
	EN	62	80	138	7	7	7
	RN	32	131	186	12	16	16
	Lifestyle Officer	1	18	11	0	0	0
	Manager	2	5	10	1	0	1
	Other	6	11	21	1	0	1
	Total	171	489	684	84	27	45

Table 5: Participants by job classification and employment sector



## COVID-19 related questions

Participants were asked if there had been any residents or clients in their workplace diagnosed with COVID-19. Of the 1,507 participants who responded to this question, only 23 individuals reported a positive diagnosis, 76 individuals were not sure, and 1,408 participants reported that no positive diagnoses had occurred. Of the 23 participants who reported positive diagnoses at their place of work, 14 said that the employer's handling had been adequate, five said it was not adequate, and four were not sure.

Fifty-eight participants provided comments regarding the issue of clients in the workplace with positive COVID-19 diagnoses. Some participants raised issues of uncertainty, especially where residents had passed away following testing but results had not been provided:

*"At the time of survey not yet, however we have had three residents pass away, two not suspected, but a sudden third, not yet confirmed."*

*"A resident passed away and was tested prior to her passing. The test was never sent off."*

Some participant comments highlighted potential problems with how suspected and confirmed infections were being handled by their facility:

*"At [my] facility didn't even contact community workers about outbreak and shut down ... Found out on Facebook ... Just got text message saying someone had it...Grrr."*

*"I have concerns when resident is flagged to be swabbed but no precautions are put in place."*

*"We have had residents with similar symptoms, but they have been reviewed by a GP who refused to test them for it. Nor were those residents isolated for infection control."*

*"There was a resident that had symptoms and was asked to isolate, but she was wandering the corridors consistently because she didn't want to feel like she was in jail. Management allowed this."*

*"Four weeks ago, two residents were in contact with overseas visitors, but management and doctor did not press for them to get them tested. Staff very alarmed. These two residents couldn't understand why everyone else alarmed."*

A number of participants noted concern with accepting new residents despite lockdowns being in place:

*"Meant to be on a lockdown and they accept new residents from Adelaide, where there were a high number of cases of COVID-19."*

*"Not at this time. We have had one tested which came back negative. But we have had new admissions coming in weekly?"*

Some participants noted that staff had been diagnosed but that these individuals had not returned to work. There was also a report of staff coming to work sick due to concerns that their employer would reprimand them and a workplace culture that does not support sick leave:

*"One staff member came to work sick and is in self isolation. She said she was scared to call in sick because the work culture does not encourage sick leave."*





## Preparedness for an outbreak

Participants were asked if they felt prepared for a potential COVID-19 outbreak in their workplace and given the opportunity to provide comments regarding their answer. Two hundred and ninety-nine participants of the 1,502 responding provided comments. Overall, just under half (43%) of participants reported that they did not feel prepared, 19 percent were not sure, and 38% reported feeling prepared (Figure 3).

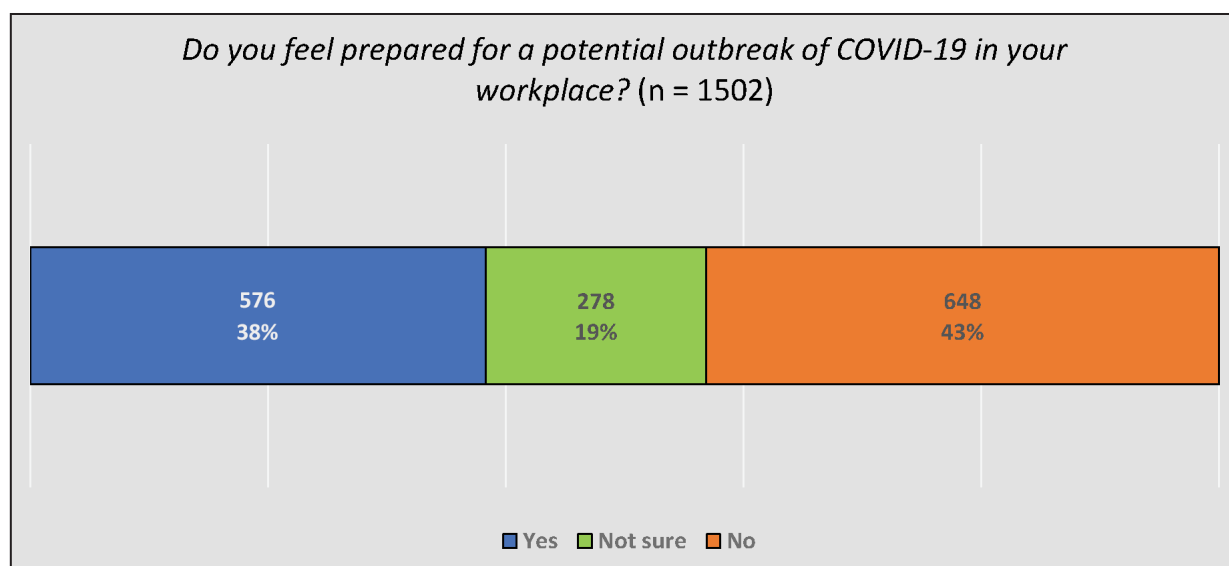


Figure 3: Preparedness for a COVID-19 outbreak (all participants)

By sector (Figure 4), participants working in for-profit facilities accounted for the largest within-sector group who reported that they did not feel prepared (45%) followed by non-for-profit (44%), public (41%), and in-home care (40%). Apart from participants from the small number of participants from 'other' sectors, for-profit and not for profit staff also had the largest proportion of participants (20%) reporting that they were not sure if they felt prepared, and the lowest (35%) proportion of staff who felt prepared.

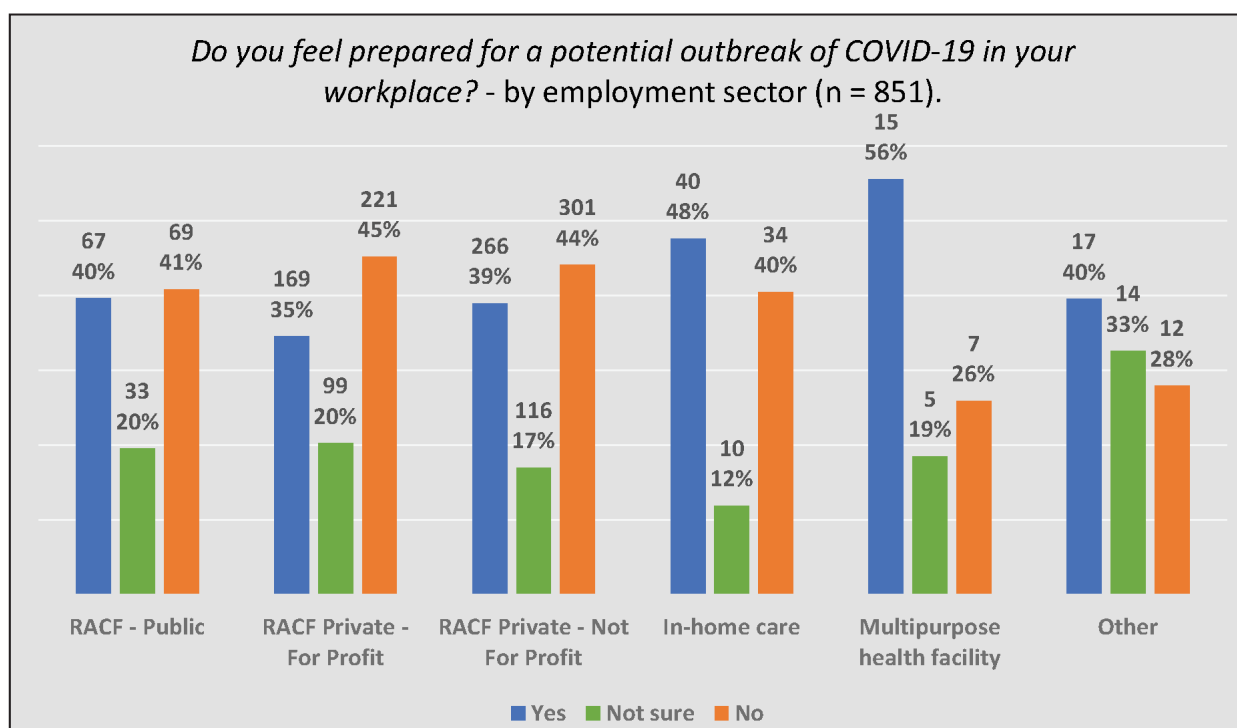


Figure 4: Preparedness for a COVID-19 outbreak by sector



When measuring preparedness by employment classification (Figure 5), people identifying themselves as managers (n = 19) had the largest within-classification group of respondents that felt prepared for an outbreak (68%). Aged care workers, the largest group of participants overall had the largest proportion of members who did not feel prepared (46%) and one of the smallest proportions of members who did feel prepared (35% - equal with the group of ENs who also did not feel prepared). Preparedness between the three largest groups (AIN/PCW, RN, and ENs) did not differ much, however a greater proportion of RNs reported that they felt prepared (40%) than ENs or PCWs (both 36%).

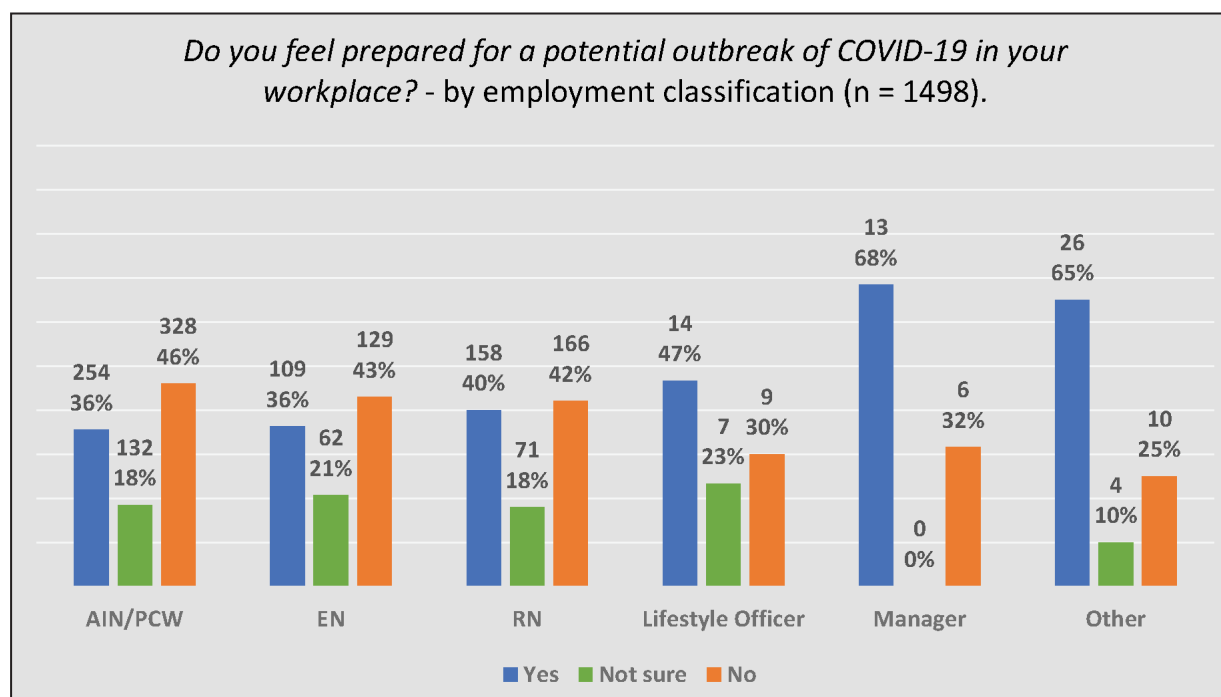


Figure 5: Preparedness for a COVID-19 outbreak by employment classification

## Comments on preparedness for an outbreak

Of the 299 respondents who provided comments on their response, most expressed concern regarding their employer's preparations for a potential COVID-19 outbreak. While there were some positive comments highlighting that some staff felt well prepared and supported by their employer to manage an outbreak should one occur with extra training and clear, regular communication, the vast majority of comments focussed upon specific concerns that may be linked to feeling unprepared for an outbreak:

*"No, we do not have a thorough contingency plan for positive cases of C-19. At our facility, we also have a new manager who does not have any clinical experience, which means that all decision making for infectious control rests solely on the shoulders of our deputy, who was only been in her role for ~12months. I am also concerned that our staff are not properly educated for C-19, our educator has only provided a leaflet in our houses for us to look at and sign when we get the chance. Education that is not compulsory or delivered face-to-face (especially around PPE best practice) increases our risk of transmission within the facility and demonstrates a lack of willingness to ensure all staff are adequately prepared."*

*"We have done a huge amount of work to try and prevent COVID-19 entering our facility, but if it does, we will have extreme difficulty managing care."*



Issues regarding PPE was the most frequently cited concern. This included worry about supply, accessibility, and suitability of supplies, lack of PPE supplies (do not have enough on hand, cannot source more), management preventing access (PPE locked away from staff or staff told not to use) and incorrect/inappropriate PPE. A lack of sufficient education and training regarding infection control and prevention including the use of PPE were also concerns related to preparedness.

*“Management has PPE, but its rationed very strictly, and not appropriately and Infection control is not appropriate as we are told to remove the PPE from the hallway and put it in the residents room, but this is not adhering to infection control at all.”*

*“Nil access to PPE, no extra staff to help with cleaning, even in lock down, residents are still going out into the community.”*

*“Our facility began planning early. However, we were low on PPE at the beginning of the outbreak and it was difficult / expensive to restock.”*

*“Apart from temperature checks, our PPE is locked up. We have had no increase in staffing levels, still suffer short staffing. I work night shift one to 40 residents. We do not have kitchen staff, laundry staff or cleaning staff, you have to do all of this plus look after residents. Now each shift is expected to clean all surfaces on top of what is previously mentioned. So no change at all, just extra work which you struggle to do.”*

*“Working agency, it is obvious there is no strong infection control or infectious disease knowledge, training or implementation of sound practices.”*

*“We have consumers coming from hospital. The management put them in 15 days COVID-19 isolation, but they don’t provide any PPE while attending them. This is really disappointing and stressful to me.”*

Some participants commented on the lack of sufficient staff and skills mix. This has been amplified by staff cuts and avoidance of the use of other staff.

*“We don’t seem to have enough care staff to cover the shifts available, there are agency staff nearly every day.”*

*“Our wondrous GM cut seven clinical registered nurse hours on 30/3/2020”*

*“Very understaffed and facility refused to utilise agency staff to help existing staff who are exhausted.”*

Lack of supplies (e.g. hand sanitiser, soap), inadequate cleaning practices, and inconsistent policy and processes regarding visitor access (e.g. visitors entering despite lockdown) were cited by many:

*“The DOC of the facility is letting certain family members come into the facility while we are meant to be on full lockdown with no visitors. The DOC picks and chooses what family members can come in. A family member was granted access to come into the facility for a resident’s birthday which resulted in one of the front receptionist being screamed and yelled at as she had told the family member she was not allowed to come into the facility. The DOC saw the family member yelling and screaming at the front receptionist and did not intervene throughout the matter. The DOC and our quality care officer are bending the lock down rules when they see fit.”*



*“Nil alcohol wipes, minimal hand sanitiser, little faith that managers will provide us stock when needed, little faith that management will know what to do.”*

Poor communication including lack of adequate handover, lack of meetings regarding outbreak, and lack of communication from management was cited by some participants:

*“We had resident tested came back negative but we who gave care were not notified and we had attended without PPE only porous gloves. The next night we were sent into dementia area. All good but scared us while waiting for the results.”*

*“We have had no staff meeting no communication at all, we are letting new admissions come in and letting family walk around the facility.”*

*“We don’t have a proper handover- we have not even had a staff meeting about it !!”*

*“As per federal guidelines, even if there’s a confirmed outbreak, we aren’t required to wear PPE unless dealing with that specific resident. This ignores the fact it’s highly contagious and spreads asymptotically.”*

## Employer planning for an outbreak

Participants were asked if their employer had provided them with a reviewed or updated plan regarding COVID-19 and given the opportunity to provide comments regarding their answer; 1,497 participants provided a response and 172 participants provided comments (Figure 6). Just under three quarters of participants reported that their employer had provided a plan, while 20 percent reported no plan had been provided, and 8 percent were not sure.

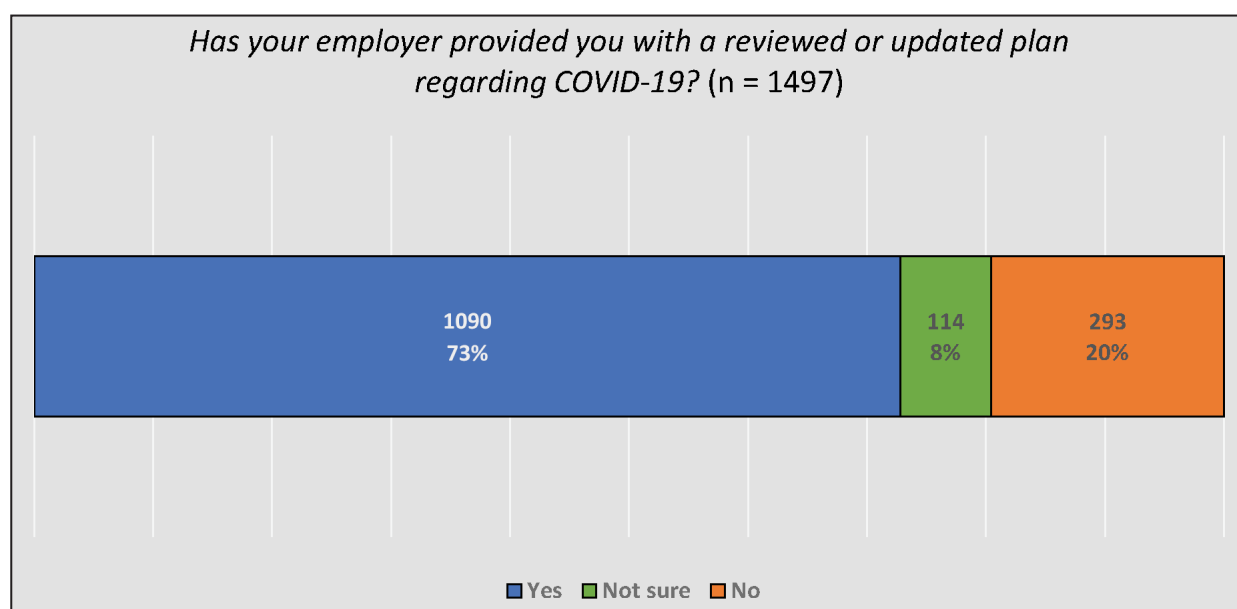


Figure 6: Employer provision of a COVID-19 outbreak plan

By sector (Figure 7), there was relatively little difference between responses from RACFs, while greater proportions of participants from multipurpose health facilities (which are attached to hospitals) – 92 percent, and in-home aged care – 81 percent, reported that employers had provided COVID-19 outbreak plans to staff. Across all RACF types, around 20 percent of participants in each sector reported not receiving a plan from their employer, and eight percent were not sure if a plan had been provided.

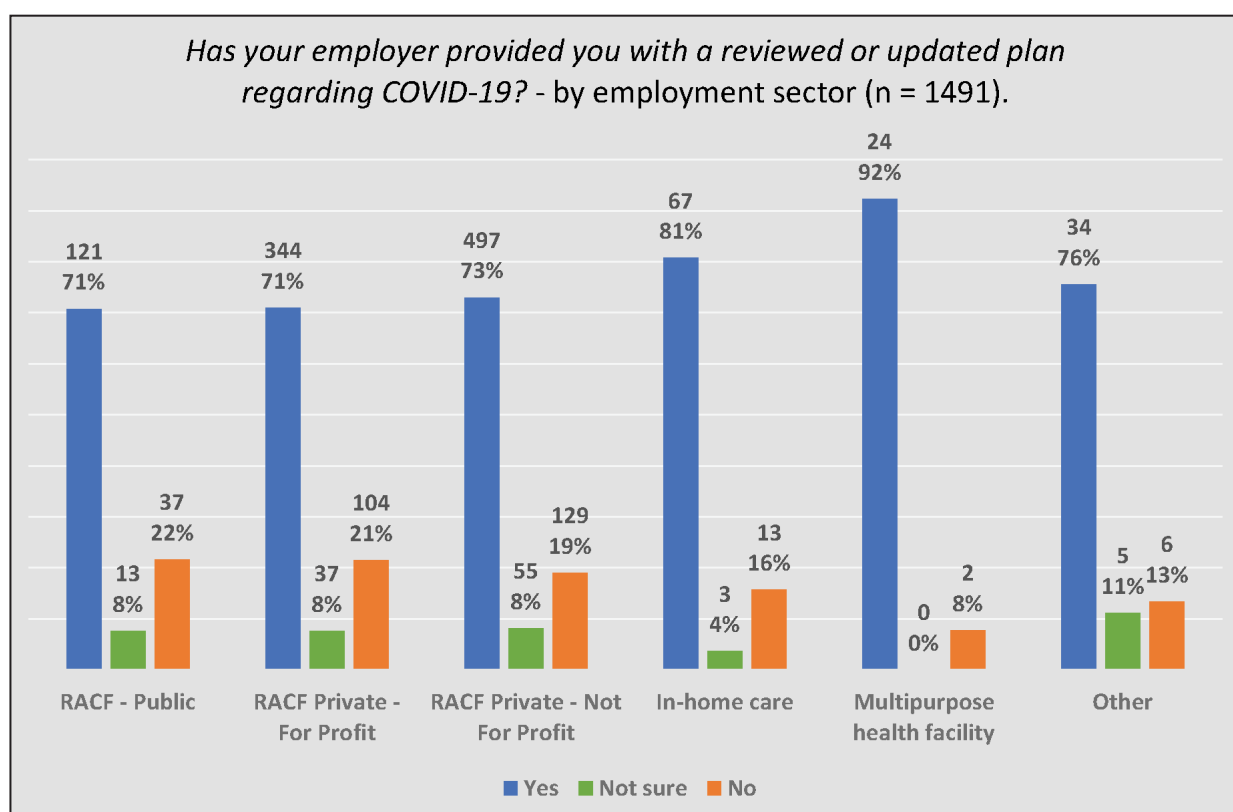


Figure 7: Employer provision of COVID-19 outbreak plans by sector

## Comments on employer planning for an outbreak

While some respondents provided positive comments regarding their employer's provision of plans around COVID-19, most respondents remarked on the lack of sufficient planning and communication with staff. These comments often noted that communication was either absent, infrequent, uninformative, or simply directed staff to State/Territory or Government Department of Health guidance. Even where participants reported the existence of suitable planning, other factors limited their confidence in the plans being effective. For example:

*"The plan provided by my employer is detailed and comprehensive, but I doubt that with the current staffing ratios and PPE we have that it is possible to adhere to."*

For agency staff who may work across multiple sites, lack of consistency between plans was noted as well as the challenges of accessing facility-specific plans if one was not a regular employee:

*"Work agency - there aren't very many places that have plans or plans that are available to agency staff. Every facility does something different, it's not consistent."*

Where local plans had been developed, some participants noted a lack of proper implementation, highlighting that more could be provided to support staff and that some information was not clear or accessible to all workers:

*"Have an Education RN but all done is leave papers in staff room to read and sign. Online education at work provided. Actual education re practice donning of PPE not done. It is all tick the boxes by collecting signatures really."*





*“It’s ever so ‘corporate’ and not written user friendly for average an aged carer. Someone employed to put big words into charts staff scarcely understand just to comply to what someone up high said to do.”*

Some respondents were very positive about the plans put in place by their employer, noting that regular, detailed communication with and to staff underpinned preparedness:

*“Our plan is so detailed, all staff are aware, all staff are constantly communicated with and to. There is so much safety and guidelines to follow so we protect our vulnerable and we are doing this on a daily basis. And we are doing this well.”*

This stands in contrast to comments provided by other respondents who felt that their employer was actively avoiding providing staff with information:

*“It is as if management and the owner want to keep staff in the dark with as little information as possible. They have even gone to the extent of accusing staff of being paranoid and spreading gossip if they raise a concern about the virus.”*

## Workplace supplies of PPE

Participants were asked whether their workplace had adequate supplies of appropriate PPE. Of the 1,504 participants who answered this question 706 participants provided a comment regarding their answer. Overall, almost half (46%) of all participants reported that their workplace did not have adequate supplies, 29 percent reported adequate supplies, and a quarter (25%) were not sure (Figure 8).

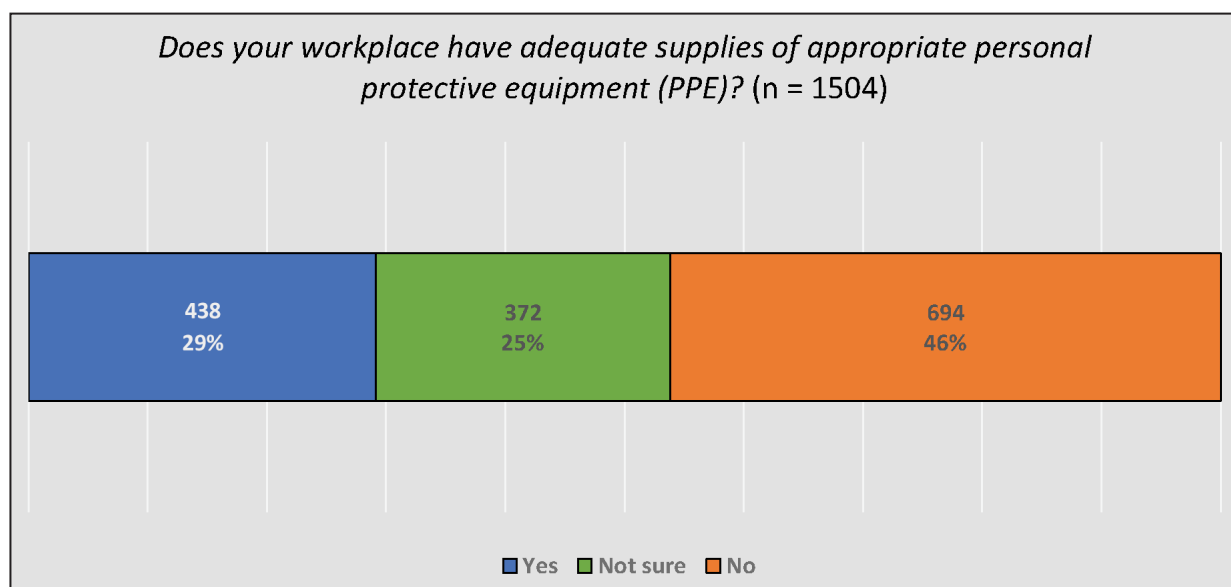


Figure 8: Supply of appropriate PPE

By employment sector (Figure 9), the largest within-group proportion of participants from the small multipurpose services group reported having adequate supply of PPE (67%). In-home care staff had the largest within-group proportion of participants reporting inadequate supply of PPE (51%). In RACFs, all groups had relatively similar results with between 45% (public) and 48% (for-profit) respondents reporting inadequate supply, around a quarter of each group being unsure whether supply was adequate. Between 26% (for-profit) and 31% (public) of respondents reported having adequate supply of appropriate PPE.

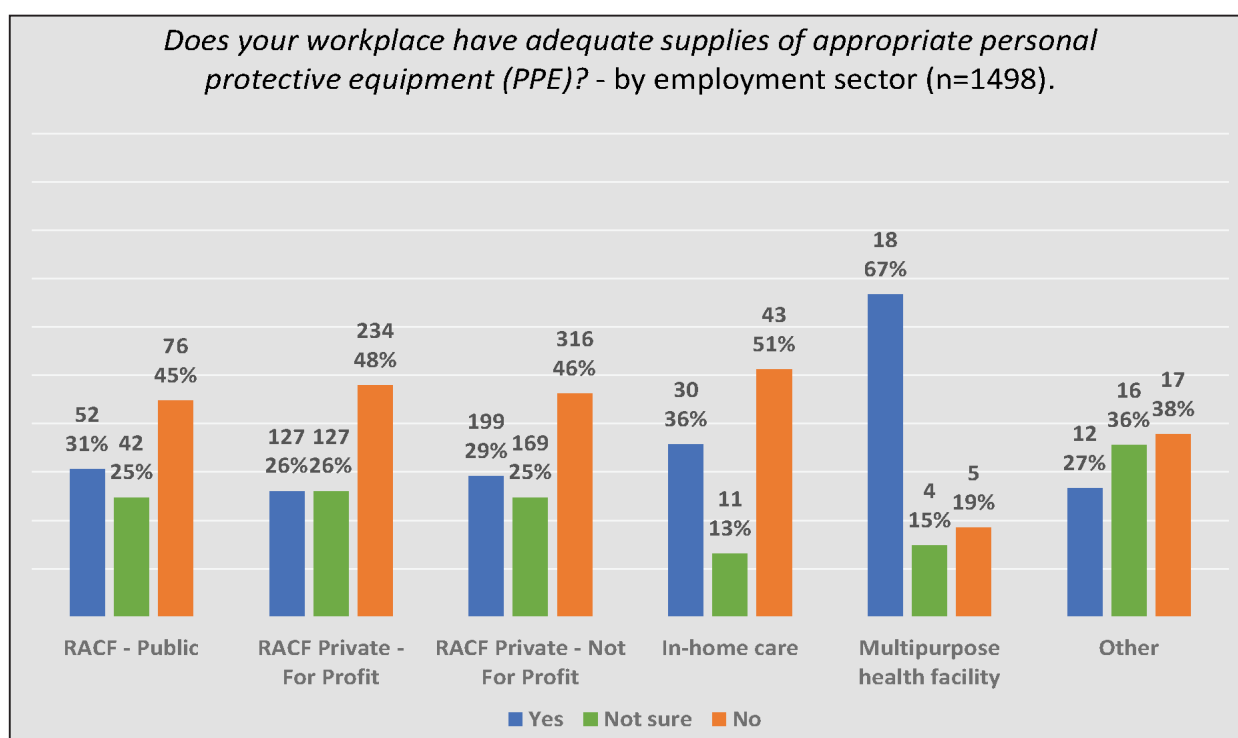


Figure 9: Supply of appropriate PPE by sector

By employment sector (Figure 9), the largest within-group proportion of participants from the small multipurpose services group reported having adequate supply of PPE (67%). In-home care staff had the largest within-group proportion of participants reporting inadequate supply of PPE (51%). In RACFs, all groups had relatively similar results with between 45% (public) and 48% (for-profit) respondents reporting inadequate supply, around a quarter of each group being unsure whether supply was adequate. Between 26% (for-profit) and 31% (public) of respondents reported having adequate supply of appropriate PPE.

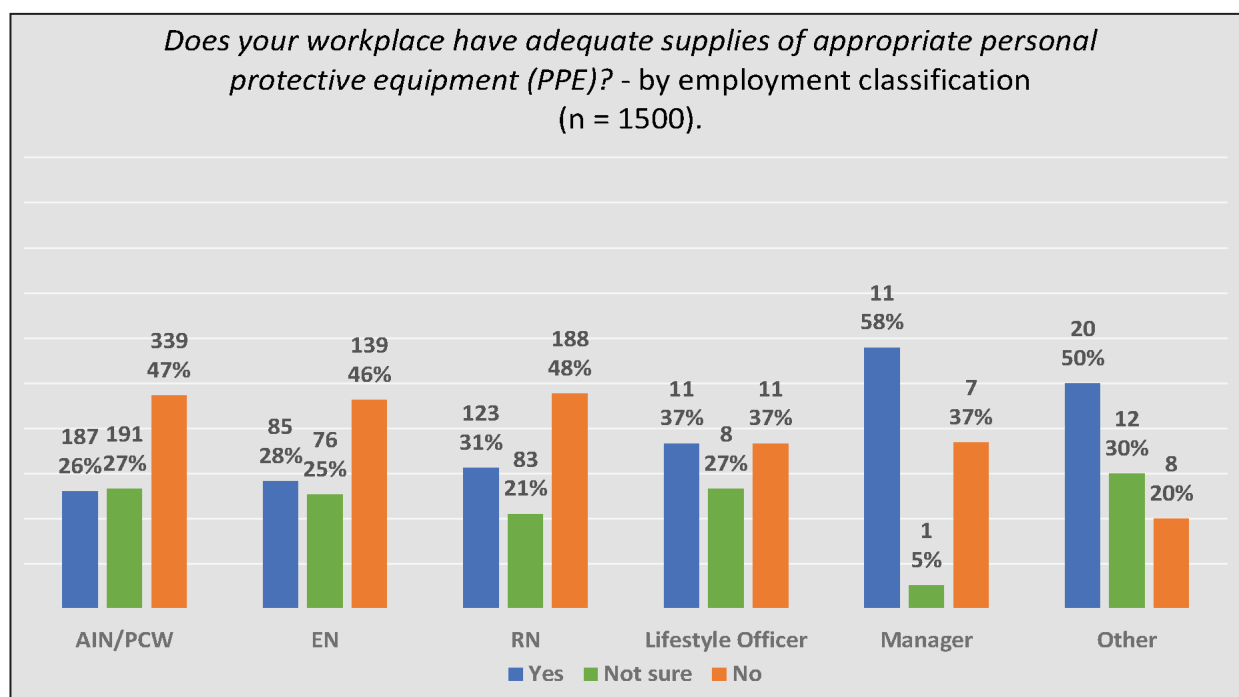


Figure 10: Supply of appropriate PPE by employment classification



## Comments regarding supply of PPE

Seven hundred and six participants provided comments regarding the supply of PPE at their employer. While only a small number of participants who reported having enough appropriate PPE provided comments, most of these comments indicated that while sufficient supply had been achieved this had either only just occurred, or may only be temporary:

*“Enough, but restricted. That is, if we take an empty glove box, we can get another box of gloves. We are getting refills for our small alcohol-based hand wash bottles, instead of our usual replacement supplies.”*

*“We have a small supply of gloves approx. enough to get by for a week should we suffer an outbreak of COVID-19. We only have enough gowns & masks for a few days. Management did not acknowledge a possibility of being affected by an outbreak & did not order extra supplies & now we are having difficulty just getting enough for each week.”*

Many participants reported that while there were supplies of PPE, staff did not have ready access to it even despite finding themselves in situations where they felt PPE may have been required:

*“Our DON has hidden/locked up masks from staff saying that we will not have enough for later in the year - we have had two new residents come into high care during this time and she did not believe that we needed to mask up even though they were in the mandatory 14 day lockdown - if they did have something we would’ve given it to the whole facility. A DR commented that all staff should be wearing masks, and if we were in short supply to contact dentists that aren’t practicing and ask to buy masks - nothing has happened as of yet.”*

*“Rationing of hand gel, running out of gloves for ADL’s. Have to top up gloves from wherever you can find them. Supplies are understandably kept locked away but no management on site to access out of business hours.”*

Others reported having such low supplies of adequate PPE and other necessary items such as soap, that staff were having to use inappropriate alternatives. Many participants were also concerned that despite an outbreak having not occurred at their facility, if one were to happen there would not be enough PPE:

*“We have very little supply of PPE and hand sanitiser, what little stock we do have has been locked up by management and RNs were instructed to ask the DON if any stock was required before we can take/ use it. Staff were washing their hands with shampoo as there was no hand soap available.”*

*“We have a limited amount of glove and gowns, so if we did have an outbreak of anything we would run out within a day or two.”*

Some participants reported they were told that they were not able to bring their own PPE to work to use, despite having limited supplies in the workplace:

*“We don’t have enough PPE and when staff tried to bring their own they were told they are not allowed to wear it unless there are confirmed cases and that management doesn’t want residents to panic if staff is seen wearing masks.”*



In some comments, participants reported several issues arising from a lack of PPE and supplies resulting in widespread problems with the provision of safe, best practice care:

*“All PPE is locked in managers office. Staff have been instructed to use only one glove. We are not allowed to wear a mask at work. We only have plastic sleeveless aprons. Manager says carers have to bring an empty box of gloves to have one replaced and are being questioned making them too afraid to ask. Staff have been buying their own and using plastic bags on their hands. Last week I asked about the residents who were quarantined and was told I (and care staff) were not allowed to wear PPE despite department guidelines saying so. Staff told not to come to work unwell but one nurse was told to come after her husband had a fever and sore throat and maintenance man had a fever on a weekend and was told to come to work Monday morning. No contactless thermometers and staff taking residents temps daily reusing disposable thermometer probe covers.”*

### Training in use of PPE

Of the 1,504 participants who responded to the question regarding whether their employer had provided them with recent training in the use of PPE (Figure 11), three-quarters (75%) of participants reported that training had been provided and 21 percent reported that no training had been provided.

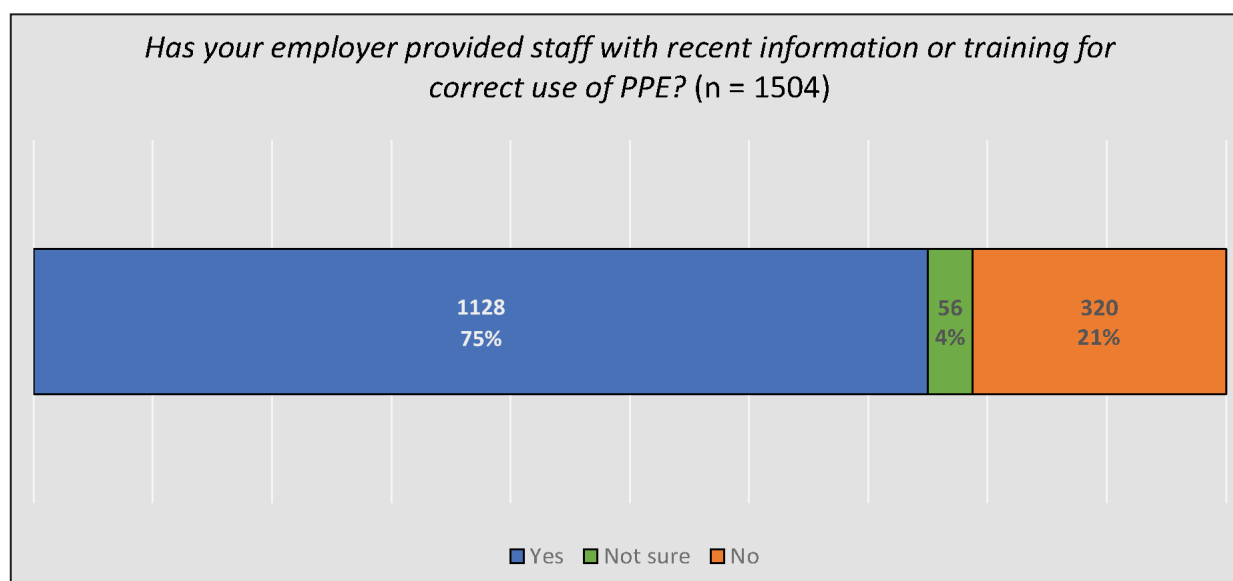


Figure 11: Provision of training in the use of PPE

By sector, the small group (n = 27) of staff working in multi-purpose health facilities reported the highest proportion of affirmative responses (96%), while responses across all other sectors differed very little from the general response profile of all participants. By employment classification, again, responses differed only slightly between groups with the small group of managers (n = 19) including the highest proportion of staff (89%) with affirmative responses. Registered nurses had a slightly larger proportion of participants (78%) than ENs (74%), and AIN/PCWs (73%) who reported that training had been provided.



## Comments on provision of PPE training

One hundred and seventy-six participants provided comments regarding employer provision of training in the use of PPE. While most comments simply referred to whether training had been provided or not there were a number of more detailed comments that provided greater insight into the situation regarding employer-provided training in the use of PPE.

The most common observation from the comments was that while PPE training was commonly provided across aged care settings, the quality, detail/ comprehensiveness, accessibility, and applicability for staff was often found to be quite limited. Training was often described as; basic, limited, online only, or of poor quality. Training was often not conducted in person and was provided only online or via posters and pamphlets.

Some participants provided positive comments regarding the training their employers had provided:

*“Had infection control nurses come around and give us instructions and training on PPE it was mandatory.”*

*“Every staff member has completed, hand washing, COVID 19, correct procedures for donning off and on PPE. Residents have been provided with updated information and education on social distancing.”*

Many comments however indicated that only basic training was delivered, often no more detailed than standard mandatory training, and often only provided online for staff to complete in their own time.

*“They have stuck up a chart on the door with instructions on how to put on PPE, there has been no verbal communication.”*

*“Online training on infection control which is the same basic vague information that is used for mandatory training.”*

*“We were required to complete one online respiratory infection unit training that included a hand washing and PPE instructions. We have not had hands on training of don and doffing PPE.”*

Many participants appeared to find the PPE training insufficient and sometimes inconsistent with other information regarding the use of PPE with guidance on the order of donning and doffing being a frequent missing element:

*“The problem is that my employer is not using current NSW health Doffing sequence.”*

*“I don’t think that our staff will be able to do the donning and doffing correctly even though we have been educating them. They tend to only take some things but not all.”*

Further, a number of participants noted that while training was provided (of variable quality) the correct PPE was unavailable to them or its use was actively hampered by the employer.

*“We have received online training, but I have not seen the correct PPE in stock or available to us if an outbreak was to occur.”*

*“We have had training on correct use of PPE... we just don’t have the PPE!!”*



Training in PPE use was also not universal:

*“Only some staff received training, I would imagine a good percentage have not.”*

*“Not sure if this is covered adequately in trainee’s education as majority of staff are trainees or care staff with limited experience.”*

## Infection control education and policy

Participants were asked whether their employer had provided them with infection control education as part of meeting the Aged Care Quality Standards (Standard 3, 4, and 8) in the preceding 12 months.<sup>11</sup> Of the 1,495 participants who responded, almost three quarters (71%) reported that training had been provided, 20 percent were not sure, and nine percent reported that no training had occurred (Figure 12).

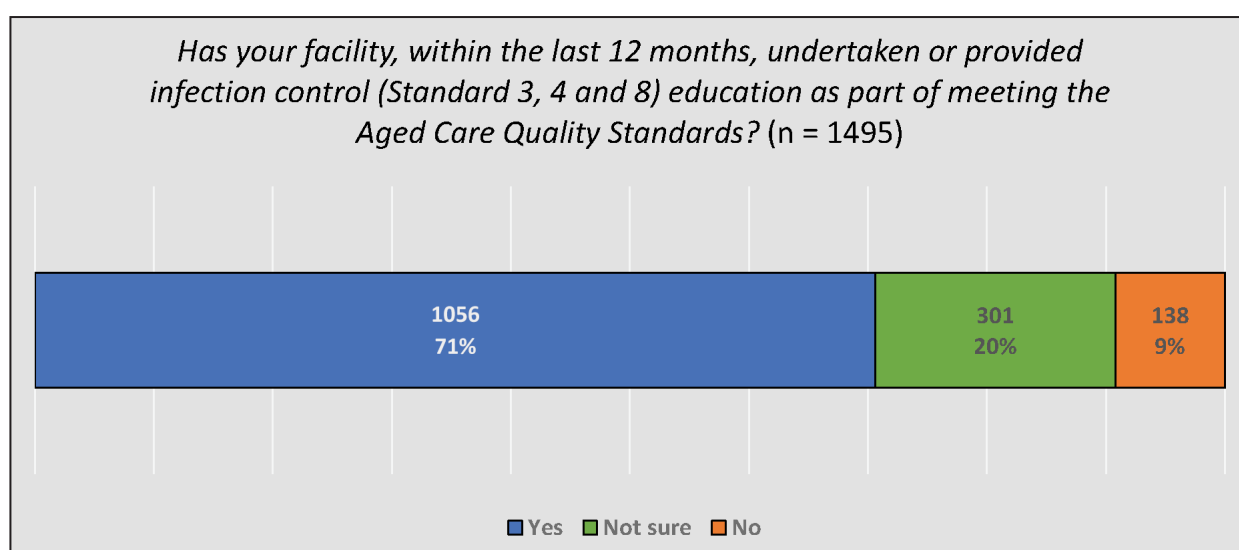


Figure 12: Provision of infection control education components of Aged Care Quality Standards

By sector, responses were very similar, however staff in in-home care (n = 27) had the smallest proportion (60%) of participants who reported receiving training. Staff in multipurpose health facilities (n = 27) had the largest proportion of affirmative responses (78%). By employment classification (Figure 13), there was little difference between groups in terms of their responses; lifestyle officers (n = 30) had the highest proportion of participants reporting infection control training (93%), and AIN/PCWs (n = 483) the lowest (68%). Seventy eight percent of the 391 RNs that responded to this question reported that training had occurred, while 18% reported that training had not occurred.



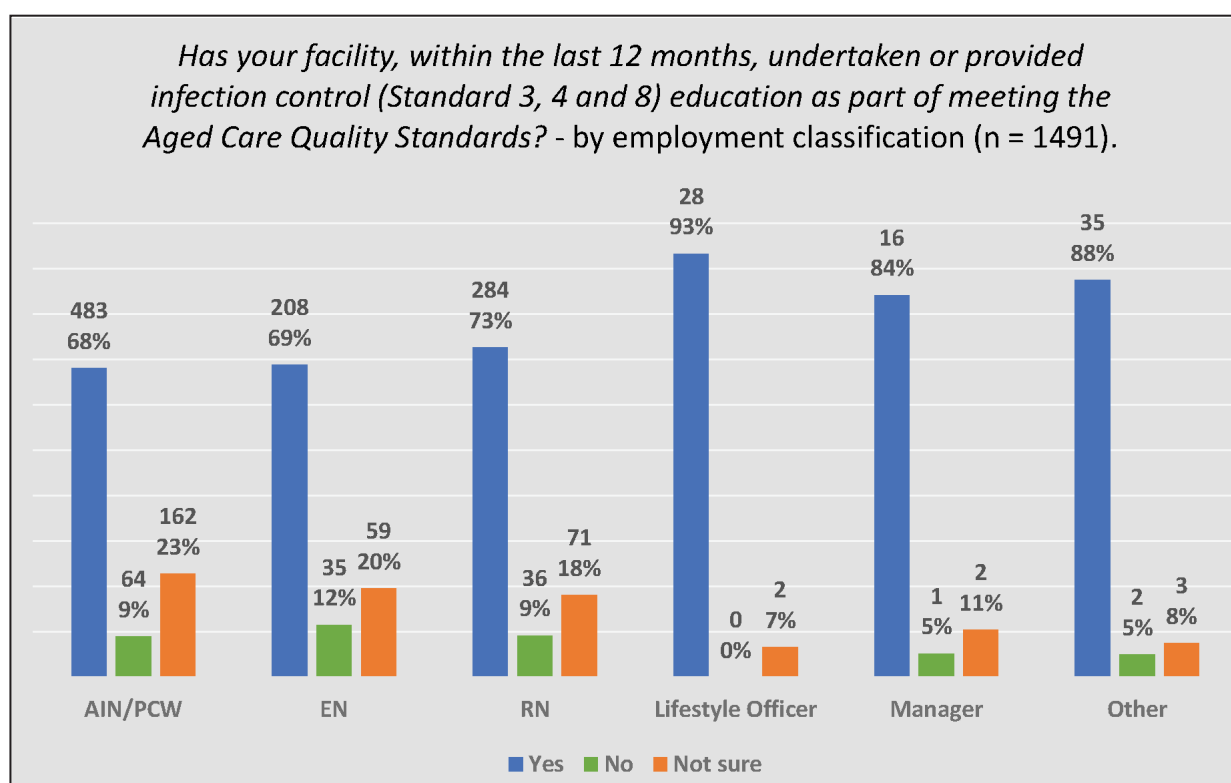


Figure 13: Infection control education provision by employment classification

## Comments regarding infection control education

One hundred and five participants provided comments regarding whether their facility, within the last 12 months, had undertaken or provided infection control education as part of meeting the Aged Care Quality Standards. Many participants reported here that information and education had only been provided online, or not in a way that supported staff to learn effectively:

*“Education modules are provided as online learning. I’m not sure if there was a specific infection control module, however we have an annual hand washing audit for all staff. This year’s audit was very disappointing, as the educator did not demonstrate how to wash your hands, did not check each individual and did not use the correct tools to show the before/ after hand washing. Rather, she stood at the front and said: “wash your hands like this and do it with me” and then signed everybody off. As there were a lot of new staff starting at this time, it’s concerning that many newcomers to aged care may not have properly learnt this important skill. Infection control was also included in the leaflet re. C-19 which was left in the offices at work for people to read and sign.”*

*“Don’t even do appraisals or performance management. Only have a small infection component in mandatory online training we do in our own time.”*



Some participants reported issues with the consistency and quality with which some providers maintained infection control standards:

*“Staff observed not using standard precaution in all facilities I have been. If I say or ask anything, my shifts get cancelled or they don’t have me back.”*

*“Not sure what each facility does but one of the managers I was talking about had no idea of infection control even though she believed she did because she follows guidelines that aren’t consistent with state, national, or international guidelines.”*

## Infection control procedures

Participants were asked whether their employer had recently updated or implemented infection control procedures for staff. Overall, almost eighty percent of the 1,505 respondents reported that infection control procedures had been recently updated or implemented (Figure 14).

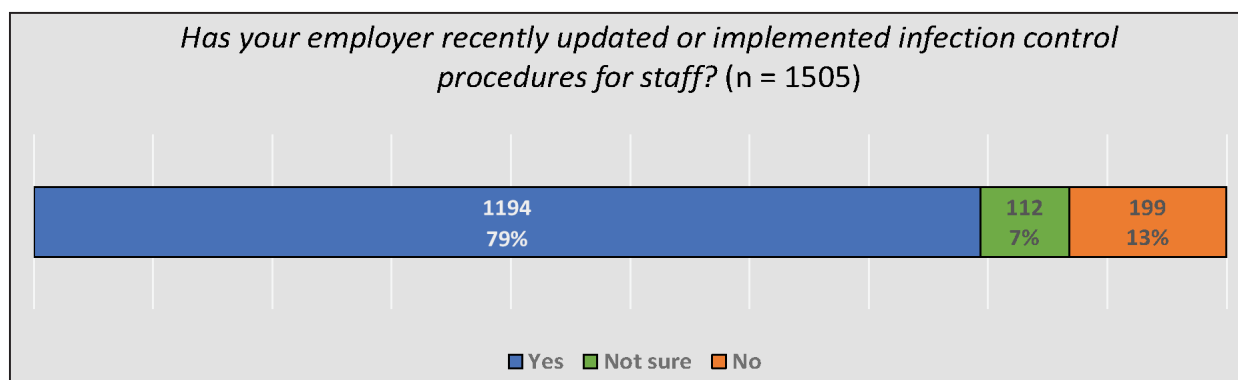


Figure 14: Provision of infection control procedures for staff

By sector (Figure 15), staff from public RACFs (n = 170) included the smallest proportion of participants (75%) that reported their employer had updated/implemented infection control procedures, while staff in multi-purpose health facilities (n = 27) indicated the highest (93%).

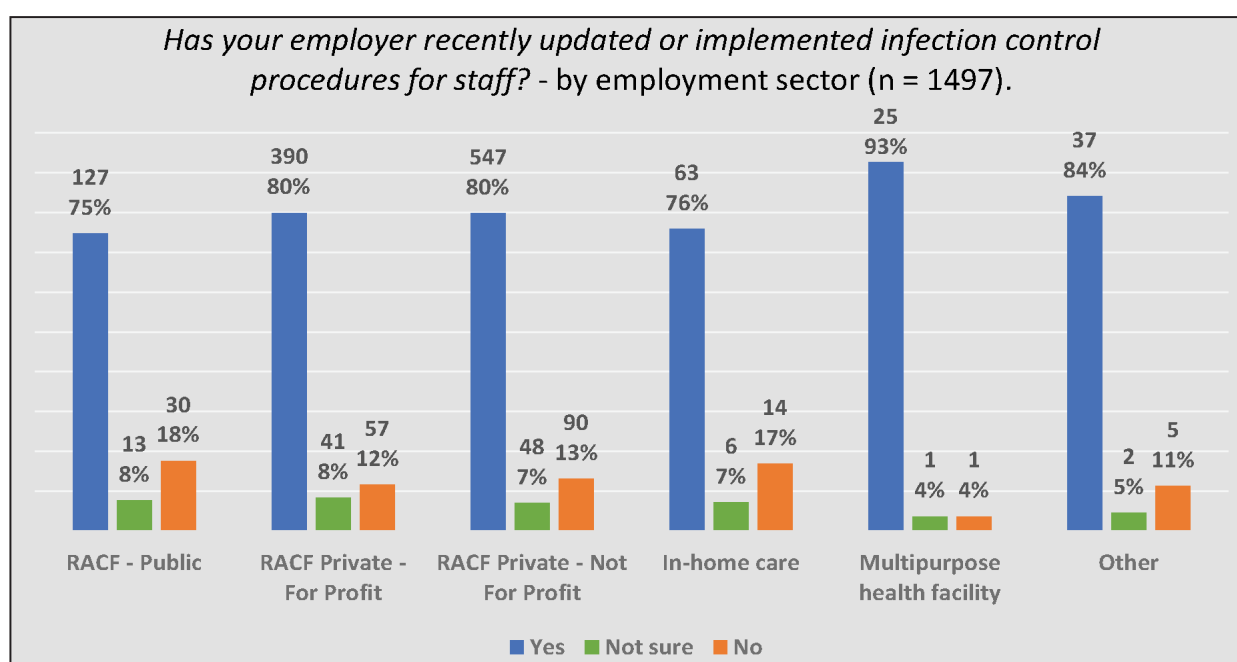


Figure 15: Infection control procedure for staff by sector



## Comments on infection control procedures for staff

One hundred and fifty-eight participants provided comments regarding their employer's provision of infection control and education. Many comments simply reported elements of infection control advice or practice occurring at their facility including; hand washing, surface disinfection, uniform wearing practices, PPE, availability of hand sanitiser, screening staff, and temperature checks. The comments indicated variation regarding the perception of quality of infection control education in aged care.

*"Staff don't even know who is responsible for infection control. We used to have a nurse [...] now we have the assistance management [sic] with no clinical experience trying to tell staff about infection control. The extra cleaning due to the virus is expected to be done by care staff to wipe down care stations etc before their shifts."*

*"But no infection control plan for actual COVID-19 cases. Majority of residents share a bathroom, but no information or plan on how we are going to manage COVID-19 cases."*

Infection control education was also not always suitable for different classifications of staff:

*"Yes, but all the things we have been trained for are questions mainly about Registered staff and not Carers or even kitchen staff etc."*

*"It is assumed by management that we are all proficient in infection control procedures. I believe we are not well trained or supervised in this area."*

Several participants provided comments regarding the frequency and quality of environmental cleaning:

*"There is only one part-time cleaner who works a few hours in the morning and cleans two buildings. No cleaners on the weekends. Staff are expected to clean but we have no wipes, disinfectants or mops. It's truly third world conditions for a profitable nursing home."*

*"So long as germs don't come to the facility on weekends as cleaning is not done as often and not at all on Sunday."*

## Infection control procedures for visitors

Participants were asked whether their employer had recently updated or implemented infection control procedures for visitors. Overall, eighty six percent of the 1,482 respondents reported that infection control procedures had been recently updated or implemented (Figure 16).

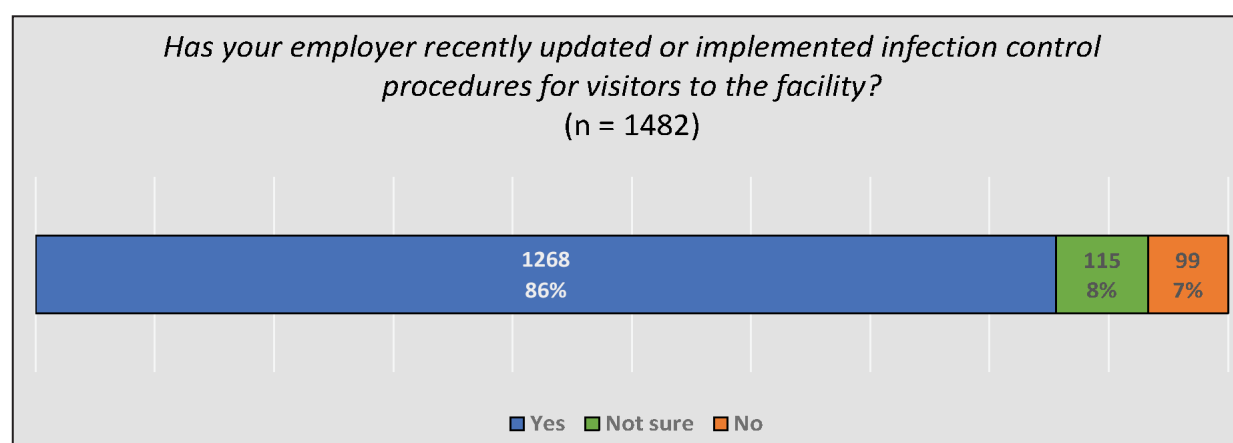


Figure 16: Infection control procedures for visitors



By sector, responses did not differ significantly with between 86% (not-for-profit) and 89% (public) reporting updated/implemented visitor infection control procedures and up to 93% in multi-purpose health facilities. Only 68% (17/25) of the staff in in-home care (n = 77) reported visitor infection control procedures.

### Comments on infection control procedures for visitors

Two hundred and eighty participants provided comments regarding their employers' update or implementation of infection control procedures for visitors. The majority of participants reported that their employer had enforced a full lock-down and that no visitors were coming to the facility at the time of the survey. Some participants however noted that visitors were still attending the facility and felt that infection control procedures were not being implemented adequately due to visitors not following the rules:

*"Poor implementation of infection control, social distancing and time limits. Visitors continue to break rules because management are not firm. It is appalling and staff are worried because of this. In the past few days, staff have reported what the visitors have been doing breaking rules but no action."*

*"We have and are following the govt guidelines. However, this is difficult to enforce. I work in a large facility with minimum staff. I have found visitors in communal areas and told them to move and have been met with verbal abuse."*

Some participants also noted that visitor infection control procedures were not implemented consistently:

*"The facility is on lockdown however, this procedure is inconsistent as management has allowed certain visitors in during the lockdown which do not meet the standards of their own directive for example- palliative care patients are allowed visitors however only one at a time, however certain patients that did not meet that criteria and were not ill were allowed multiple visitors at once."*

*"They have but it's inconsistent, they put the facility on precautionary lockdown but over the Easter weekend there for visitors and church service. Social distancing is not being encouraged besides in the dining room. Families visiting are in common areas."*

*"Changes were implemented but were inadequately communicated to staff, residents and families leading to a LOT of confusion, misunderstanding and some episodes of aggression toward staff."*

Some participants noted that while family may not be able to visit, other staff in the facility may have been potentially negatively impacting infection control procedures.

*No family allowed but too many people coming in from elsewhere. Unnecessary foot traffic. Kitchen, management, cleaning staff in acute and nursing home."*

### Staffing during the COVID-19 pandemic

Staff were asked several questions regarding staffing at their place of employment during the COVID-19 pandemic. Of the 1,494 participants who responded to this question, just over three-quarters (76%) reported that nursing and care staff had not been increased in preparation for dealing with the outbreak (Figure 17).

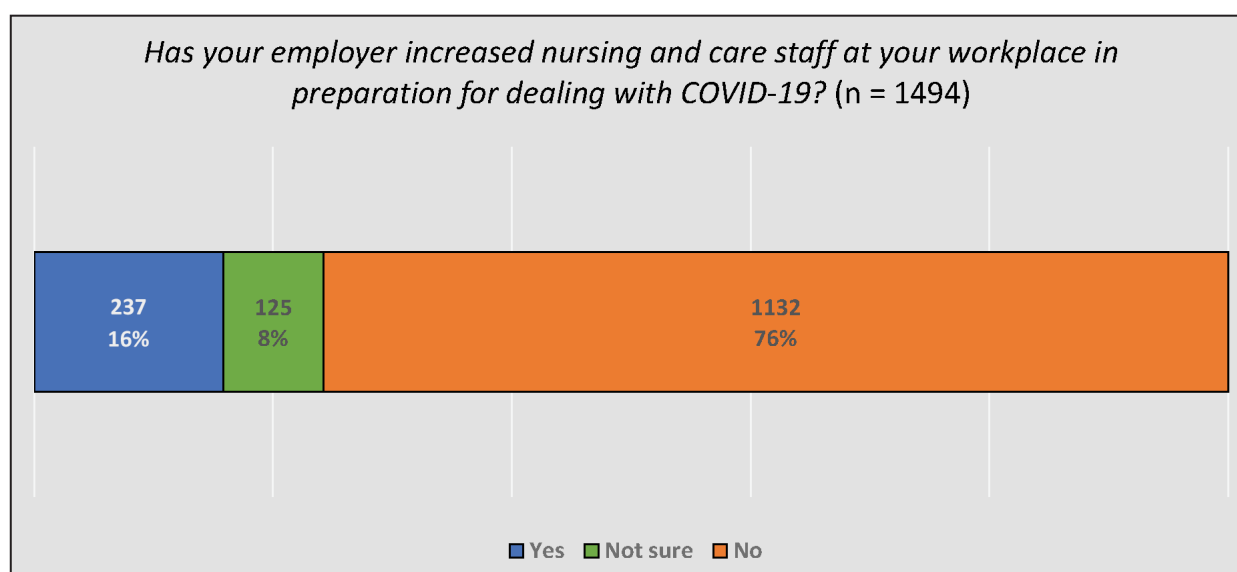


Figure 17: Increases of care staffing

Comments from participants who reported that no staffing increases had been made commented on how provider expectations from workers were often unreasonable, especially where staffing cuts had been made, and particularly where short staffing was a problem even prior to COVID-19. Many reported a lack of recognition of the extra work that faced staff due to COVID-19 even where there were no cases. The absence of visitors and staff being off sick compounded this feeling and unpaid overtime appeared to be common, simply to get through all of the work required.

*“Hours have been cut and staff were openly told at handover this morning that shifts will NOT be covered when someone calls in sick. Today the carers were three short. Nurses are getting out of work up to several hours late.”*

*“We have been in shorted staff for three years and we are still the same situation. No more staff for this situation.”*

*“We have stayed back most days/shifts to complete documentation without pay as the workload is very heavy. If one of our residents got sick with COVID-19 we would not cope with the workload.”*

*“We requested extra staff as residents are more time demanding due to no visitors, but our request was denied.”*

*“Not enough staffing levels at regular times let alone during covid 19 pandemic, currently asking staff to volunteer on their days off.”*

*“We were already over worked and understaffed. Now because of covid-19 we have extra tasks to attend to. We start earlier and never get out on time. We don’t get paid for the extra time we put in. We are extremely stressed and overworked.”*



*“They expect us to work harder and longer hours. We have been told we will have to pick up the slack if staff are off sick. If COVID breaks out in my Facility I will leave as I do not trust them to look after me. Our lives mean nothing. To listen to the dreadful comments from Mr Hazzard and others re the staff at Newmarch nursing home why would any of us stay and be blamed for killing the elderly people in our care. To be referred to as uneducated and unskilled and then give the RNs all the praise. When it comes to praise it’s the RN’s when comes to blame it’s the care staff. The care staff are being made out to be malicious murderers. Angry damn right I am. Those staff in Newmarch are risking their lives by staying there. Their dedication needs to be recognised. They need to be applauded not belittled, blamed and humiliated. The first case of COVID-19; I’m out of my workplace. Newmarch is a perfect example of why not to stay. I am not going to stay and have my reputation publicly dragged through the mud. When you have a Facility on your resume the reputation of that home goes with you. Meanwhile NSW Health let hundreds of people leave a ship and spread the virus all over Australia and overseas. Meanwhile the reputation of the staff in a Nursing Home is dragged through the mud. How can I not be angry? I have invested 37 years of my life to Aged Care. Give Aged Care workers the respect they deserve. Kick the boot into the operators and Managers, they are the ones responsible for the terrible reputation of most Nursing Homes.”*

Forty-five participants reported that staffing had been increased and provided comments. A number of these participants highlighted that the staffing increase would be inadequate as the facility was understaffed prior to COVID-19:

*“Yes, however as the facility was understaffed to begin with the current staffing ratio would be inadequate if there were cases of co-vid 19 at the facility.”*

*“Doesn’t seem to help as more staff are taking sick leave (not flu like symptoms related) we have been short staff every shift for the past week.”*

Many comments only stated that small staffing increases had been made and some highlighted that while new hires had been made, these staff had not actually begun working shifts:

*““They are on the books as backup but have not completed buddy shifts.”*

*“They have hired more nursing staff but not increased the amount of people on each shift.”*

Some participants reported effective staffing interventions to protect against COVID-19 outbreaks:

*“Extra staff have been employed so we do not have to use agency to increase the risk, so we do not have staff going between sites which also increases the risk and staff to ensure the welfare and social needs of our residents are looked after during this very difficult time.”*

*“Because the RNs cannot come down and administer the medications in the evening round. We gained a 40-hour shift on the roster for this. We also have the community day centre (closed due to COVID-19) staff as additional lifestyle therapy.”*





Of the 16 percent who did report that staffing had been increased (N = 233), almost a quarter reported that the increases were not sufficient to meet the needs of all residents/clients (22%) with the same amount reporting that they were not sure if increases would be sufficient. Just under 60 percent (n = 130) reported that staffing increases would be sufficient (Figure 18).

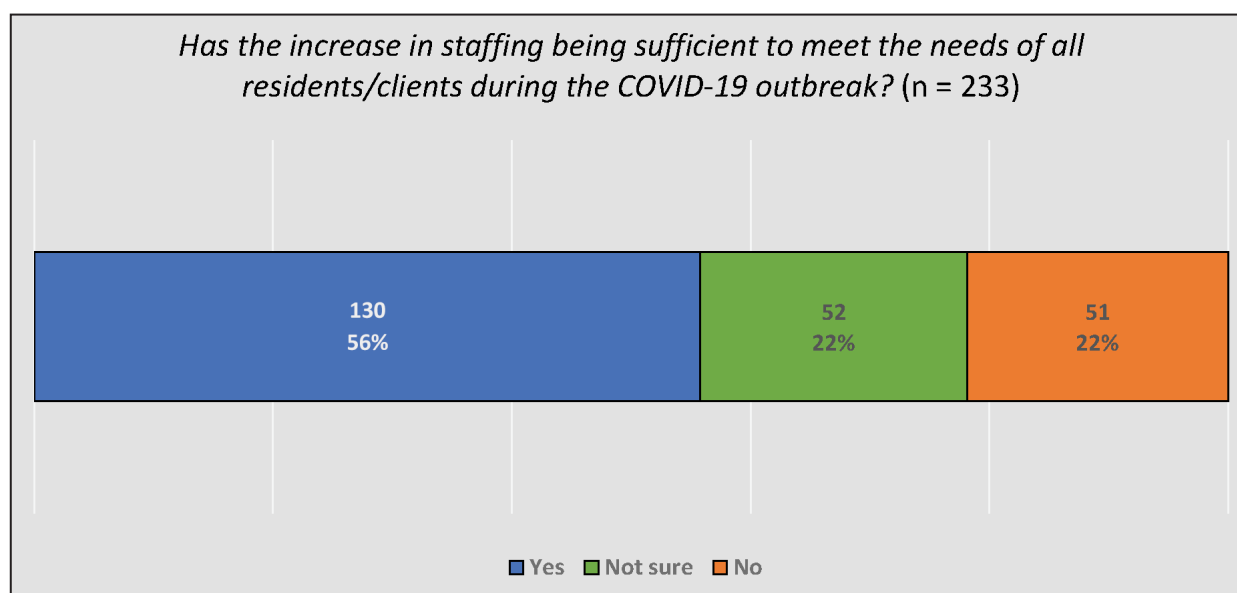


Figure 18: Adequacy of care staffing increases

Twelve participants who reported that staffing increases were made but were insufficient to meet the needs of all residents/clients provided further comments. Some participants raised concerns regarding the type of staffing increases that had been implemented:

*"[Name of employer] are employing more management Staff. Not enough staff 'on the floor '.*  
*"Too many chiefs, not enough Indians" situation; concerns me."*

Some suggested staffing measures that they felt would be effective to cope in an outbreak:

*"I believe we need another two nurses on should we have an outbreak two to deal with COVID-19 residents and two nurses for other residents who don't have it as a clean team so those dealing with COVID-19 only stay with COVID-19 patients a clean team and a dirty team."*  
*"Need more lifestyle staff to provide more activities for residents and enable them to have more access to skype type contact with their families so you aren't taking the carers away from their work to do this."*

A number of participants expressed concern for residents who could no longer spend time with visitors in the context of ongoing short staffing:

*"We are always short staffed! The residents are all locked in their units with no personal contact with relatives n friends. They need more stimulation with activities but are receiving less... We definitely need more staff!"*  
*"Obviously more staff required in Dementia ward. Resident with constant fever for several shifts was allowed to wander in the public area as no space to isolate the resident and under staff to do the redirection work."*



By sector (Figure 19), participants from for-profit providers included the largest proportion of individuals (80%) who reported that no staffing increases had occurred, followed by staff at not-for-profit nursing homes (77%), then staff in public nursing homes (73%). Staff from for-profit nursing homes had the smallest proportion of reports of staffing increases (13%).

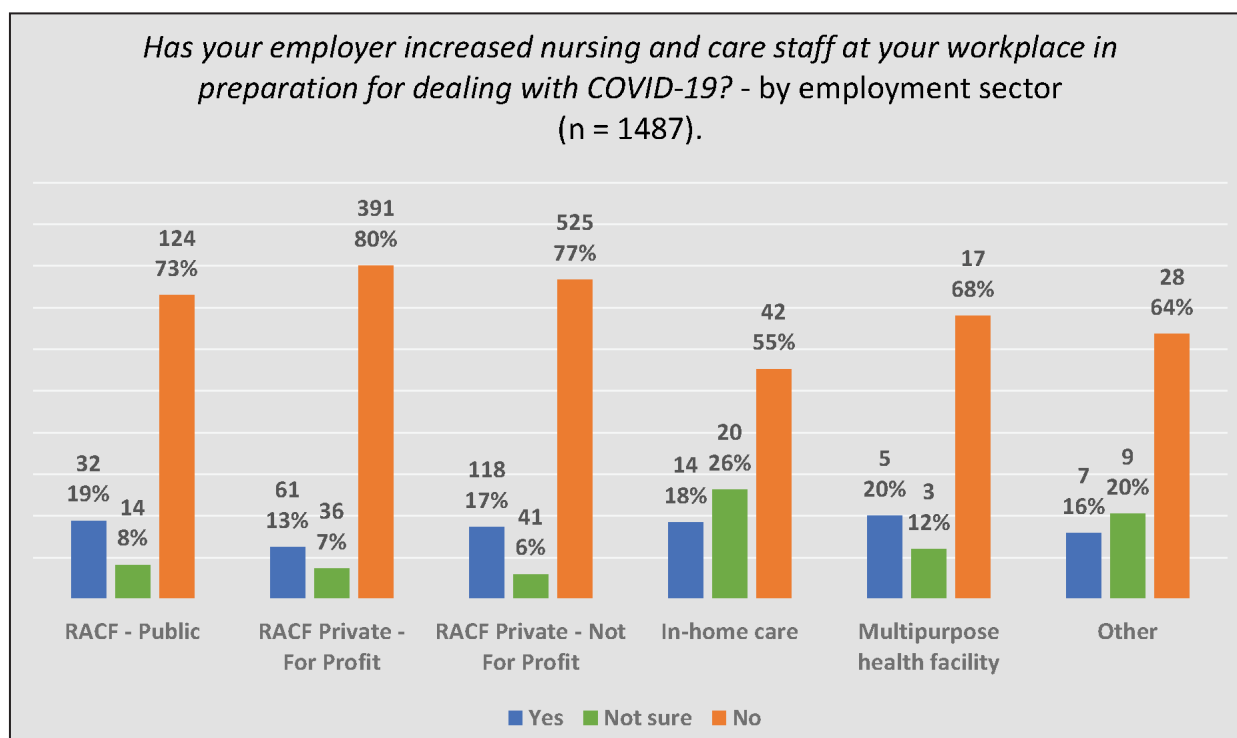


Figure 19: Care staffing increases by sector

Two hundred and thirty-one participants who reported that staffing had not been increased by their employer provided comments. Many participants reported staffing cuts being implemented despite the ongoing COVID-19 outbreak:

*“They are about to decrease the RNs by 50% in an attempt to align with similar rosters at other sites.”*

Pre-existing staffing shortages were also commonly reported:

*“Not at all. There’s always shortage of staff in every shift. Staff are working very hard in spite the challenges and lack of support from management.”*

Some participants reported temporary staffing increases in response to suspected cases:

*“In response to one of the wards being placed in quarantine due to a positive result from a worker, [name of employer] has had to employ a few more staff who are only working in that house for the three-week period.”*

Participants were asked if their employer had made any cuts to staff and hours since the beginning of March. Of the 1,491 participants who responded (Figure 20), 64% reported no cuts while just under 20% reported that staff cuts had occurred (19%) or were not sure (64%).

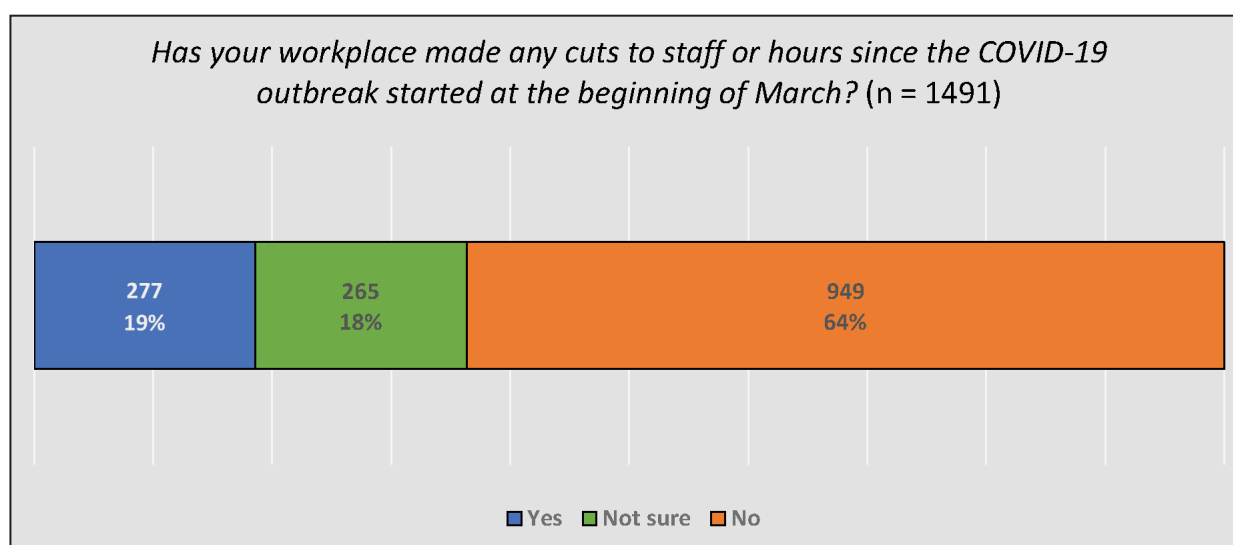


Figure 20: Staffing cuts during the COVID-19 outbreak

Ninety-four participants who reported that staff cuts had been made during the COVID-19 outbreak provided comments. Many comments focussed on the significant impact that the pandemic has had on casual workers who have had shifts cut or been required by provider policy to choose one workplace only. Others highlighted problems with not replacing staff who resigned or cannot come to work due to sickness:

*“They always cut hours and staff. All about profit. Doesn’t care at all to all staff who work above and beyond their duties. Staff are over worked, burnout, and stressed.”*

*“Most casuals (a normally large part of workforce) not getting very many shifts. Some nurses laid off!”*

*“Since March I’ve been told I wasn’t allowed to come to work and haven’t been offered any shifts as I’m a casual and also work at another institution. They said that it’s their policy to not allow staff that work elsewhere to work there. I had all my upcoming shifts cancelled and haven’t had any work since March.”*

*“Staff have been made choose between employers and as such we have lost valuable staff as they choose better conditions at other facilities.”*

*“Some residents are not getting any care until after lunch. Management don’t seem to care because family members aren’t around to complain.”*

*“As people resign due to our poor leadership and work environment positions are being left empty with no effort to employ replacements.”*

By employment sector (Figure 21), respondents provided relatively consistent answers by group, however participants from the in-home sector had the largest proportion of participants (40%) that reported that staff cuts had occurred.

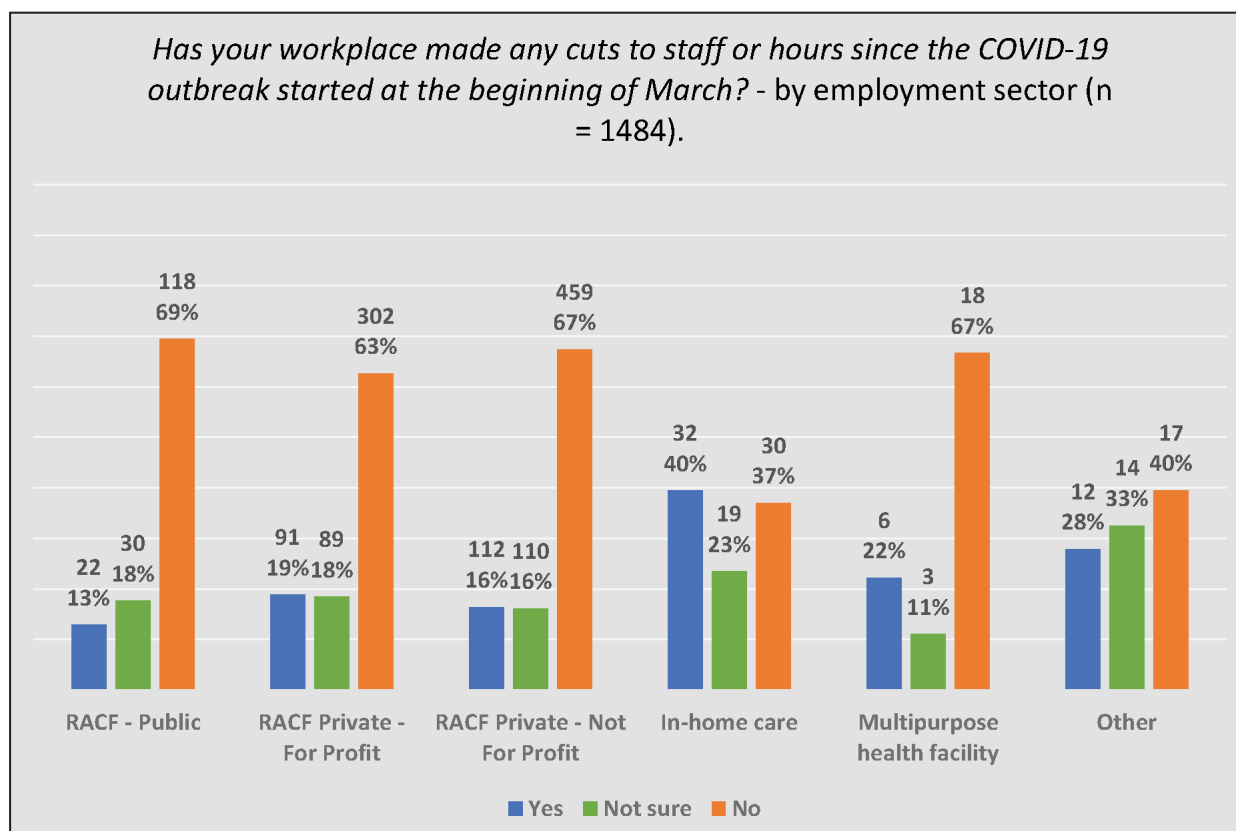


Figure 21: Staffing cuts by sector

## Kitchen, cleaning, and other staff

Participants were asked if their employer had increased kitchen, cleaning, and other staff at their facility (Figure 22). Of the 1,480 responses received, almost 60% reported that no increases had taken place, while a quarter reported staffing increases in these areas.

Two hundred and twenty participants provided comments on their responses. While some participants commented on increases to cleaner staffing, issues concerning the requirement for care staff to clean nursing home areas and give out meals, and cuts to cleaning, laundry, and kitchen staff were raised:

*“Service manager expects night staff to clean. It’s a 90-bed facility with four care staff and one registered staff members and yet we are told to make sure all touch points are continually clean. Impossible.”*

*“Still cutting down staff, trying to save money and increase profit margins especially now the facility is lockdown there is nobody to see what is truly happening.”*

*“Cleaning shifts are now available on weekends, normally there are no cleaners on weekends or public holidays. One staff member for 80 residents.”*

*“We still have no cleaners on a weekend and they only the main areas and do a light mop in a resident’s room if no one is inside when they call past.”*

*“We have nursing staff doing these tasks completely against infection control but they are saving money.”*

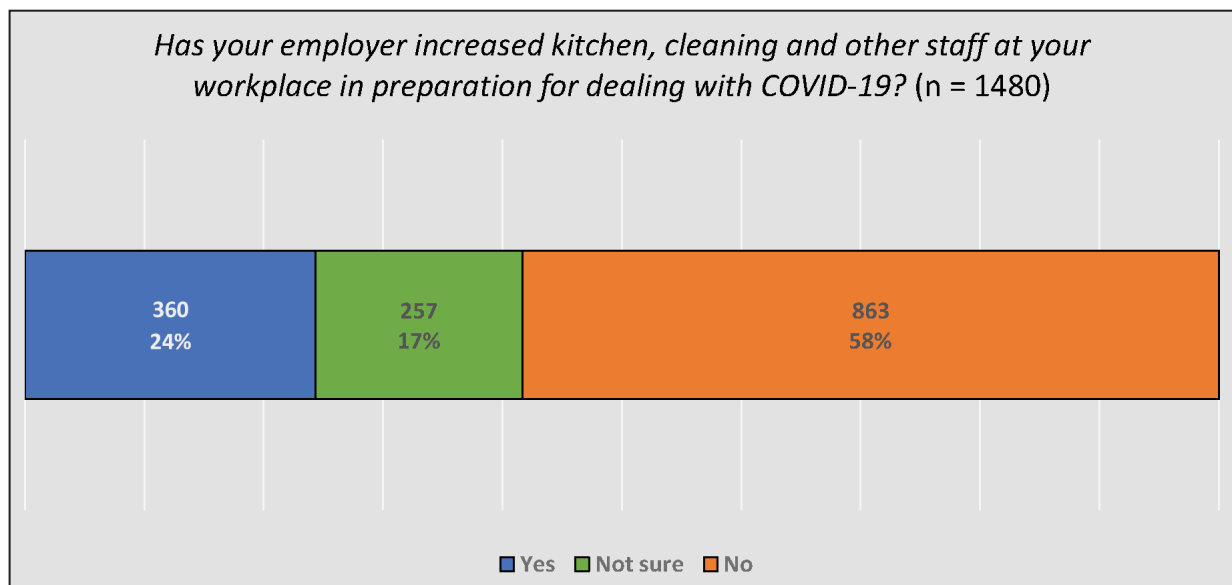


Figure 22: Increases in non-care staffing

By sector (Figure 23), at 63 percent, participants from for-profit providers included the largest proportion of respondents who reported that kitchen, cleaning, and other staff had been increased to deal with COVID-19. Across all sectors, around a quarter of participants (22% in for-profit RACFs to 30% in public RACFs) reported that kitchen, cleaning, and other staff hours had not been increased.

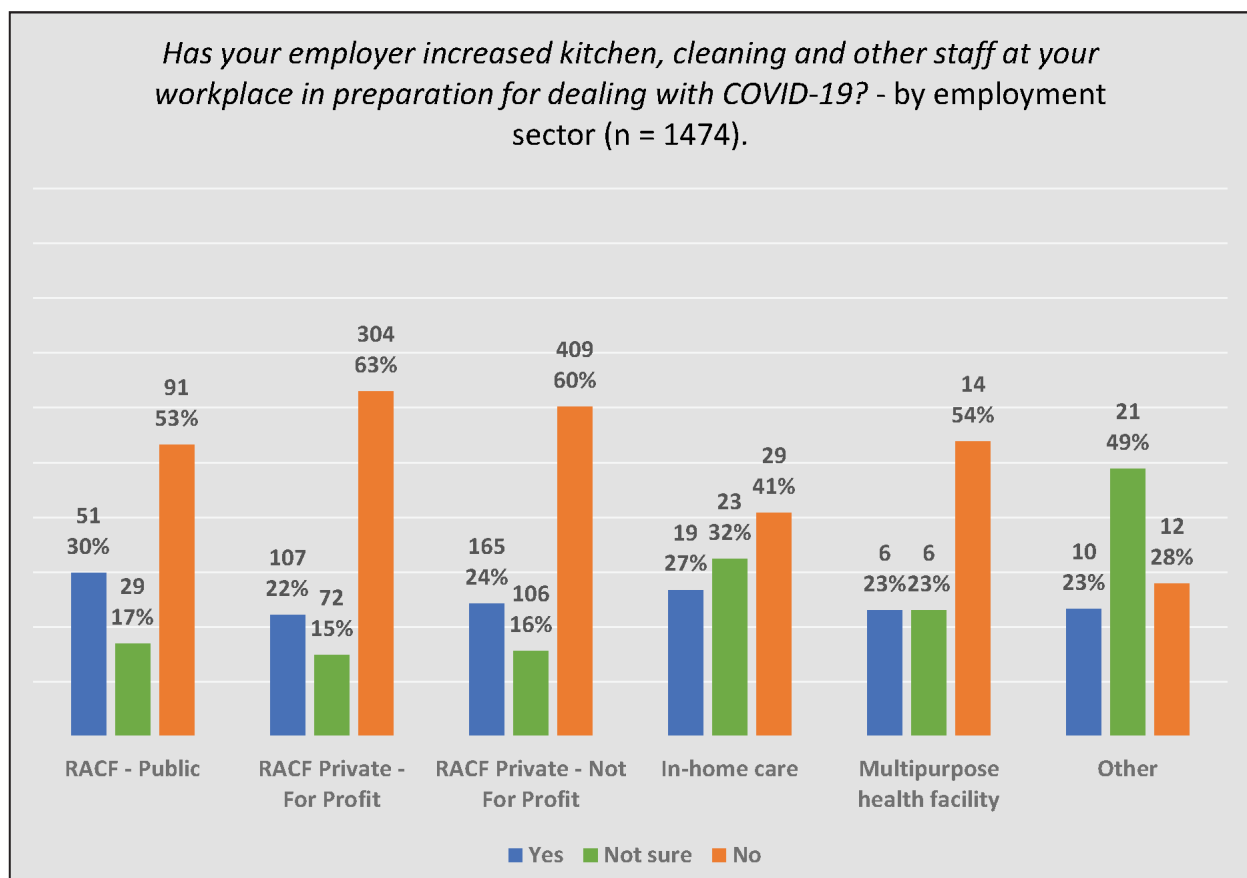


Figure 23: Increase in non-care staffing by sector



## Registered nurse rostering

Participants were asked about RN rostering at their facility. Of the 1,492 participants who responded to this question, 83 percent reported that there was an RN rostered on for every shift including weekends at their facility (Figure 24).

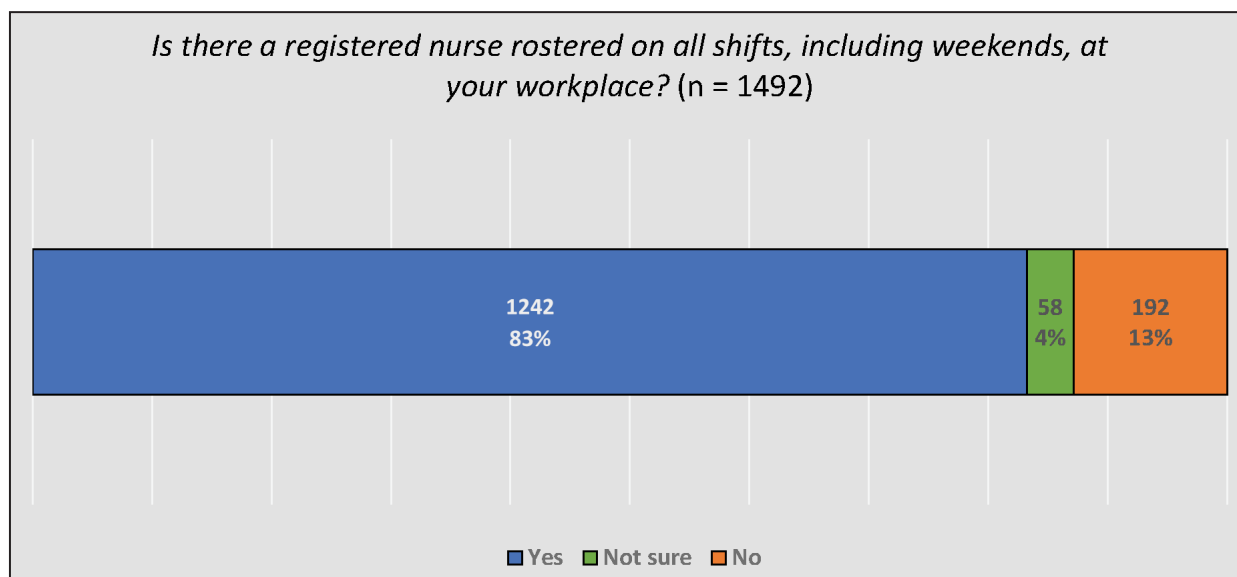


Figure 24: Registered nurse rostering

By employment sector (Figure 25), there was little difference between most participant groups; in-home care had the smallest proportion of RNs rostered for every shift however this is consistent with the manner of work in the sector. Among RACFs public (81%) had the smallest proportion of respondents who noted an RN rostered on every shift, and for-profit (90%), had the highest proportion.

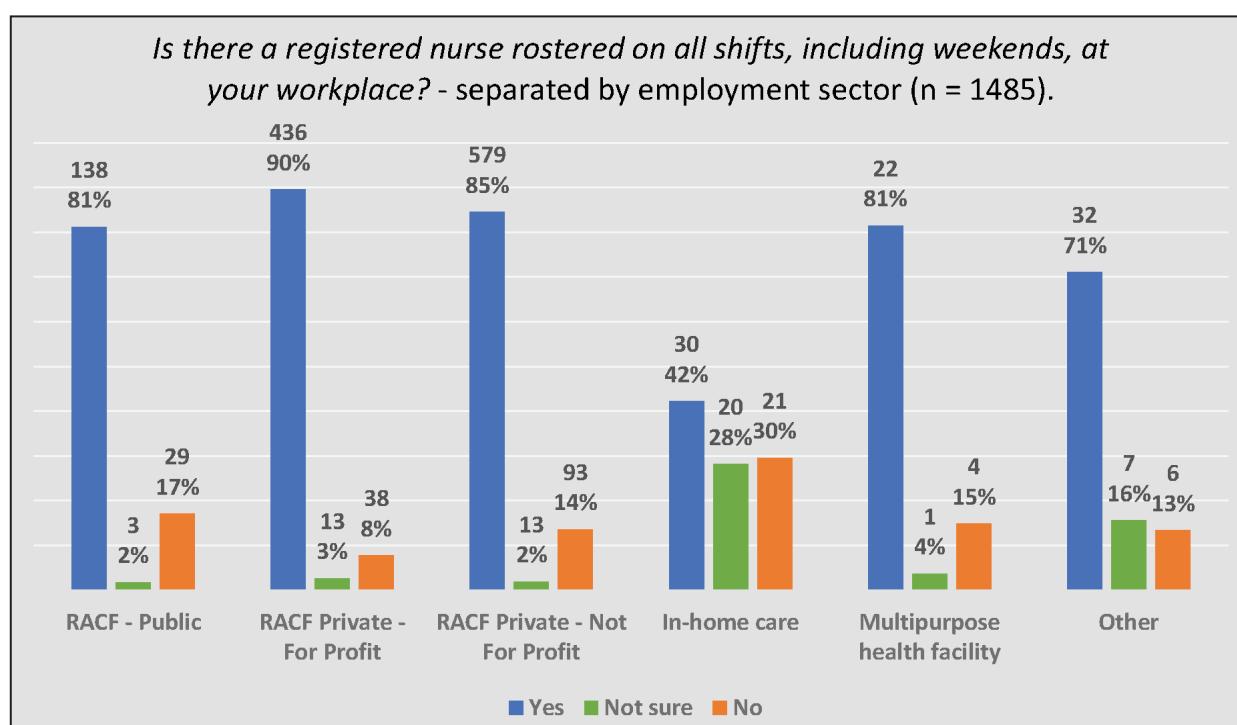


Figure 25: Registered nurse rostering by sector





## Comments regarding registered nurse rostering

Two hundred participants provided comments regarding the rostering of RNs at their facility. While the majority of participants reported that an RN was rostered on for every shift, this may not always be adequate. Many participants noted that while an RN may be rostered on, it was often still only one RN responsible for a large number of residents and other staff members, particularly over night:

*“One registered nurse night shift for 120 residents in a multi-story building.”*

*“One RN to 103 residents on night shift.”*

*“But only one for 60 residents.”*

A number of participants reported that there were shifts where no RNs had been rostered on. In these instances, an RN may be on call, substituted by an EN, or only have AIN/PCWs on staff. For some participants, the practice of having no RNs rostered at all appeared to be so common that the thought of an RN rostered for every shift seemed incredible:

*“No there isn’t. The enrolled nurses are supervisors on evening shifts. Personal carers x three work on night shift for 68 residents. A registered nurse is on call overnight.”*

*“No only two AINs on at night. And we do a lot of the cleaning including the kitchen!”*

*“Hahahahaha... Is this a real question? Sorry, but we often go a day or two without an RN on site. But we can call one if needed.”*

*“There is no RN on afternoon or night shift and only covers a small amount of morning shift on the weekend.”*

Many participants noted that while an RN may be rostered on for every shift, often if that nurse could not come to work (e.g. sick) they would not be replaced, indicating that some shifts would not have any RNs onsite. Providers may also have unreasonable expectations for the amount of work that one RN can cope with, especially when additional RNs do not work but are not replaced. Providers may also be telling RNs that they will not be replaced if they call in sick which could lead to staff feeling pressured to work when unwell:

*“In several occasions, shortage of nurses is becoming a norm. Management doesn’t try harder to cover vacant shifts.”*

*“Told if they call in sick won’t be replaced.”*

*“Nights we are allocated one RN to four separate buildings of upwards 170 residents. But we do not always have one turn up and they don’t replace the shift, so we work with two ENs and 10 AINs for night shifts.”*

*“It used to be two RNs in the morning shift, but since they have temporarily stood down staff working two nursing homes, some days it has been consistently not replaced. One RN is expected to work the same workload if the two RN and they replace the RN shift with an AIN to assist one RN on the floor. We were told that if you are not able to manage, which means they cannot roster or give you the shift.”*



The lack of rostered RNs appeared to also highlight systemic problems in aged care for many participants:

*“Insufficient numbers of Registered Nurses... That is why they reduced their hours or left! Sick of the bullying and harassment and demands to work unpaid hours.”*

*“We have trouble retaining nursing staff. Had a big turnover as the nurses come to facility but worried about their registration being compromised due to management of facility not being medically qualified to advise them on how to do their job. We only opened a couple of years ago and only have a couple of our original nurses still there. Much agency nurses used.”*

### Willingness to work additional hours/shifts during the COVID-19 outbreak

Participants were asked whether they would be willing to work more shifts or hours during the COVID-19 outbreak if they were offered these by their employer. Of the 1,492 participants who responded, just over half (53%) reported that they would be willing to work more (Figure 26).

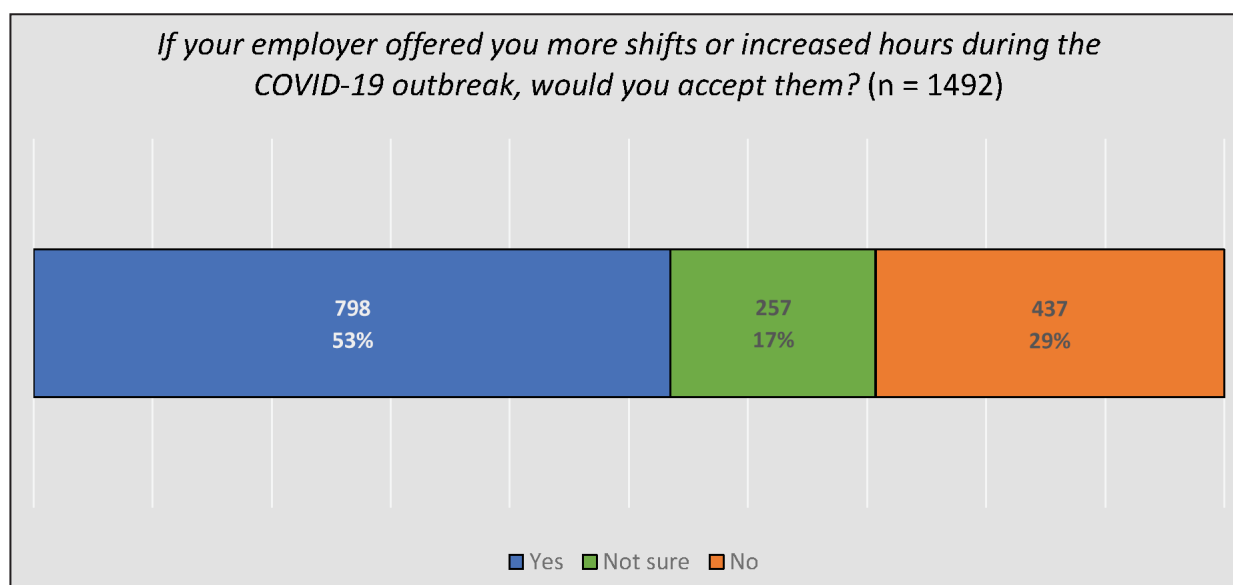


Figure 26: Willingness to work additional shifts/hours during the COVID-19 outbreak

### Comments on willingness to work additional hours/shifts

Eighty-nine participants reported that they would be willing to work additional shifts/hours during the COVID-19 pandemic and provided comments on their response. Many participants reported that they were already working additional hours while others reported that while they would be willing to work, they didn't believe their employer would make more shifts/hours available:

*“My workplace wouldn't though. Management believe COVID-19 won't even get into the facility because they believe they are doing such a great job.”*

*Some participants reported a desire to work more, but were concerned with unreasonable workloads due to ongoing problems with low staffing:*

*“So long as there is adequate staff and other sick staff are replaced. Often sick staff are not replaced and this decreases incentive to cover extra shifts.”*



Some participants reported that while they would be willing to work more, the hours/shifts were not available or had been cut. This was reported by casual and agency staff:

*“There are hardly any shifts available for agency. I was only able to get three shifts in four weeks.”*

*“Definitely. However, many staff who are casual will tell you they have had a huge reduction in hours. Not only due to leave being cancelled but also due to people who previously only able to work 20 hours can now work double that and are getting the hours that casuals would usually be offered. Also because of the push to bring people out of retirement and hire students.”*

A number of participants felt responsible for working additional shifts and cited wanting to provide care for their residents and support for their overworked colleagues:

*“I would want to help out in any way to nurse any patients and ease the pressure on permanent staff.”*

*“I am a uni student so restricted at present but yes if they needed help and I was free, I would be happy to accept more shifts.”*

*“I care a lot about my residents. It pains me knowing there is not enough staff to efficiently care for them, so I step up when need be.”*

*“I am passionate about what I do. if the time comes and those residents need me, I would happily to do so.”*

Several people also indicated they simply needed more work as family members had lost their jobs due to the COVID-19 pandemic:

*“I would have no choice but to accept any extra shifts, as I am the only person in my home working, my wife and daughter have both been stood down.”*

One hundred and twenty-nine participants reported that they would not be willing to work additional shifts or hours and provided comments on their response. Many of these participants reported that they already work full-time hours, with many also reporting doing additional overtime – often unpaid.

*“I work night shift and the staff numbers are too low for the care needs of the residents, extra audits, and showers that are expected of us to do. Our workload is often becoming unachievable in our time span and with doing showers at 0600 hrs to 0700 hrs, by one staff it is becoming dangerous.”*

*“I work by myself with forty residents on a night shift. Not only do I care for my residents, I am expected to do their laundry, clean my area, cook for the residents and many other tasks.”*

*“This is already exhausting with all the extra emotional support needed for residents, Phone calls from families and extra work monitoring and recording temps each day.”*



Many participants also reported that they could not take on additional hours or shifts because they either held a position elsewhere or because they had ongoing caring duties for young children or older family members of their own:

*"I can't work extra nights as I have kids and can only work what I currently do ... Would do more if I could, but can't."*

Some participants reported that they would be unwilling to work extra due to additional work they have already undertaken for their employer without recognition or pay:

*"I am currently full-time 76 hrs a fortnight, during this pandemic I have been working a min 12 hours extra a week with no pay or acknowledgement, Last week I needed to have a day off work to take my son to a specialist appt and they didn't even give me the day off as time in Lieu I had to have it off as leave without pay. So, no they will no longer get any more hours out of me."*

*"If our safety is ensured, but by the looks of it, the management just don't care. Few of our experienced registered nurses resigned as they are very upset with the management plan as management do not ensure staffs' safety. One of the managers even stated that; 'This is the kind of job you choose isn't it' !!!"*

Some participants also felt fearful of working additional hours as they already did not feel looked after by their employer for the hours they currently work:

*"Because I do not feel safe at the hours I'm currently work."*

Some participants felt pressured to work harder and more due to fear of losing their job, but did not want to, due to stress and lack of recognition:

*"It's very stressful time at work as you are always threatened of losing your job if you do not do what they all expect you to do. We were asked to complete the COVID-19 depart of health nine modules and not paid for education."*

Some participants appeared to feel torn; referring to their feelings of responsibility as being at war with their concern for their own safety and wellbeing:

*"I would not let them down, but I do not want to burn out."*

Older participants and those who may be immunocompromised were concerned for their own health and safety due to their high-risk status:

*"As I am 71 years old and this is a concern for me as in high-risk bracket."*

*"I am immune compromised so do not want any more shifts at this time. If there was a case in the facility I would not be able to work."*

A number of participants also cited concerns regarding payment for additional hours/shifts based on previous/existing conflicts with employers over unpaid wages:

*"They don't even pay right. We always have to chase for our pays. I am chasing last 2 pays and nothing happened."*



*“Probably not. We have not had a pay rise in three years. We are trying to get more staff just to help out with the workload even without the COVID-19.”*

*“Our employer REFUSES TO PAY OVERTIME. As with most staff, there are times (very frequently) not leaving on time at the end of your shift due to work commitments and documentation. They will file note staff of reprimand staff if not completed but will not pay you if you are required to attend someone at the end of your shift past knockoff time.”*

## Willingness to work by employment type

When analysed by existing employment type, almost 70% of casual staff, 58% of full-time staff, and 49% of part-time staff were willing to work additional shifts or hours (Figure 27).

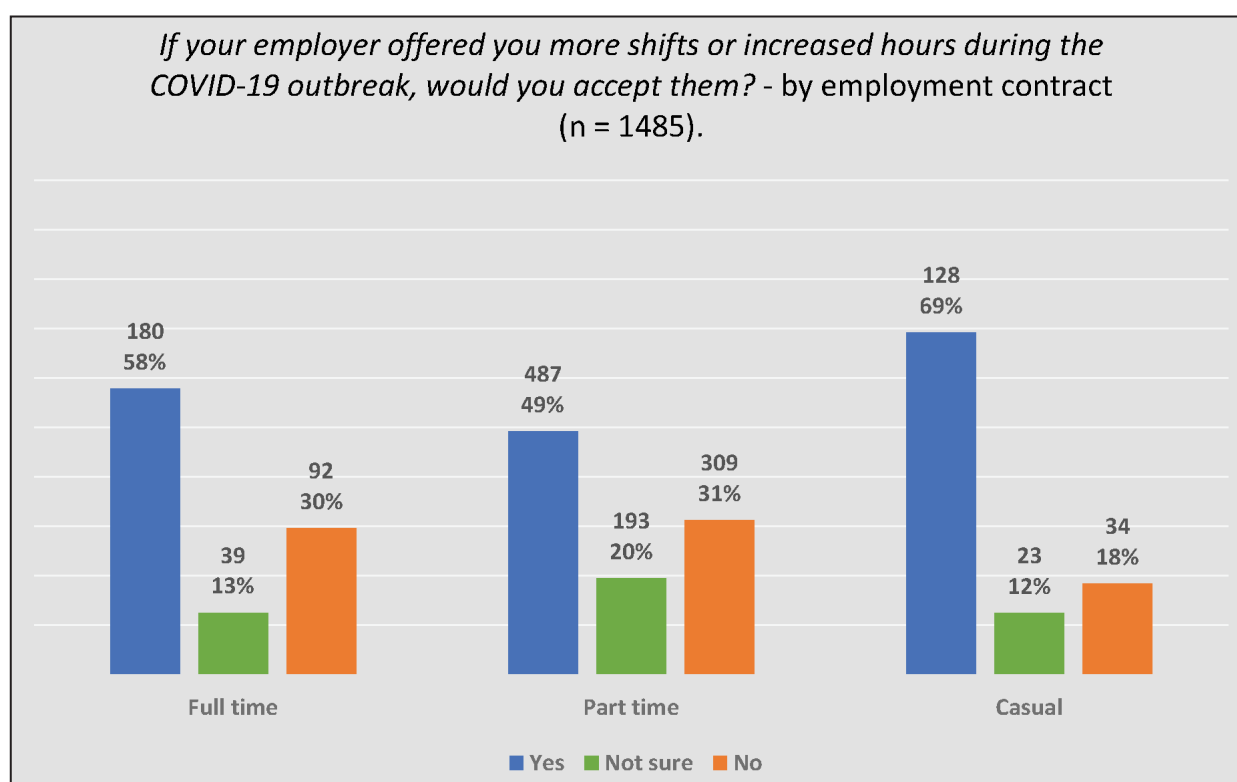


Figure 27: Willingness to work additional shifts/hours by current employment contract

By employment classification (Figure 28), responses were similar across all classifications with RNs being the least willing to take on additional work (50%) and the small group of managers (n = 17) maintaining the largest proportion of participants who reported a willingness to take on additional work (59%).

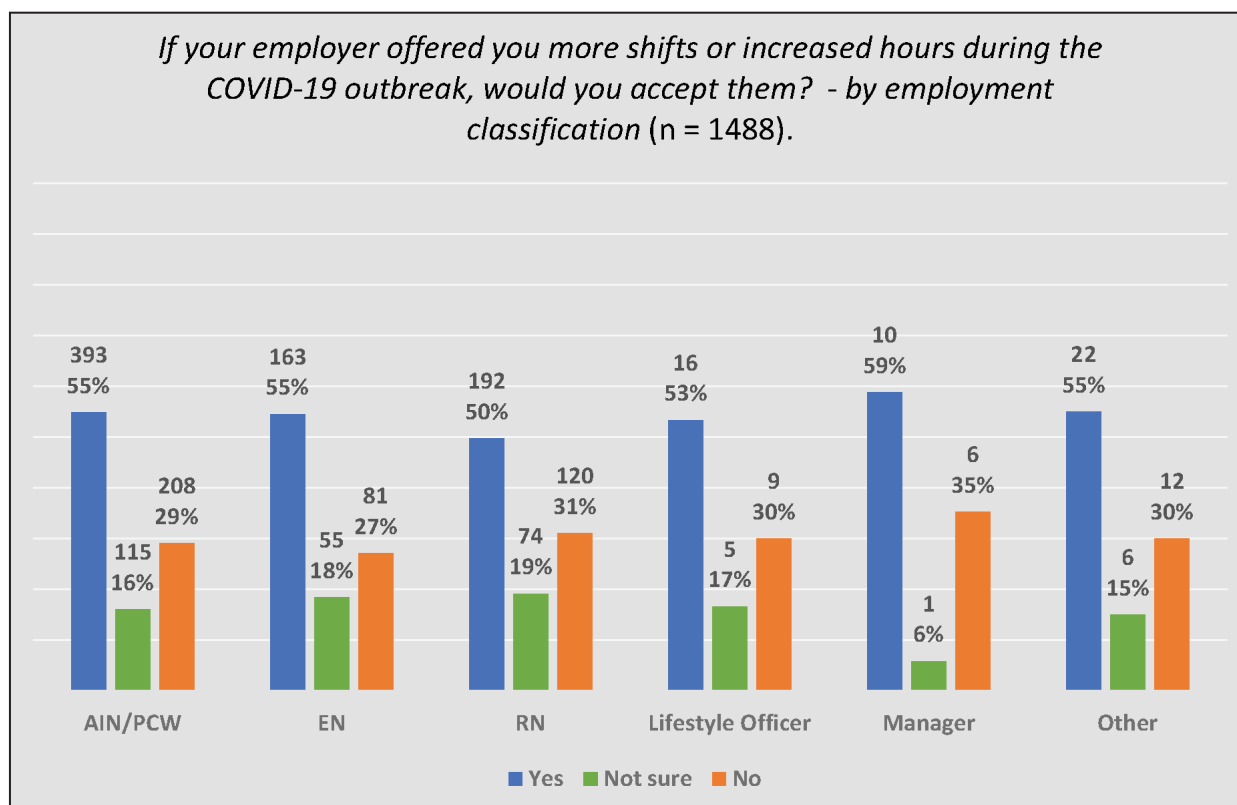


Figure 28: Willingness to work additional shifts/hours by current employment classification

## COVID-19 special leave

Participants were asked if their employer had made any arrangements for them to access additional or special leave from work to self-isolate if they had experienced potential exposure to COVID-19. Of the 1,419 participants who responded, 42 percent reported that no leave arrangements had been made, 28 percent reported that leave arrangements had been made, and 30 percent were not sure (Figure 29).

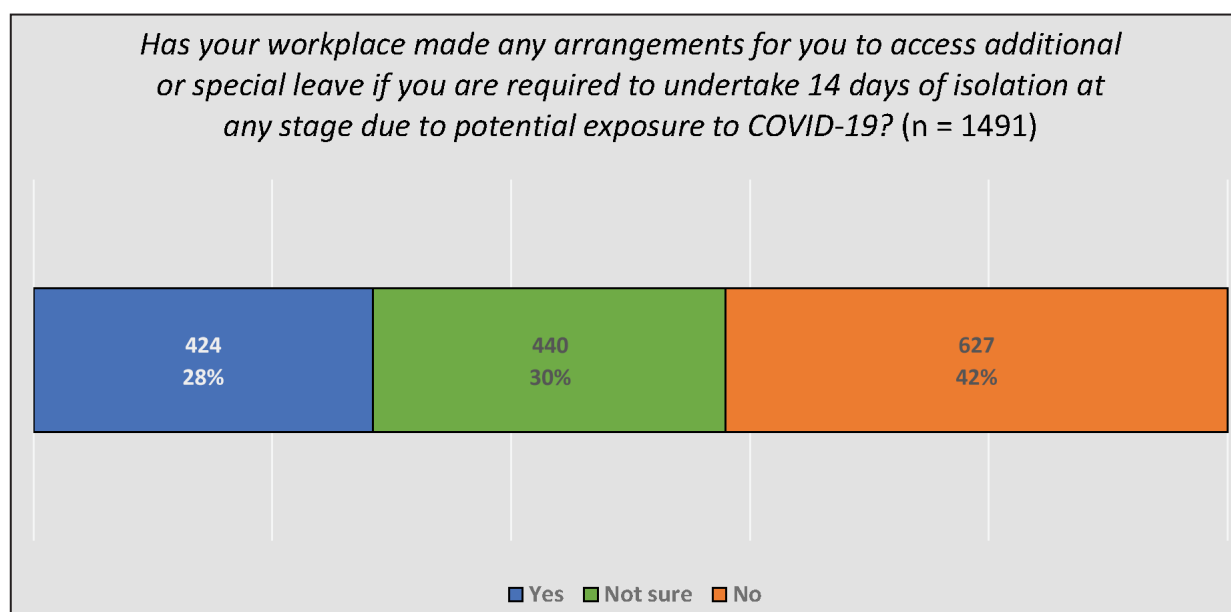


Figure 29: Arrangements for special COVID-19 isolation leave





By sector (Figure 30), for-profit RACFs (46%) and not-for-profit RACFs (45%) had the largest proportions of participants who reported no special leave arrangements had been made for staff potentially exposed to COVID-19. In-home care (43%) and multipurpose health services (46%) included the largest proportions of participants who reported that special leave arrangements had been made by employers.

By employment classification, lifestyle officers (n = 30) included the largest proportion (n = 15, 50%) of participants who reported that their employer had not made arrangements for special leave. This was followed by AIN/PCWs (n = 326, 46%), ENs (n = 120, 40%), and RNs (n = 148, 38%).

## Comments regarding special COVID-19 leave

Two hundred and twenty participants provided comments regarding leave during the COVID-19 pandemic. While some participants noted that they would be able to access paid special leave, many participants commented on their employers requiring them to take annual leave, sick leave, long service leave, or unpaid leave if they became ill or were suspected of having COVID-19. This was a particular problem for people who did not have remaining sick leave. Other staff were forced to take sick leave or unpaid leave.

*“Certain conditions are imposed; staff are informed that annual leave is used first- seems unfair.”*

*“You have to use your sick, holiday or long service.”*

*“I had a cold; didn’t let me work. Also, no pay as I was new no annual leave as well. So no support from anywhere. My two weeks wasted.”*

For some participants, despite negative test results, they were forced to take their annual leave:

*“Yes, I had to do that even though my test results were negative, they gave all my Shifts away for two weeks even though my Doctor had cleared me...I had no option other than to ask that I be paid out of my annual leave...otherwise I would not have had pay for those two weeks...(I had a very minor cold & consequently took myself to the Dr who then sent me to the Hospital for the COVID-19 Test) I had not been overseas or in contact with anyone who had gone overseas...”*

*“I tested negative for COVID-19 just before Easter. The organisation’s policy that anyone who has tested takes 2 weeks leave even if the result is negative and they’ve received medical clearance. My supervisor is unable to confirm my sick leave entitlement and has informed me as of 15 April I will be paid disaster leave at the minimum rate in my EBA. I’m waiting for my next payslip to confirm what entitlements have been accessed. Our sick leave entitlement isn’t recorded on our payslips, only when SL hours are taken/paid.”*

Policies sometimes also meant that leave would only be offered if the person became infected due to exposure in the line of work:

*“Not really sure about that. We only get paid 14 days leave IF we GET the virus from work. I.e. someone is diagnosed and then we get it. We have to use our own leave if we acquire it from outside of work. If one of our family come into contact with COVID-19 we have to take self-isolation and use our own leave also.”*

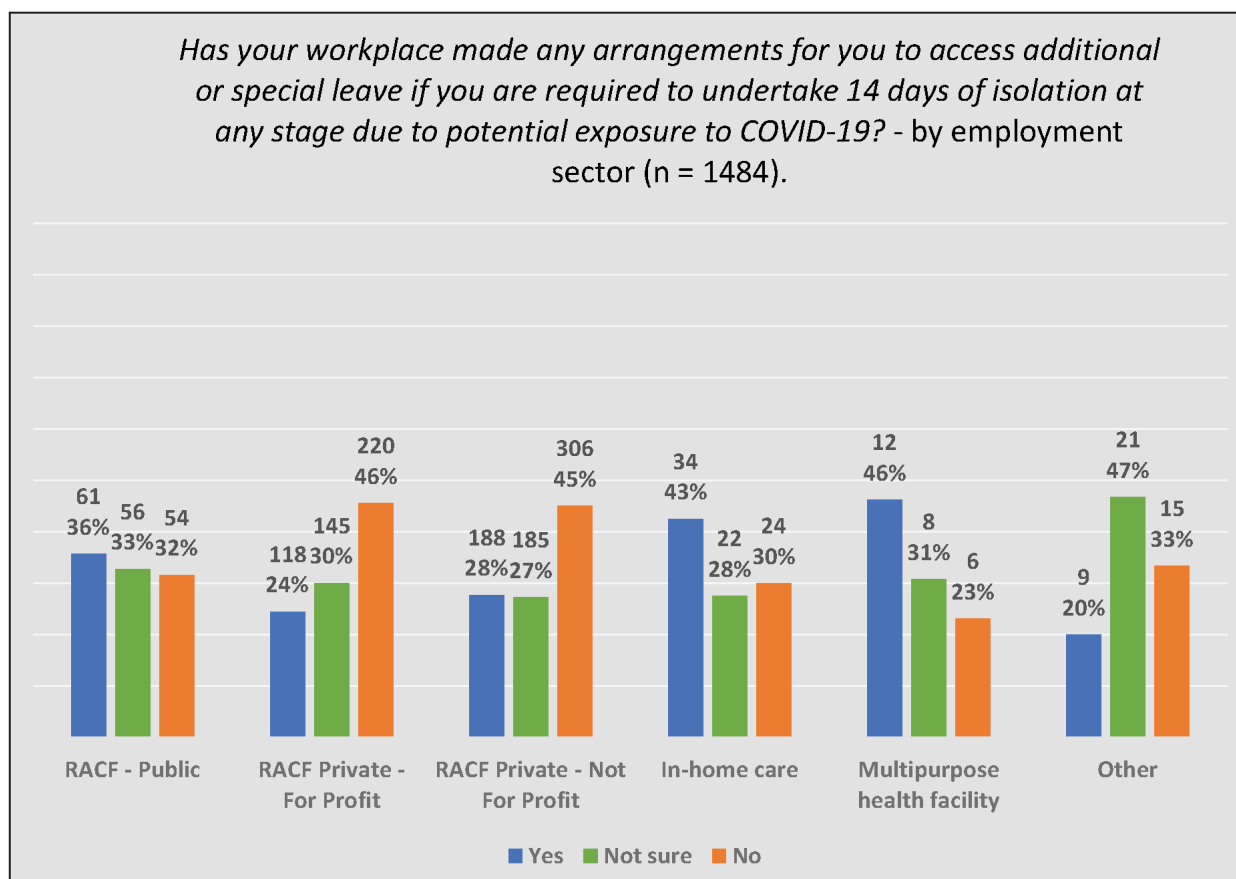


Figure 30: Arrangements for special COVID-19 isolation leave by sector

## Aged care retention bonus

Participants were asked if their employer had discussed the aged care retention bonus with them. Of the 1,493 participants who responded, 81 percent reported that it had not been discussed (Figure 31). When responses were separated by employment classification, there was very little difference between the proportions in responses. A slightly larger percentage of RNs (16%) reported that the retention bonus had been discussed with them, as opposed to AIN/PCWs (14%) and ENs (12%). Those who fell within the managers group (n = 19) were the second most likely to indicate the retention bonus had been discussed with them (21%) behind staff with 'other' classifications (28%).

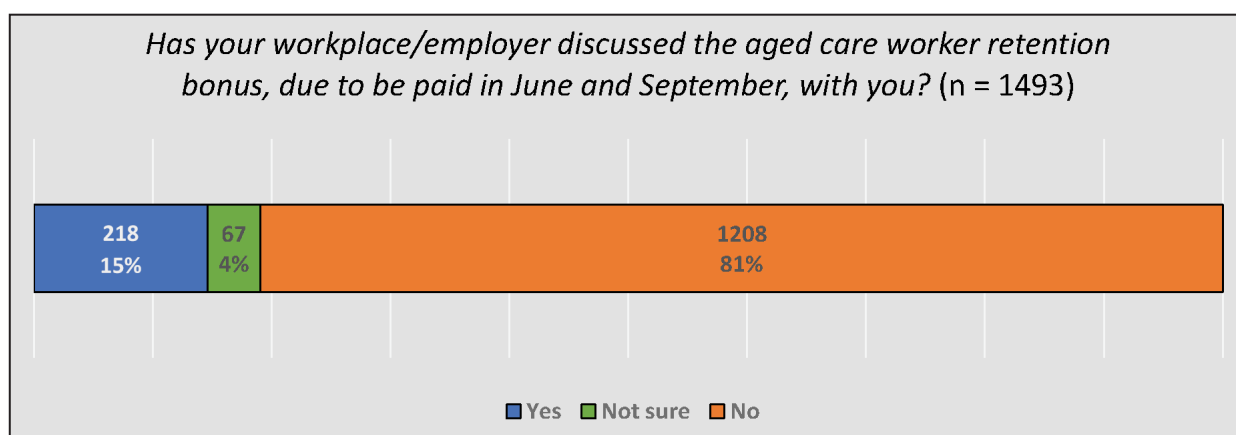


Figure 31: Employer discussion of the aged care retention bonus with staff



By sector, there was very little difference between responses from different groups (Figure 32). Across all sectors, around three quarters to almost 90 percent of participants reported that the retention bonus had not been discussed with them, with those from Public RACFS accounting for the largest within-sector proportion (87%). By employment classification, results were also very similar across groups, ranging from 68 percent of managers (n = 19) reporting that the retention bonus had not been discussed to 90 percent of lifestyle officers (n = 29). Seventy-nine percent of RNs (n = 390), 83 percent of ENs (n = 301), and 82 percent of AIN/PCWs (n = 710) reported that the retention bonus had not been discussed with them.

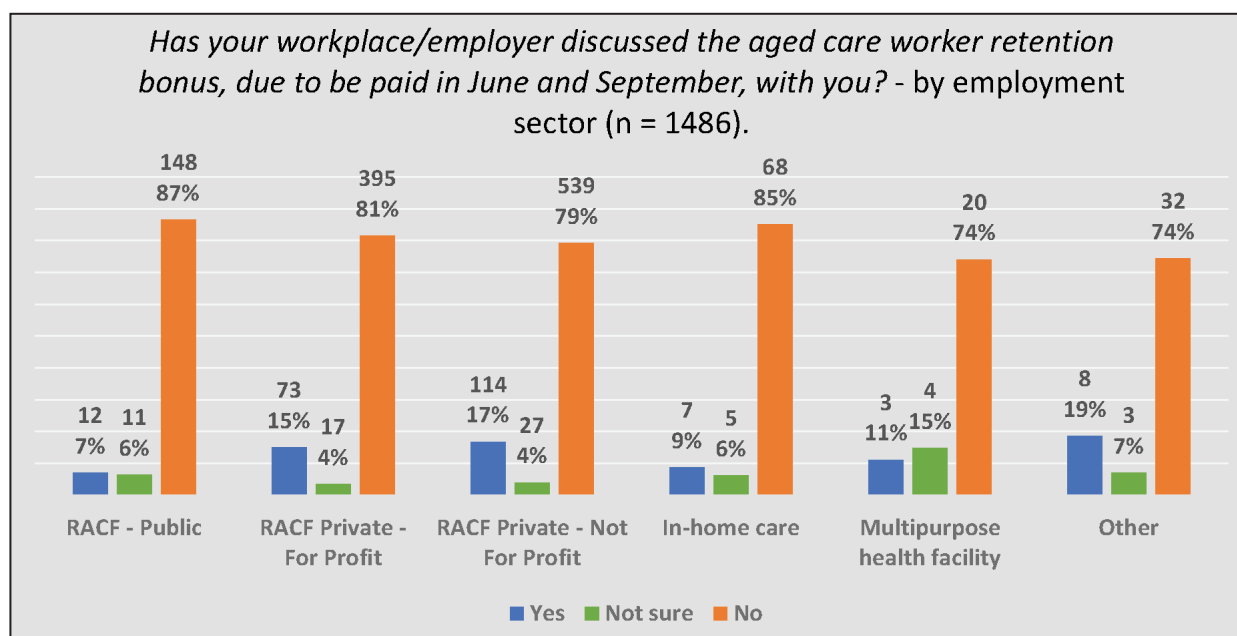


Figure 32: Employer discussion of the aged care retention bonus with staff by sector

## Comments regarding retention bonus payment

Two hundred and five participants provided comments regarding employer discussions regarding the aged care retention bonus. Most comments were simply a few words restating whether or not a discussion had occurred, while other comments highlighted various issues with the bonus, their employer, and how the payment of the bonus (or not) had been communicated to them:

*"They will probably not pay it to staff they told some staff it was only for head office staff."*

*"I only found this information out through the official aged care govt site. No email sent from management to advise of same."*

*"Executive management never discuss financial matters with staff or even senior clinicians. No area is given a budget or knows how much money they can spend. No transparency and a culture of secrecy."*

*"They haven't informed us and when we ask they said they have no idea about it We don't know if casual staff are getting this or not We work hard with the same job as permanents it's so unfair if we don't get it."*



A number of participants had not heard of the retention bonus themselves and others were not sure what the bonus would cover or were unclear on the details of eligibility:

*"Has been discussed amongst care staff but not mentioned by managers. But are nurses included as care staff?"*

*"Majority of us aren't covered as we are all casuals who have worked less than a year, but more than nine months so we don't qualify under the rules for the schemes support."*

*"Concerned that because I am a casual-agency nurse (although working full-time hours at the moment) I will be over-looked in regard to this."*

*"I have heard though that lifestyle staff WILL NOT BE ELIGIBLE?? Not sure why as we are frontline workers also."*

## Aged care funding

Participants were asked whether their employer had discussed with them how they were planning to, or already spending, money received from the Australian government. Of the 1,497 participants who responded, 92 percent reported that the funding was not discussed with them, four percent were not sure, and three percent reported that the funding had been discussed (Figure 33). Responses differed very little from these figures by sector and employment classification.

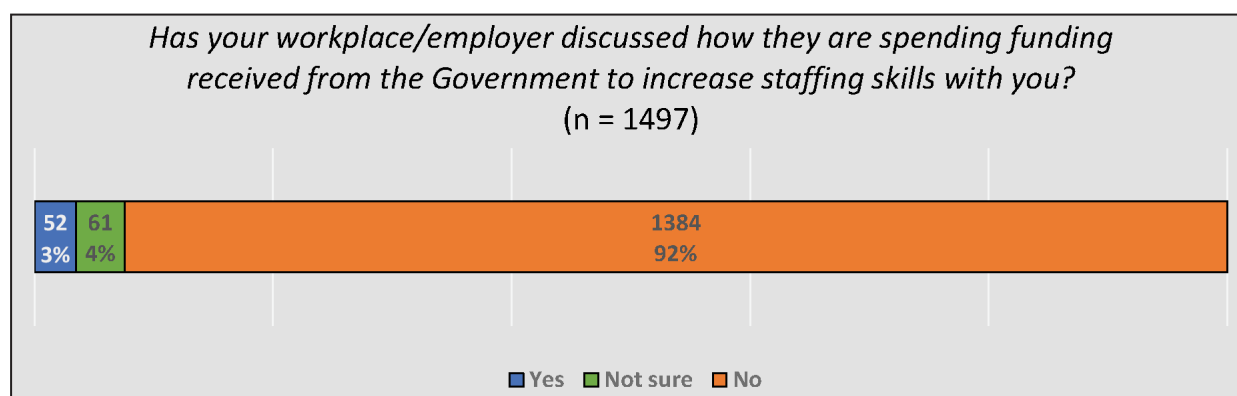


Figure 33: Employer discussion of spending of additional aged care funding with staff

## Comments regarding use of aged care funding

One hundred and ten participants provided comments regarding whether their employer had discussed their spending of money from the Australian government with them. Only six participants who reported that funding use had been discussed with them provided comments:

*"Additional lifestyle hours rostered to allow for assisting residents to stay connected to their loved ones and small group /1:1 activities."*

*"Many new training and education and updates have taken place since the COVID outbreak."*

*"Not so much as discussed but I'm seeing the result of this spending in additional staffing."*

*"They said they spent it on extra cleaning and admin. The cleaning increase is minimal though, they just get an extra half hour either end of the shift to wipe down surfaces."*

*"Using only if confirmed cases."*



Most comments simply reiterated that their employer had not provided any information and/or highlighted that their employer was not likely to share that sort of information with staff anyway. Some participants raised issues regarding the potential use of such funding but did not report that their employer had discussed the issue of funding with them.

*“NO just more staff and too much education. You can educate till the cows come home but without adequate staff numbers education is a waste of time. Without properly trained cleaners it will be a losing battle.”*

*“We are unaware where the funding is going and what the funding is for. But we see no evident changes in our day to day, in most cases it seems they are cutting more costs.”*

*“They have been using the money to sit an agency RN at the front door to take temperatures... All day. Sooo much money wasted when they could have had a PCW who already works there do it.”*

*“Didn’t even know they were receiving money. This might explain the “coffee run” happening on mornings the bosses are working.”*

*“What funding from the Government? They have taken face to face training and training staff away, for all to be taken on line. So if you are confused or need more information who do you ask? What about those who have learning difficulties, they are great at their work, but written or cognitive difficulties are not addressed. A lot of the training we are getting online is honour system really. I know of staff who get others to do it for them. Some struggle, some don’t have time, some don’t care. Online is not the answer.”*

## Other comments

Five hundred and sixty-eight participants responded when asked the final open-ended question of the survey “do you have any other comments?”. This question allowed participants to provide comment about anything they wished. Due to the number of comments and the broad nature of their foci, several themes have been developed based upon an analysis of their responses.

### **Proactive, regular, and informative communication with staff supports safety and wellbeing of staff and residents**

A number of participants reflected positively and with pride upon how they and their employer prepared and managed in the face of the COVID-19 outbreak. Participants reflected upon receiving information and support from employers and leaders in the workplace as well as support to take leave if deemed at high risk. Interfaces with other healthcare services were also remarked upon positively, as were situations where staffing was deemed to be suitable.

*“I believe my employer is working hard to protect both residents and staff from potential infection of COVID-19. They have put in support for at risk employees by allowing them to take indefinite leave without risk of losing their jobs and have been flexible in considering employees with school age children and rostering.”*



*"We have a wonderful, caring and informative manager, she is an amazing human. I love where I work, I have only worked in one facility and one company, career change, from retail, eight years ago. But the feedback I hear from visitors to the facility, educators, family, work placement students, are positive, I had a teacher come to visit with her student and she said our facility had a certain vibe. She felt it as soon as she entered, she said 'you can feel the love'. I was pretty proud to hear this and to be part of a care facility that others felt this way about. We did hire the student she had been visiting; a caring addition to our team."*

*"Organisation-wide we have done an extraordinary amount of work to prepare; staff survey for skills/redeployment/ hours of work, staff working from home, one point of entry and exit to monitor traffic, temperature checks for all staff at shift start, weekly updates from executive and executive teleconference twice a week, and more if required. Our GPs have coordinated approach. We feel very supported."*

*"Great proactive management and clinical team. Teamwork 100% for the safety and wellbeing of our residents. Up to date daily correspondence from management."*

*"I feel my manager is very hands on; she is constantly in contact with family taking photos and video and sending them. She is transparent to staff and families about procedure. I recently orientated a new carer who was shocked at how many staff we had during the day, this is our normal staffing."*

*"I personally feel our workplace has ensured we are educated about COVID-19. we have all redone our infection prevention training, taken mandatory training on COVID-19 and its management. They have kept us informed with changes which were happening very rapidly, they did this by using email, text messages, and an information folder."*

*"I feel that my employer was proactive early on, took brave and difficult steps to protect staff and residents. It hasn't been easy at all. I do not approve of visitors being let in to our homes. I can't see my mum, she's lonely and socially isolated at home. Aged care residents have each other, staff and are in many respects blissfully unaware. I think it's their families who are struggling. The atmosphere is calm, good and relaxed inside our homes."*

### **Staff feel undervalued and unrecognised – especially AIN/PCWs**

Conversely, in other workplaces, participants did not feel valued or recognised for their work nor supported by management in terms of their access to resources, their well-being and safety, or their ability to prepare for a potential outbreak. This was particularly noticeable in comments made by AIN/PCWs. Many staff felt that management was doing little to support them or protect their residents and noted that there did not appear to be any genuine efforts towards using funding to improve conditions or care.

*"We have had a few staff members feel extremely uneasy about working during this pandemic and our boss has been extremely rude not acknowledging how they feel. Our boss also told us she expects us to work extra shifts in case of an outbreak at work. We would definitely not have enough care workers at all to cover an outbreak... and then you could expect staff to call in sick if they were not feeling well leaving us even more short staffed. We are already constantly working short staffed but because it's a for-profit business; management do not care. They do not care that their staff are feeling stressed and have no regards to the mental health of staff members. I feel extremely anxious if there were*





*an outbreak as I wouldn't feel comfortable in working. I would hate to bring the virus back to family. We would get absolutely no help from management so they wouldn't be in the front line, our boss seriously has no regards for her staff and everyone is feeling uneasy about it."*

*"I think large aged care employers need to look after their nurses more. They are either worried about their image, their budget, or cater to complaining relatives – but neglect the nurses and their safety."*

*"Upper management don't and haven't even consulted with us or sought any input from us regarding our views or how we are coping."*

*"Private sector all about the profits. Will work staff to death to save money and won't care if staff or patients contract coronavirus. Staff hours will not increase."*

*"I'm in a leadership role and am very frustrated by the corporate response. Frustrated but not surprised."*

*"It is quite disappointing that staff are not protected as there is shortage of PPE. Staff do not get enough support from management."*

*"It is a debacle and very poorly instigated. It is only good luck and wonderful care staff that we have not had any cases."*

*"[Company name] are PROFIT based first and foremost... Staff are a disposable commodity... Minimum staff to resident ratios plus workload and resident demands ensures staff burn out and extremely high staff turnover... Slave labour with low pay rates = a totally dissatisfied workplace with high stress and unrealistic expectations... To put it plainly... CRUEL - Corporate GREED wins..."*

*"We have a new manager at our facility, she is a dreadful piece of work. Shows the staff no respect at all, tells staff in front of other staff that they should be ashamed of themselves, and makes it clear she has no time for Unions. Really need a union to stick up for us."*

## **Lack of planning and policy, slow and inconsistent uptake of precautions**

While many participants did describe how their facility was prepared for a potential outbreak as described above, many others did not feel prepared and were extremely concerned regarding their workplaces' ability to successfully manage a COVID-19 outbreak. Reasons for lack of preparation included poor access to equipment and supplies, lack of clear or informative communication, and lack of support from management. Many participants reflected that their lack of preparation for COVID-19 highlighted pre-existing problems in the workplace and sector.

*"Seriously under prepared for an ordinary outbreak i.e. flu or gastro. Cheap gowns and gloves used that tear easily. Did get into an argument with facility Care Manager over providing eyewear (had a suspect COVID-19 who would spit at staff) - said her guidelines said that she did not need to provide it. Only six pairs of glasses in facility, had to get staff to wipe down and reuse."*

*"I am not confident in my workplace that we are anywhere near prepared to deal with COVID-19. I am considering leaving my employment there."*





*"We have received no face to face talk from our management about what our plan is or anything to do with coronavirus for that matter. Management have not advised staff of anything except via memos so everything on paper looks correct."*

*"Lack of well-informed and educated management. [It] is frightening - they are inconsistent and contradictory in some responses, their communication is poor, and generally staff feel unsure and fearful."*

*"It has been handled very poorly, no-one really knows what is going on, no preparation as far as I can see. If we get COVID-19 cases onsite we will be in serious troubles as our management are not up to the task of supporting us through such an event."*

*"Are any aged care facilities really prepared and ready for a COVID-19 outbreak??? Understaffed and overworked on a normal day - I have my doubts."*

*"[Name of employer] is not prepared for any outbreak; they give a lot of education but there is no PPE available on the floor and there is no infection control. And if the aged care royal commission visit, they hire more RNs and carers, and after that they just get rid of them."*

*"I'm concerned by the unsure answers I have left. I should know these answers and that rests on management. Staff don't feel supported at work by management and we should be being encouraged with positives such as extra payments available to us, knowing we have enough PPE and what they are spending the extra money on that they are receiving from the government because it is certainly not floor staff."*

### **Doing our best in a changing environment**

Many participants wrote about the challenging and fast-paced nature of preparing to deal with COVID-19 in terms of changing policies and procedures and the need to adapt to these quickly. Some commented that this felt uncoordinated and indicative of poor preparation while others focussed more on the notion of doing their best during a very challenging time.

*"Our facility rules changed from day to day like no one knew what they were doing. Staff working short, not being replaced, just all over the place very uncoordinated."*

*"The info and training and updates we have are ongoing and transparent (except the retention bonus). I feel confident we have a well-planned process and will have a good handle on it. Won't be Scary... I guess it will still be Scary in the event we do have a resident who tests positive. I have also felt my head was spinning from all the updated updates that can change three times in one day. Overwhelming!!?"*

### **Ongoing lack of sufficient staffing, staff cuts compounding existing problems**

Many participants reflected upon the state of staffing in aged care and highlighted how the ongoing COVID-19 pandemic had compounded problems in an already stretched and understaffed sector. These participants wrote of the stress as the strain of working in the sector during the outbreak and noted that even where there were no cases, workloads and expectations were unreasonably high, staff were exhausted, and lacked the support of an adequately sized workforce with a suitable skills mix.

*"Just the lack of staffing. During these hard times we should be provided with more support, yet it seems to be the opposite and is extremely stressful and hard on staff members."*



*“Our worksite is unfairly placing staff and understaffing us. Cutting hours and also leaving unfair ratio to worker to residents. COVID-19 hasn’t breached the walls but it has certainly caused a lot of overworked and stressed staff and unhappy residents as no one is having their needs met.”*

*“We are run off our feet - expectations and requirements have increased significantly but no extra staffing or support for lifestyle. Expect us to link residents with families but no additional IT support or resources - having to use my own phone.”*

*“Very poor skills mix on floors. Lack of experienced staff; recent trainees are being placed with last group of trainees which have not been signed off (have not been post course 6 - 12 months) to “buddy”. THIS HAS BEEN AN ONGOING ISSUE FOR AN EXTENDED PERIOD OF TIME. This is very demanding on the limited experienced staff on the floor to supervise the inexperienced care staff. Poor rostering, having staggered shifts, multiple staff rostered off during times off high care needs often leaving the floors short-staffed and at dangerous levels both for staff and resident safety. It has been mentioned to management on numerous occasions that the rostering is NOT WORKING but as usual NOTHING CHANGES. Management constantly saying inadequate funds to boost care staffing levels, however the company seems to be very top heavy with management/ admin staff.”*

*“Disappointing to see management and clinical staff who do no hands-on nursing not caring that we are working short-staffed. We were told that the facility was over budget and could not afford agency staff. Staff extremely stressed and exhausted dealing with angry residents. Staff staying back to work extra hours are useless as they are too tired to be of any help. Unbelievable all this continues to happen considering we have had the aged care inquiry. We are reminded frequently at [Company name] that it is a business and has to make a profit and that the residents now have to be called consumers.”*

*“In regards to staffing numbers - not enough! And certainly not enough to deal with an outbreak. There needs to be defined ratios. For nursing students, facilities should be taking these students under their wings and utilising them to assist the overworked EENs in a AIN capacity. Nurture those who could end up as valuable nursing staff for your facilities!”*

## **Lack of PPE, inconsistent information and messaging, inability to access or use existing PPE**

Many participants returned to the issue of lack of PPE, poor access to PPE, or unclear policies, procedures and education and training for the use of PPE.

*“Our infection control officer asked us to keep reusing our masks and store them in plastic containers. I refused as it defeats the purpose. I am worried that a lot of the PCWs and ENs don’t question the directive. Fingers crossed our facility does not get COVID-19.”*

*“We are not provided with enough PPE at work. We have requested many times, but nothing happens. We even don’t have enough gloves to protect ourselves and the residents whom we look after. Care Manager has got no skills when it comes to listening. If we do raise matters, we get threatened of losing employment.”*

*“Staff safety is not priority. They talk about isolating all residents with cough and fever and those coming back from hospital but does not provide enough PPE.”*



*"I would say it will be inadequate. They tell me that the boat is bringing more PPE. I have purchased goggles and a full-face shield from Mitre 10 just in case."*

*"We are made to feel guilty for asking for PPE..."*

### Significantly increased workloads

Many participants commented on the increased workload that COVID-19 had caused within the aged care sector. As a vast majority of participants were not dealing with active cases of COVID-19, this demonstrates how workloads were hugely impacted across the aged care sector. Often, these massive workloads were linked to inadequate staffing, poor rostering, and lockdowns.

*"The increase in workload has been huge. No extra staff constantly dealing with families and distressed residents."*

*"I observe that the employer is attempting to appear as actively responding to risks however without expending any additional resources. I.e. staff requiring to do more vitals assessments each day, liaising with families because they can't come in. And not providing adequate PPE meaning staff have been paying for it themselves. No extra carers, nurses kitchen or lifestyle staff to compensate."*

*"We need to increase staffing level. What is happening now is if one staff member called in sick there is no replacement or won't dare to find replacement. We staff left on the floor are working double time and harder, which is not good for our own wellbeing. We need support. We are also considered an essential worker/ front-liners not just the nurses/doctors in the hospital. Please support us that work in aged care."*

### Concern for the residents' wellbeing

A number of respondents' comments focussed on their concern for residents both due to the limitations regarding visitor access, worries about their vulnerability to the virus, and the impact of isolation. Participants felt saddened by the fact that older people they care for were suffering, particularly those who were nearing the end of life.

*"Elderly in lockdown from loved ones. Talking through a phone looking through a public window. Resident with very little sight cannot see [their] daughter's face. Not a good response to a virus for the elderly who may not have many more months left. This is residents who are all well, afebrile, no symptoms. Feel ashamed to provide such poor care."*

*"Poor communicating and mixed messages from management workload has increased and the stress of isolation on the residents is concerning."*

*"I am extremely concerned if the virus comes into my facility most of my clients will die. The facility will do too little too late."*



## Conclusion

*“I care a lot about my residents. It pains me knowing there is not enough staff to efficiently care for them, so I step up when need be.”*

As of the 4th of June 2020, it appears the peak of the COVID-19 pandemic has passed.<sup>2</sup> Due to the generally effective and efficient action and preparation on the part of governments, healthcare providers, the community, and some aged care providers the potential for an unmanageable surge of patients with COVID-19 has thankfully been avoided to date. This does not diminish the loss and sadness felt by those who have lost loved ones and family members to the outbreak. For the families, friends, and health and aged care staff of the 102 individuals who have died – many of whom who were vulnerable older Australians – the scale and scope of protections and preparations were sadly not enough. At a population level, Australia, its healthcare and aged care system, and the patients, residents, and clients who are cared for there have largely been spared. This is in stark contrast to several other nations, many of which are large well-developed economies like our own.

*“I am passionate about what I do. if the time comes and those residents need me, I would happily to do so.”*

The lessons we can learn from the ongoing COVID-19 pandemic and outbreak in Australia are valuable and should be carefully considered and reflected upon by decision-makers across government, health, and aged care. Many have known for decades of the potential for a global pandemic and how this might impact health and aged care and while previous warnings tended to focus on the threat of viral influenza and other diseases such as Ebola, COVID-19 did follow similar transmission pathways to viral influenza and could be argued to have had a similar impact to a highly contagious and virulent strain.

*“We have done a huge amount of work to try and prevent COVID-19 entering our facility, but if it does, we will have extreme difficulty managing care.”*

While this report cannot directly compare the response in health and aged care, what we have found is that many of the conditions, brought to the attention of the public prior to the pandemic through the Royal Commission into Aged Care Quality and Safety and other studies, have persisted.<sup>3,4</sup> Australia's aged care sector is indisputably understaffed and the workers who are there are in many cases doing the best they can with little support, few resources, and limited recognition by providers and more broadly within the public domain. While only isolated outbreaks of COVID-19 appear to have occurred in residential aged care, and further more specific evidence and inquiry is needed to examine these instances further, a number of issues are clear:

- Many aged care providers need to increase their staffing levels and skills mix to deliver safe quality care for vulnerable residents and clients.
- Higher levels of staffing and better skills mix with greater numbers of registered nurses and enrolled nurses would provide better infection control and health care as well as greater support to nurses, care workers, and other staff.
- Workloads in aged care are often unmanageable and were intensified by the COVID-19 pandemic across the sector.
- Many aged care providers were prepared for an outbreak, but many were also unprepared. High quality communication, information, resources, education, and training, and safe staffing levels all appear to be critical features of better preparedness.



- Personal protective equipment was a major concern for many staff. There needs to be greater investment and preparation to ensure adequate supply, stocks, training, and information regarding use.
- Infection control policies and procedures could be improved and implemented better across many areas in aged care in a consistent and evidence-based manner.
- Staffing levels and responsibilities of auxiliary staff (e.g. cooking, cleaning, and other staff) are vital and may require further examination regarding how these roles contribute to aged care's ability to respond to infectious disease outbreaks.
- Aged care providers may not utilise funding to support the delivery of safe and quality care for residents as use of funding to ensure an adequately sized, appropriately supported workforce appears to be limited.
- Registered nurses may be rostered on but this appears to occur in such low numbers that they may not be present on every shift or able to do their jobs effectively.
- Aged care workers feel undervalued and unrecognised for the important work they do to care for residents.
- Many aged care staff were willing to work extra hours or shifts during the COVID-19 outbreak but this willingness to work does not appear to have been taken up by employers.
- Many providers did not provide special leave for staff who may have needed to self-isolate due to potential COVID-19 infection.

The results of this survey, as well as the overall low number of cases and deaths in the Australian aged care sector, highlight the clear willingness and commitment held by aged care staff towards the protection and safety of those in their care. The hardworking people who go to work - often with little recognition and little reward, even during a global pandemic which has placed them, their loved ones, and their jobs at risk, should be thanked and recognised for their passion and dedication to caring for Australia's most vulnerable population. In contrast to the impact felt by many other nations globally, COVID-19 has so far been contained across most of Australia and this is in no small part due to the integrity and professional conduct of the aged care workers, nurses, doctors, specialists, and staff who have borne the responsibility and risk required in achieving a result truly in support of the nation.

*“Please help Australian aged care show the good work that is being done each and every day. Stop only showing how bad, because when you look at the rest of the world, we did not abandon our posts and leave people to die. We did not have inadequate policies and procedures and measures to allow our residents to suffer.*

*We have provided safety, security, love, and extreme resourcefulness and quality of life in the most difficult of circumstances that we as an industry have ever had to face and we are tired of being seen as substandard and all rogues because we are most certainly not.*

*Our residents matter and we are on the job each and every day to provide the very best love and care to them as we possibly can. Tell that story. Is that newsworthy? I hope yes. Then show the contrasts of the rest of the world. We should be able to hold our heads high and not hang in shame. Thank you.”*





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