

Hearing the voices of Australian healthcare workers during the COVID-19 pandemic

Michelle Ananda-Rajah ¹, Benjamin Veness,² Danielle Berkovic,³ Catriona Parker,³ Greg Kelly,⁴ Darshini Ayton³

► Additional material is published online only. To view, please visit the journal online (<http://dx.doi.org/10.1136/leader-2020-000386>).

¹Central Clinical School, Monash University, Melbourne, Victoria, Australia

²Psychiatry Department, Public Hospital, Melbourne, Victoria, Australia

³School of Public Health and Preventative Medicine, Monash University, Melbourne, Victoria, Australia

⁴Intensive Care, Public Hospital, Sydney, New South Wales, Australia

Correspondence to

A/Prof Michelle Ananda-Rajah, Central Clinical School, Monash University, Melbourne, Victoria, Australia; michelle.ananda-rajah@monash.edu

Received 18 September 2020
Revised 2 November 2020
Accepted 15 November 2020

ABSTRACT

Background The statistics of healthcare worker (HCW) COVID-19 infections do not convey the lived experience of HCWs during the pandemic. This study explores the working conditions and issues faced by Australian HCWs.

Methods Qualitative analysis of free-text responses from Australian HCWs from 3 August to 26 October 2020 from an open letter calling for better respiratory protection for HCWs, transparent reporting of HCW COVID-19 infections and diversity in national infection control policy development. The open letter was sent to an email list of 23 000 HCWs from a previous campaign and promoted on social media.

Results Among 3587 HCWs who signed the open letter during the study period, 569 free-text responses were analysed. Doctors and nurses accounted for 58% and 33% of respondents, respectively. Most respondents came from Victoria (48%), New South Wales (20%), Queensland (12%) or Western Australia (11%). Dominant themes included concerns about: work health and safety standards; guidelines on respiratory protection including the omission of fit-testing of P2/N95 respirators; deficiencies in the availability, quality, appropriateness and training of personal protective equipment; and a command-and-control culture that enabled bullying in response to concerns about safety that culminated a loss of trust in leadership, self-reported COVID-19 infections in some respondents and moral injury.

Conclusion Deficiencies in work health and safety, respiratory protection, personal protective equipment and workplace culture have resulted in a loss of psychological and physical safety at work associated with an occupational moral injury. The challenge for healthcare leaders is to repair trust by addressing HCW concerns and fast track solutions in collaboration with them.

INTRODUCTION

Compared with many developed countries, Australia has been relatively spared the impacts of COVID-19. Total case numbers were 7767 until 30 June 2020, but increased when Victoria, a state with a population of >6 million, experienced a resurgence in early July 2020 accounting for 20341 (74%) of a total of 27513 infections by 26 October 2020.¹ This resurgence was associated with a sharp increase in healthcare worker (HCW) infections in Victoria (national data unavailable) from 388 on 16 July² to 3577 by 27 October with one death reported in April 2020.³

There are parallels between the Australian and international experience with HCWs disproportionately infected with COVID-19 compared with the general community. The prevalence of COVID-19 in HCWs from the USA and the UK is 2747 cases per 100 000 HCWs, compared with 242 cases per 100 000 people in the general community.⁴ By 16 September 2020, an

estimated 3 million HCWs globally had been infected, and as of 16 July 2020 over 3000 had died.⁵ Over 1300 HCWs have died in the USA⁶ and 600 in the UK,⁷ with HCWs from non-Caucasian backgrounds comprising nearly two-thirds of deaths.⁸ While many jurisdictions have struggled to prevent HCW infections, some have effectively protected their HCWs, with China,⁹ Singapore¹⁰ and Taiwan¹¹ the notable exceptions.

Statistics, however, do not convey the lived experience of HCWs. In Australia, the media and professional societies have highlighted some of the issues faced by HCWs, who have reported workplace bullying,¹² concerns about personal protective equipment (PPE)¹³ and mental health morbidity.¹⁴ HCWs have turned to the media to help broadcast their concerns¹⁵ in response to a lack of progress using conventional channels.

At the start of the Victorian resurgence, national guidelines on respiratory protection for HCWs was a surgical mask for the routine care of COVID-19 suspected or confirmed patients with the N95/P2 respirator reserved for aerosol-generating procedures.¹⁶ However, in late July, major hospitals in Melbourne introduced N95 respirators for COVID-19 confirmed and suspected patients in response to multiple hospital outbreaks¹⁷ with the state guidelines aligning with this approach soon after.

It was against this backdrop that some of the authors (MA-R, BV and GK) spearheaded a national advocacy campaign to elevate the occupational safety of HCWs. On 2 August 2020, a letter signed by 23 doctors was sent to the Australian Federal Minister for Health (<https://tinyurl.com/y3pyp567>). The letter called for better respiratory protection, greater diversity on our national infection control guideline committee and transparent reporting of HCW infections. The letter was shared via email to 23 000 HCWs (61% doctors and 28% nurses) who had responded to earlier campaigns by BV and GK advocating lockdown. It garnered over 2700 signatures by the morning of 5 August 2020 and a total of 3587 by 26 October 2020 when it was closed. An optional question was included for respondents to share concerns about their occupational safety. This triggered an outpouring of responses from HCWs that have been thematically analysed to better understand the challenges they have faced during the COVID-19 pandemic.

METHODS

Qualitative analysis

Experienced health services researchers (DA, CP and DB), who were not involved in development of the open letter, coded the responses. Twenty responses were initially coded to create a coding framework. The primary codes were individual, organisational and system level factors with barriers and enablers



© Author(s) (or their employer(s)) 2020. No commercial re-use. See rights and permissions. Published by BMJ.

To cite: Ananda-Rajah M, Veness B, Berkovic D, et al. *BMJ Leader* Published Online First: [please include Day Month Year]. doi:10.1136/leader-2020-000386

Table 1 Demographic characteristics of healthcare worker respondents

Role	Count (n=569)	%
Nurse	188	33
Doctor	331	58
Allied health	25	4
Paramedic	13	2
Clerical	7	1
Midwife	5	1
State/territory	Count (n=569)	%
Vic	275	48
NSW	111	20
Qld	68	12
WA	63	11
Tas	18	3.2
SA	18	3.2
ACT	13	2.3
NT	3	0.5

ACT, Australian Capital Territory; NSW, New South Wales; NT, Northern Territory; Qld, Queensland; SA, South Australia; Tas, Tasmania; Vic, Victoria; WA, Western Australia.

identified for each category. Approximately 190 responses were coded by each investigator, with coding disagreement resolved through discussion and consensus.

RESULTS

The open letter was signed by 3587 HCWs with 569 free-text contributions. The majority (48%) of respondents were from Victoria (VIC), followed by New South Wales (NSW) (20%) and similar representation from Queensland (QLD) and Western Australia (WA) (12% and 11%, respectively). Doctors and nurses accounted for 91% of responses, with remaining respondents from paramedicine, allied health and clerical backgrounds (table 1).

The themes below represent the spectrum of issues concerning HCWs. To convey their voices, results have been presented in a narrative style below (Online supplemental file 1 provides a table of HCW quotes mapped to the themes below).

Work health and safety issues including policies/guidelines

We don't want to be heroes. We just want protection in line with OHS standards. (GP, Victoria)

HCWs felt that they deserve *'the same occupational health and safety demanded in any other industry'* (anaesthetist, VIC) and that *'with community transmission rates climbing, subpar PPE is just unacceptable'* (trainee doctor, VIC). HCWs highlighted the mining and asbestos removal industry where *'no worker can work without the appropriate respirator'* (nurse, WA). HCWs perceived guidelines derived from the WHO to be *'woefully inadequate...[with] studies showing the virus to be airborne since March, whereas WHO only got on board in July'* (general practitioner, QLD). This WHO position gave *'managers and hospital executives an excuse to lower the standard of PPE to a surgical mask, face shield, and apron'* (nurse, WA) with HCWs noting *'very poor leadership from executive'* (doctor, VIC). Many perceived that guidelines were *'dictated by resources and not staff safety'* (nurse, QLD) and that Australia has *'waited until our own staff got sick and intubated before we very gradually changed the PPE quality supplied to staff in Australia'* (doctor, VIC).

HCWs decried that *'staff becoming sick is unacceptable'* (nurse, TAS) and *'having any fellow HCWs at the same health network with confirmed COVID is far too many'* (doctor, VIC).

They asked, *'since when was it acceptable for miners to die from preventable OHS accidents? Never - so don't make it acceptable for HCWs'* (doctor, VIC) noting that *'We give everything for our patients, but we don't expect to have to give our lives'* (nurse, TAS).

The approach to occupational safety was, *'reactive not proactive as numbers began to grow'* (nurse, VIC). Instead of introducing *'PPE appropriate for airborne transmission, and scale back if required'* (doctor, VIC), policies dismissed precaution and were *'dragging their heels ... Adopting the cheapest PPE instead of the most suitable'* (paramedic, VIC). Respondents drew a comparison with SARS, where *'respiratory protection was upgraded well before the evidence-based studies regarding respiratory protection "proved" that aerosol spread was occurring which saved hundreds of HCW lives'* (physician, TAS).

Opportunities had been squandered given, *'Australia had so much time to learn from the experiences overseas'* (nurse, TAS). Instead we *'lost valuable time to prepare for this pandemic due to government and department effective obstructiveness'* and did not consult broadly enough, *'occupational medicine doctors should have been involved in expert groups from start to prevent workplace outbreaks'* (occupational medicine physician, WA). HCWs recognised the threat to health system functionality where asymptomatic patients who had *'moved across many areas of the hospital'* could cause an outbreak *'affecting hospital flow and productivity'* (midwife, VIC).

Issues with PPE: access, quality, appropriateness and training

Protect us PROPERLY so we can protect you! (Nurse, Western Australia)

Despite HCWs being *'essential'*, a lack of or limited supply of PPE was reported across Australia. Respondents emphasised that they *'need PPE in our practice consult rooms, not in a "National Stockpile" thousands of kilometres away!'* (doctor, QLD). The lack of availability of PPE had led to rationing, with PPE being *'locked in cupboards'* (doctor, NSW) and respondents being *'directed to store surgical masks in a plastic bag and reuse them for the same patient on multiple occasions'* (doctor, NSW). PPE had quality issues with *'gowns that tear easily, surgical mask quality is often poor'* (nurse, WA), masks that *'often require a tremendous amount of "MacGuyver-ing"'* but still *'slid down, exposing my nose'* (trainee doctor, VIC), *'poorly fitting ear loop ones'*, which affected critical manoeuvres where *'several colleagues had to remove eye protection as they kept fogging up'* (surgeon, NSW).

Fit for purpose PPE was important particularly for first responders where they *'do not function in a controlled environment'* and *'face wind, weather, manual handling of infected patients, difficult extrications, patient lifts, carries, and sit centimetres from patients in confined spaces'*. Gowns were prone to *'billowing in the wind, spreading droplets, contaminating faces and surfaces, as well as providing no protection to legs when bending, lifting, sitting'* (paramedic, WA). Proceduralists encountered PPE failures, *'on a patient who had suffered a cardiac arrest, the mask developed a major leak and fogged up the face shield which meant I was exposed to viral aerosol and had poor visibility. It is incredibly stressful. Make fit testing mandatory and provide us state of the art PPE.'* (anaesthetist, VIC). Even anaesthetists, who are at high risk due to intubation responsibilities are being asked *'to use cheap N95 duckbill masks without formal fit testing... intubators' face shields are fogging so badly that it is almost impossible to see. Full face Respirators must be made available'* (anaesthetist, VIC). Guideline variability resulted in

mask confusion with the need *'to juggle between different masks based on the interventions we use to treat patients' where 'we are not able to predict these decisions until we are already on scene'* (paramedic, NSW).

HCWs were angered by a lack of internal support: *'My hospital's Chief Medical Officer has been silent on this issue, even when it was raised in a public forum'* (trainee doctor, VIC), citing that the inadequacy of PPE *'runs contrary to OH&S regulations in every other facet of working life'* (trainee doctor, QLD). The lack of representation in policy making meant that, *'General Practice is under-represented in the decision-making process and the allocation of PPE, despite our high profile in the early presentations'* (nurse, WA). Consequently, HCWs are *'purchasing their own masks, at extreme cost'* (nurse, SA) including non-approved items such as *'an elastomeric P3 filter mask but I would be disciplined if I wore it to work despite it likely being superior to a non-fit tested N95/P2 respirator'* (doctor, VIC).

In addition to fit testing, PPE training was required. *'Donning and doffing correctly, needs education and compliance monitoring! I've seen so many nurses do it incorrectly'* (surgical nurse, VIC). There were calls for *'a nationwide respiratory protection programme incorporating the training, use and centralised cleaning of PAPRs and reusable elastomeric respirators for those who do not fit disposable P2/N95 masks'*. Without this level of oversight, *'Governments and healthcare organisations are currently failing in their duty of care to provide a safe working environment for HCWs'* (anaesthetist, NSW).

Fit testing

We were horrified by the mismatch in different people's faces to various brands of P2/N95. (GP, Tasmania)

The provision of respirators is not a one-size-fits-all matter. Respiratory protection is only effective if HCWs *'have quantitative Fit Testing'* (anaesthetist, VIC) *'to ensure that they provide an adequate seal. Without proper fitting, these masks provide no additional protection over and above a standard surgical mask'* (anaesthetist, NSW). One surgeon recounted how they *'had to apply strips of Micropore tape around the mask to achieve an adequate seal. ... It beggars belief that HCWs are expected to jury-rig N95 masks to achieve a life-protecting air-tight seal'* (surgeon, WA).

In-house fit testing was occurring, with alarming results, where *'around 40% of women failed a quantitative fit test on the disposable P2/N95 masks'* (anaesthetist, NSW), noting that *'women and non-Caucasian faces appear at greatest risk of failure. They also appear to be disproportionately the HCWs exposed and dying in the UK'* (anaesthetist, QLD). Arranging fit testing was not easy, with HCWs having to *'fight to even be fit-tested for N95 masks'* and having to *'to pay for that fit-testing myself before the hospital relented and tested the rest of the department'* (doctor, TAS). HCWs were bewildered as to *'why certain industry sectors make it mandatory for their workers to have such rigorous testing performed and others such as healthcare, where lives matter just as much, do not seem to be implementing this'* (anaesthetist, VIC). *'Supply issues'* was the reason cited for organisational resistance to fit testing even when there were *'multiple HCW infections despite adhering to the current policy for PPE'* (emergency department doctor, VIC).

Reusable respirators such as powered air-purifying respirators were seen as viable alternatives to disposable respirators *'as it provides superior protection in those who cannot achieve adequate seal with N95 or P2 masks'* (anaesthetist, WA) and had a proven track record in safety during SARS: *'I owe my life to the*

wearing of the 3M Jupiter Hood System with ventilatory filters... issued by the hospital administration' (physician, WA). However, there was resistance to reusables even when *'none of the N95 masks fit my face and my hospital won't let me wear my own 3M respirator, so how do I minimise my risk?'* (anaesthetist, NSW).

Fear for self and others, bullying and censure

I have not been sleeping well for a long time. I am likely to be called up for active service on the COVID-19 wards and this fear is playing on my mind. (Physician, Victoria)

HCWs described being bullied and victimised in their workplaces, being told they were *'not a team player'* (ED doctor, NSW) and *'face shaming tactics from colleagues'* (GP, WA), in a workplace that *'has actively tried to silence me'* (allied health, QLD) for expressing concerns about their safety. HCWs were *'threatened to be stood down for requesting an N95 mask'* (paediatrician, NSW), having *'N95 masks taken out of our hands before going into see positive COVID-19 patients'* (physician, VIC) and of being *'bullied by admin staff who don't want us to ask for appropriate PPE, and lied to'* (anaesthetist, QLD).

Senior managers had told staff that they *'need to toughen up'* (ED doctor, QLD), while infection control nurses were *'chastising front-line ED nurses caring for suspected COVID-19 patients for wearing N95s, saying they should only use surgical masks'* (trainee doctor, TAS). Requests for use of personal higher grade PPE was discouraged by infectious diseases experts as it may *'set a precedent and that the optics of not following the [Department of Health and Human Services] guidelines were not good'* (nurse, VIC). Infection control was *'very poor in backing up the HCWs'* and preferred to *'toe the executive line rather than evidence-based practice'* (ED physician, NSW), creating *a very bad taste in our department* (ED physician, NSW). HCWs were angry that infectious diseases experts *had determined N95 masks were only needed for aerosol generating procedures in COVID-19 patients* and accused them of expressing *'hubris when they were asked about HCW infections'* implying *'that the high rate of HCW infections and deaths was due to incorrect donning and doffing rather than the grade of the PPE itself'* (physician, VIC).

Concerns about workplace safety had *'caused increased anxiety'* (nurse, WA), leading to withdrawal from family noting that being *'away from my family and my pets is hard emotionally, but I do this so I can serve my community and protect my family'* (doctor, WA). HCWs were *'mentally exhausted stressing about the possibility of bringing home the virus'* (trainee Doctor, WA), with *'growing burnout ... We are losing sleep at unprecedented levels due to worry'* (GP, NSW). They felt *'threatened coming to work and seeing COVID suspected patients with inadequate PPE'* (doctor, WA).

Self-disclosed HCW infections

I was denied N95 masks, informing me they are 'unnecessary' when caring for COVID19 positive patients. I am now COVID19 positive, and won't see my baby for weeks. All because of trying to care for people, when no one cared for me'. (Nurse, VIC)

HCWs stated that COVID-19 infections were *'almost certainly contracted in my workplace'* (doctor, COVID-19 clinic, VIC) as *'evidenced in 10% of cases being HCWs. Rates in the community are far lower than 10%. HCWs are acquiring this infection in their places of employment'* (anaesthetist, VIC). Many felt that they contracted COVID-19 despite *'wearing the correct PPE, and yet it still wasn't safe enough'* (nurse, VIC). PPE guidelines were ineffective as *'three nurses on our ward tested positive to COVID-19, only surgical masks were provided to nurses when caring for*

suspected positive patients' (nurse, VIC). Similar stories were evident for community-based HCWs: *'my colleague looked after two COVID-19 patients in their home wearing the current PPE and is now at home isolating as he is COVID-19 positive'* (physician, VIC). *'The risk is real and it is too great not to act'* said an infected ED doctor (VIC) especially with a *'close friend in ICU after contracting COVID-19 working in ED'* (GP, VIC).

Poor consultation and loss of trust in leadership

We have the knowledge and skills required to sort this out. The bureaucracy is getting in the way of safety. (Anaesthetist, NSW)

Underlying the themes was a loss of trust in leadership at service, state and national levels. *'We use our judgement and analyse situations as part of our daily work. Do not lie to us and gaslight us when we assess the situation to be unacceptably risky'* (ED doctor, WA). Throughout the pandemic *'there is one thing which is constant and consistent, which is no transparency and no honesty reflected in the leadership's policies'* (ED doctor, NSW). *'We have had very poor leadership from executive, they have cut corners with our safety at every turn'* (physician, VIC), such that *'I have lost faith in leadership that sees risk to my safety at work as acceptable'* (trainee doctor, VIC). Directives were top-down with little consultation with HCWs because *'Hospital admin only take advice from the health department despite requests and recommendations by local physicians'* (physician, NSW). Requests for extra precautions were *'not responded [to] at all despite repeated requests and lobbying'* (physician, VIC). HCWs found *'it hard to trust leadership'*, which *'makes already low morale, even lower'* (physician, VIC) and were *'seriously thinking of leaving nursing due to the lack of leadership, support and respect within the system'* (nurse, NSW). The lack of precaution was short sighted with a HCW wondering *'what happens when we've infected all our staff and don't have adequate staffing levels to provide care'* (anaesthetist, NSW).

DISCUSSION

This study provides insights for organisational leaders, managers and policy makers to enable them to address barriers to work, health and safety and to better understand the perspectives of HCWs. HCWs described a lack of physical and psychological safety that transgressed a normative expectation that they should feel safe and will be kept safe at work.¹⁸ Themes inductively identified from the data spanned the system, organisational and personal impacts of COVID-19 with leadership cross-cutting all of them. Policies on respiratory protection were perceived to have disregarded the precautionary principle that is implicit within work health and safety legislation.¹⁹ Issues regarding access to PPE, its appropriateness, training and quality; a lack of respirator fit testing within a respiratory protection programme; and a command-and-control culture in the workplace that had disregarded respondent concerns were felt to have contributed to self-reported workplace acquisitions of COVID-19. Respondents were critical of leadership, at all jurisdictional levels, which has resulted in a loss of trust that will take time to repair. The moral injury to HCWs would appear to be the 'hidden pandemic', resulting in emerging mental health issues including anxiety, sleeplessness, withdrawal, resentment and anger.

Respondents reported being in the untenable position of needing to deliver patient care while facing unacceptably high risks to themselves. The list of injurious events started with concerns about national guidelines on respiratory protection recommending the surgical mask for the routine care of patients with COVID-19 rather than fit-tested P2/N95 respirators or

above. When Victorian guidelines changed to recommend greater use of N95 respirators in response to escalating HCW infections, it demonstrated a potential strength of a federated system in that states are guided but not bound to national policy. To respondents, however, academic arguments of disease transmission referencing the aerosol versus droplet dichotomy²⁰ were resolved early in the pandemic. Instead, they felt forced to follow policies at odds with their own assessment of personal risk. Raising legitimate concerns appeared to have invited bullying, intimidation and censure within their organisations. Respondents cited a disregard of work health and safety obligations bordering on hubris by managers and infection control/infectious diseases experts who were unfortunately perceived as being more intent on enforcing guidelines rather than meaningful engagement with frontline staff. As a result, several HCWs took matters into their own hands, organising in-house fittesting or the purchase of reusable respirators. Similar references to suboptimal workplace culture and hubris have been raised in other jurisdictions but poorly researched during the pandemic.²¹⁻²³

During this pandemic, moral injury has referred to challenging decisions involving patient care that conflict with provider values.²⁴ The concept originated in the military and was extended by Litz *et al*²⁵ to 'perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations'. A complementary variant has emerged from the social sciences in reference to healthcare where 'it arises from sources that include injustice, cruelty, status degradation and profound breaches of moral expectations'.¹⁸ It is not a mental illness, but rather a violation of an individual's moral or ethical code that results in psychological distress.²⁴ The voices of respondents suggest an established moral injury where they feel like they are being treated as 'expendable' rather than essential to the pandemic response.

Reversing occupational moral injury is not easy once established, but this is the challenge healthcare leadership must rise to. Shale,¹⁸ in a seminal and timely commentary, presents a practical roadmap for moral repair. This framework prefaces each of the seven actions with acknowledgement: of the injured party as a moral equal, of shared norms, of testimony in a climate of safety, of the responsibility of leaders (which is not equivalent to directing blame at them), of remediation, of negative feelings and, finally, authentic acknowledgement of regret that are not rehearsed apologies.¹⁸ The high degree of engagement required for reparation stands in contrast to the limited consultation experienced by many respondents on matters relating to their occupational safety. Inadequate consultation has been a missed opportunity that also contravenes Australian Work Health and Safety legislation designed to address the power imbalance between management, who issue directives and workers placed in the risk zone.¹⁹ Potential solutions including two-way interaction as invoked by several respondents, supported by adaptive or decentralised leadership models²⁶ deserve exploration, especially during this crisis.

This study has several limitations. The purpose of the open letter was primarily to advocate for increased protection for HCWs, and thus the methodology was not designed to optimally probe HCW perspectives. The study may not be representative of all HCWs as the response rate was 16%, and it did not capture sufficient numbers of nurses, allied health or support staff. Victorian perspectives dominated because Victoria had been worst affected. Occupational moral injury deserves further research to better understand its root causes, preventative strategies and evidence-based remediation. These findings require confirmation from other studies as response and non-response

bias favouring the most activated or concerned HCWs may be operating. Finally, there was no ‘check’ to ensure that respondents were indeed HCWs; however, the consistency of themes would argue otherwise.

Constructive engagement with HCWs that also acknowledges their moral injury presents a major challenge for healthcare leaders during this pandemic and beyond. This process should be seen as an opportunity to harness the resourcefulness of HCWs that many respondents felt had been sidelined with the wealth of governance and operational intelligence among healthcare leaders, policy makers and government in order to fast track solutions. Not doing so risks the contagion described in this report spreading throughout Australia’s healthcare system with implications for other jurisdictions.

Twitter Michelle Ananda-Rajah @rajah_mich

Contributors MA-R, BV and GK conceived the study. DA, CP and DB performed the analysis. MA-R wrote the draft. All authors reviewed the manuscript.

Funding MA-R is supported by a MRFF (Medical Research Future Fund) TRIP (Translating Research Into Practice) Fellowship.

Competing interests None declared.

Patient consent for publication Not required.

Ethics approval Ethics approval was received from the Monash University Human Research Ethics Committee (Project ID 26132).

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement The free text anonymised responses are available in an open source repository at Bridges Monash University. <https://doi.org/10.26180/13308506.v1>

Supplemental material This content has been supplied by the author(s). It has not been vetted by BMJ Publishing Group Limited (BMJ) and may not have been peer-reviewed. Any opinions or recommendations discussed are solely those of the author(s) and are not endorsed by BMJ. BMJ disclaims all liability and responsibility arising from any reliance placed on the content. Where the content includes any translated material, BMJ does not warrant the accuracy and reliability of the translations (including but not limited to local regulations, clinical guidelines, terminology, drug names and drug dosages), and is not responsible for any error and/or omissions arising from translation and adaptation or otherwise.

ORCID iD

Michelle Ananda-Rajah <http://orcid.org/0000-0001-7164-3108>

REFERENCES

- COVID-HQ. Johns Hopkins coronavirus resource centre. Victoria – COVID-19 data Dashboard, 2020. Available: <https://covid-hq.web.app/dashboards/victoria> [Accessed 30 Oct 2020].
- Victoria State Government. Coronavirus update for Victoria, 2020. Available: <https://www.dhhs.vic.gov.au/coronavirus-update-victoria-thursday-16-july-2020> [Accessed 30 Oct 2020].
- Department of Health and Human Services. Coronavirus/Latest news and data/ Updates, 2020. Available: <https://www.dhhs.vic.gov.au/victorian-healthcare-worker-covid-19-data> [Accessed 30 Oct 2020].
- Nguyen LH, Drew DA, Graham MS, *et al*. Risk of COVID-19 among front-line healthcare workers and the general community: a prospective cohort study. *Lancet Public Health* 2020;5:e475–83.
- Bodell M. Governments not ‘prioritising nurses’ as COVID-19 death toll surpasses 1,000. Available: <https://nursingnotes.co.uk/news/workforce/governments-prioritising-nurses-covid-19-deaths-surpass-1000/> [Accessed 30 Oct 2020].
- The Guardian and Kaiser Health News. Lost on the frontline, 2020. Available: <https://www.theguardian.com/us-news/ng-interactive/2020/aug/11/lost-on-the-frontline-covid-19-coronavirus-us-healthcare-workers-deaths-database> [Accessed 30 Oct 2020].
- Amnesty International. Global: health workers silenced, exposed and attacked, 2020. Available: <https://www.amnesty.org/en/latest/news/2020/07/health-workers-rights-covid-report/> [Accessed 30 Oct 2020].
- Rimmer A. Covid-19: two thirds of healthcare workers who have died were from ethnic minorities. *BMJ* 2020;369:m1621.
- Liu M, Cheng S-Z, Xu K-W, *et al*. Use of personal protective equipment against coronavirus disease 2019 by healthcare professionals in Wuhan, China: cross sectional study. *BMJ* 2020;369:m2195.
- Koh FH, Tan MG, Chew M-H. The fight against COVID-19: disinfection protocol and turning over of CleanSpace® HALO™ in a Singapore Hospital. *Updates Surg* 2020;72:311–3.
- Schwartz J, King C-C, Yen M-Y. Protecting healthcare workers during the coronavirus disease 2019 (COVID-19) outbreak: lessons from Taiwan’s severe acute respiratory syndrome response. *Clin Infect Dis* 2020;71:858–60.
- McCauley D. Doctors ‘bullied’ by hospital administration for asking to wear masks, 2020. Available: <https://www.smh.com.au/national/doctors-bullied-by-hospital-administration-for-asking-to-wear-masks-20200703-p558v2.html> [Accessed 30 Oct 2020].
- The Royal Australasian College of Physicians. RACP survey: 10 percent of physicians in public hospitals sourcing their own PPE - calls for greater transparency on government stockpile, 2020. Available: <https://www.racp.edu.au/news-and-events/media-releases/racp-survey-20-per-cent-of-physicians-in-public-hospitals-sourcing-their-own-ppe-calls-for-greater-transparency-on-government-stockpile> [Accessed 30 Oct 2020].
- ABC News. Healthcare workers struggling with mental well being during the pandemic. Available: <https://www.abc.net.au/news/2020-09-08/hand-n-hand-peer-support-helps-struggling-healthcare-workers/12631032> [Accessed 30 Oct 2020].
- ABC News. Are you a healthcare worker concerned about COVID-19? tell us your story, 2020. Available: <https://www.abc.net.au/news/2020-08-20/are-you-a-healthcare-worker-concerned-about-covid-19/12542428?nw=0> [Accessed 30 Oct 2020].
- Infection Control Expert Group. Guidance on the use of PPE in hospitals during the COVID-19 outbreak. Available: <https://www.health.gov.au/sites/default/files/documents/2020/07/guidance-on-the-use-of-personal-protective-equipment-ppe-in-hospitals-during-the-covid-19-outbreak.pdf> [Accessed 30 Oct 2020].
- McCauley D. Hospital upgrades infection control guidelines after COVID-19 outbreak, 2020. Available: <https://www.theage.com.au/politics/federal/hospital-upgrades-infection-control-guidelines-after-covid-19-outbreak-20200724-p5557y.html> [Accessed 30 Oct 2020].
- Shale S. Moral injury and the COVID-19 pandemic: reframing what it is, who it affects and how care leaders can manage it. *BMJ Leader* 2020. doi:10.1136/leader-2020-000295
- Ananda-Rajah MVB, Miller A, Heslop D. Healthcare worker safety has fallen short of best practice. *MJA Insight+*, 2020. Available: <https://insightplus.mja.com.au/2020/38/health-care-worker-safety-has-fallen-short-of-best-practice/> [Accessed 30 Oct 2020].
- MacIntyre CR A-RM, Nicholls M, Quigley AL. Current guidelines for respiratory protection of Australian health care workers against COVID-19 are not adequate and national reporting of health worker infections is required. *Med J Aust* 2020.
- Lincoln M. Study the role of hubris in nations’ COVID-19 response. *Nature* 2020;585:325.
- Oliver D. David Oliver: silencing NHS staff who speak out is sheer stupidity. *BMJ* 2020;369:m1388.
- Vergheze A, Topol E. Courage in a climate of fear. *Sci Transl Med* 2020;12. doi:10.1126/scitranslmed.abb2461. [Epub ahead of print: 04 Nov 2020].
- Greenberg N, Docherty M, Gnanapragasam S, *et al*. Managing mental health challenges faced by healthcare workers during covid-19 pandemic. *BMJ* 2020;368:m1211.
- Litz BT, Stein N, Delaney E, *et al*. Moral injury and moral repair in war veterans: a preliminary model and intervention strategy. *Clin Psychol Rev* 2009;29:695–706.
- Ahern S. Leadership during the COVID-19 pandemic: building and sustaining trust in times of uncertainty. *BMJ Leader* 2020;0:1–4. doi:10.1136/leader-2020-000271

Supplementary Table 1.

Theme	Illustrative quotes
<p data-bbox="253 341 477 368">Work health and safety issues</p> <p data-bbox="253 472 376 499">including</p> <p data-bbox="253 539 365 566">policies/</p> <p data-bbox="253 603 387 630">guidelines</p>	<p data-bbox="506 341 1644 368">“We don’t want to be heroes. We just want protection in line with OHS standards”. (GP, VIC)</p> <p data-bbox="506 416 1731 520"><i>“The fact that we are expected to work with inadequate PPE is disgraceful, and runs contrary to OHS regulations in every other facet of working life. At my hospital, we have masks rationed, and are only allowed to use surgical masks to intubate patients. We re-use goggles (when you can find them).” (Trainee doctor, QLD)</i></p> <p data-bbox="506 568 1731 743"><i>“We have questioned our hospital administration and consultants back in March 2020 about inadequate PPE (no neck coverage, no proper seal) for COVID clinic and ward... We did swabs with our neck and hair exposed at one point. Hair net was not essential apparently. We were not provided with scrubs or attire. We bring our ‘contaminated’ clothes home to our family, straight into the washing machine and shower. We were short on PPE by April, was told to conserve as much as we can. We ran out of eye shields (not goggles). I cannot imagine what’s going to happen if we get a second wave.” (Doctor, WA)</i></p> <p data-bbox="506 791 1731 1046"><i>“I then rotated to a hospital, where I was shocked to see the norm of PPE for COVID-suspected patients be a white patient gown with normal gloves thus leaving wrists open to the air, and in most cases a simple surgical mask only. Again, in the intensive care this was escalated to routine N95 mask use due to higher likelihood of aerosol-generating-procedures, but the respiratory ward would use surgical masks only, and I was on many occasions told they did not even have N95 masks available on the ward when I asked for one to review a deteriorating patient. Given the increasing evidence for aerosol transmission even outside of what has been considered the higher risk aerosol-generating-procedures, I find it shocking that a whole ward of COVID-suspected patients be cared for by staff only wearing surgical masks.” (Doctor, VIC)</i></p> <p data-bbox="506 1094 1731 1302"><i>“I have been working at different health services during this pandemic. The variable recommendations around HCW PPE and communication across sites greatly concerns me. We are all dealing with the same virus and practices for covid-19 precautions should be standardised to minimise HCW exposure and rationalise use. Guidance on covid ward setup and models of care would also be helpful for some centres. There is variability in leadership and culture across health services but there is no disadvantage with being extra cautious when it comes to infection control. Everyone should unite to prevent HCW infections and ease HCW anxiety so they can focus on their clinical roles and prevent our hospitals from destabilising during this pandemic.” (Physician, VIC)</i></p>

“My concern is regarding the patients who don’t report their symptoms of fever, sore throat and cough to the triage nurse- then don’t get triaged appropriately into an isolation room but then mention they’ve had these symptoms for the last 48hrs to the doctor who doesn’t have PPE on- their ignorance is potentially exposing us health care workers to COVID-19.” (Doctor, QLD)

“PPE guidelines have been completely inadequate and way to slow. I work where over 100 people are now infected. This was completely preventable. They were way to slow to implement mandatory masking and way to slow to institute N95 for endoscopy and for managing covid patients. With common sense this could have been prevented.” (Doctor, VIC)

“Basically, the WHO guidance is grossly insufficient. Lead clinicians in Australia blindly followed the WHO guidance. They ignored the testimony of our international colleagues who said the WHO PPE recommendations were insufficient. We waited until our own staff and trainees got sick and intubated before we very gradually changed the PPE quality supplied to staff in Australia.” (Doctor, VIC)

“PPE guidelines based on those of the World Health Organisation are woefully inadequate as health care worker infection rates overseas and now in Victoria sadly demonstrate. Studies showing the virus to be airborne have been around since March or thereabouts, whereas the WHO only got on board with this in July.” (Rural GP, QLD)

“Very concerning that government, hospitals and private GP practices are taking a reactive approach, rather than precautionary. I’ve seen many staff asking for more protection, such as receptionists asking to wear masks in the first wave and clinic management not allowing this because they didn’t believe there was “evidence” for aerosol spread and “we don’t want to intimidate the patients and scare them from coming to the practice.”(GP, NSW)

“Sadly, hospital settings remained reactive not proactive as numbers began to grow a number of weeks ago. People in positions of authority dismissed concerns of nursing staff and after arranging our own PPE were told we were causing hysteria. Sadly, these people got it wrong and now over 1000 HCW’s are infected with COVID.” (Nurse, VIC)

“We should be proactive, not reactive. Introduce PPE appropriate for airborne transmission, and scale back if required, rather than leaving HCWs exposed, and upgrading if transmission is proven to be airborne.” (Doctor, VIC)

“Thankfully our hospital guidelines have now been changed to allow use of n95 masks for SCOVID/COVID interactions. Sadly it took multiple infections of our healthcare workers for our voices to be heard. These standard personal safety at work should be made uniformly available to all health care workers in all states. With community transmission rates climbing, subpar PPE is just unacceptable. We all have a right to feel safe to come to work.” (Trainee doctor, Vic)

“I asked the head of infection prevention at my organisation whether he would feel safe showering a confused, combative elderly Covid19 positive patient in an enclosed space with just a surgical mask and goggles gown + gloves. He spoke about 'stratification of risk' and didn't answer my question. I also asked whether we could supply our own N95 masks. I was told that he didn't want to 'set a precedent' and that the optics of not following the DHHS guidelines were not good.” (Nurse, VIC)

“Issue is essentially risk of COVID-19 being semi-airborne from data and organisations dragging their heels for updating info based upon the new data. Adopting the cheapest PPE instead of the most suitable.” (Paramedic, VIC)

“We must not forget that SARS respiratory protection was upgraded well before the evidence based studies regarding respiratory protection 'proved' that aerosol spread was occurring which saved hundreds of healthcare worker lives. COVID-19 is being spread by aerosol with known transmission to healthcare workers not directly on the front line. A national register of healthcare worker infections is needed now.” (Physician, TAS)

“It seems to me guidelines reflect supply issues rather than care of HCWs” (Anaesthetist, VIC)

“I feel that the messaging has predominantly been to save money and preserve resources at the expense of OHS, and that it takes many infected staff before the knee-jerk reaction of the organisation to provide guidelines for adequate PPE.” (Doctor, VIC)

	<p><i>"I do not expect my patients to be 'responsible' for my safety at work. It is our own, and our employers' responsibility to ensure a safe working environment."</i> (Nurse, NSW)</p>
<p>PPE: access, quality, appropriateness and training</p>	<p><i>"Protect us PROPERLY so we can protect you!"</i> (Nurse, WA)</p> <p><i>"Work in aged care. Do not have access to PPE, is locked up. Have new residents, residents that go to hospital, visit family come back to the facility. I have no PPE to protect myself or them."</i> (Nurse, NSW)</p> <p><i>"Staff concern about looking after Covid patients without P2 mask available. Eg we were asked to wear surgical masks for Covid/suspected caesar patients having spinal. We need to stay with patients for more than one hour. Patients may cough during the surgery or need urgent airway intervention. Surgical mask is not enough in this setting."</i> (Anaesthetist, NSW)</p> <p><i>"As an RN working in primary health, I feel General Practice is under represented in the decision making process and the allocation of PPE despite our high profile in the early presentations of possible Covid-19 cases. There is no distribution of N95 masks to General Practice currently however, we play a significant role in identifying cases via examination, pathology collections etc."</i> (Nurse, WA)</p> <p><i>"I'm currently pregnant and put myself and unborn child and my family at risk every time I assess a febrile patient wearing a simple surgical mask (this is all we are to have access too unless confirm case then N95 provided) it's not soon enough we are the frontline and exposed to febrile unwell patients without sufficient protection."</i> (Doctor, QLD)</p> <p>Poor quality PPE</p> <p><i>"COVID intubators at our institution are being asked to use cheap N95 duckbill masks without formal fit testing. As well as a questionable seal with these masks, intubators face shields are fogging so badly that it is almost impossible to see. This is one of the highest risk COVID activities. Full face Respirators must be made available."</i> (Anaesthetist, VIC)</p>

	<p><i>“The gowns provided for care of suspected covid-19 patients work up are not impervious. In March/ April the quality Of those gowns was much better and they were thicker with long sleeves and snug sock like grip at the wrists but not anymore for the last few months. The N95 (greenish) mask is definitely not ideal as doesn’t match any fit check, there is always a gap below the chin.” (Emergency Medicine Doctor, NSW)</i></p> <p><i>“The PPE we have been given has been sub-optimal, surgical masks sent from China with very poor packaging and have been very flimsy/ not moulding to our faces properly. We have been told we cannot wear N95 masks until a patient is proven positive, which at times is taking several days. Our health is compromised every day we work and I fear for my colleagues and my own safety.” (Nurse, VIC)</i></p> <p><i>“In the operating theatres regular surgical masks were in short supply, with poorly fitting ear loop ones only available. Several colleagues had to remove eye protection as they kept fogging up and couldn’t see to complete cases.” (Surgeon, NSW)</i></p> <p><i>“ICU nurses have bought rolls of door seal foam from Bunnings to put inside their mask to try and obtain a better seal and some level of pressure relief from the mask.” (Anaesthetist, VIC)</i></p>
Fit testing	<p><i>“We were horrified by the mismatch in different people’s faces to various brands of P2/N95” (GP, Tasmania)</i></p> <p><i>“The debate whether to wear an N95 or not should have been over and done with months ago, as compelling evidence emerges that COVID 19 may in fact be transmitted by the aerosol route. I have little faith in the PPE policy and worse is the fact that frontline workers such as myself who are willing to pay for their own advanced PPE to be worn during clinical encounters or high risk situations are not allowed to do so, due to the restrictions imposed by the local health institution one works for. Additionally, the fit check recommended widely does not constitute scientific expert protection as opposed to the fit test , which again is deemed as complex and cumbersome and not implemented widely enough. I don't understand why certain industry sectors make it mandatory for their workers to have such rigorous testing performed and others such as healthcare, where lives matter just as much do not seem to be implementing this.” (Anaesthetist, VIC)</i></p>

“The nurse who fitted me for my N95 had to apply strips of Micropore tape around the mask to achieve an adequate seal. Seriously? Is that the best that we can do for health care worker PPE? It beggars belief that health care workers are expected to jury-rig N95 masks to achieve a life-protecting air-tight seal.” (Surgeon, WA)

“These masks are notoriously fickle and often require a tremendous amount of “MacGuyver-ing” (especially for people with smaller faces) to make them sit securely. Despite these measures, mid-way through my review of the patient, the mask slid down, exposing my nose. I had no way to protect myself against this. Luckily the patient was negative for COVID-19, but this does not change the fact that I could have been exposed. My hospital’s Chief Medical Officer has been silent on this issue, even when it was raised in a public forum. Stop treating us like we are expendable!” (Trainee doctor, VIC)

“We had to fight to even be fit-tested for N95 masks, and I had to pay for that fit-testing myself before the [health service] relented and tested the rest of the department. My director was castigated by the organisation for “not being a team player” in insisting that the frontline staff were fit-tested. One supply of N95 masks we were issued (which fitted nobody on fit-testing anyway) were so old that the elastic perished and the mask fell off during a suspected COVID intubation undertaken by one of my colleagues. Frontline staff are not “heroes, putting themselves in harm’s way for the good of the community”; they are employees and deserve to have the same occupational health and safety which would be demanded in any other industry.” (Anaesthetist, TAS)

“I have been offered 4 types of disposable N95 masks at 2 different hospitals, none of which fit me without a detectable leak around the mask. Getting any hospital to agree to provision of objective fit testing for its staff has been impossible. That I have had to purchase my own respirators (2 Sundstroms and 1 3M 7500) and negotiate with hospital infection control to implement cleaning protocols just so I can use something that subjectively fits me, is ridiculous.” (Anaesthetist, VIC)

“It is essential that there is quantitative fit testing of P2/N95 masks to ensure that they provide an adequate seal. Without proper fitting these masks provide no additional protection over and above a standard surgical mask. In our health service we have been fit testing since March and there are a large number of individuals who do not fit the available N95/P2 masks. In our anaesthetic department around 40% of women failed a quantitative fit test on the disposable P2/N95 masks we had available. There needs to be a nationwide respiratory protection program incorporating the training, use and centralised cleaning of PAPRs and reusable

elastomeric respirators for those who do not fit disposable P2/N95 masks. Governments and health care organisations are currently failing in their duty of care to provide a safe working environment for healthcare workers.” (Anaesthetist, NSW)

“We have had multiple HCW infections despite adhering to the current policy for PPE. My hospital has refused to have us fit tested citing supply issues as the reason.” (ED doctor, VIC)

“We have a fit test machine at our practice to test N95/P2. We were horrified by the mismatch in different peoples faces to various brands of P2/N95.” (GP, Tasmania)

“Women and non-Caucasian faces appear at greatest risk of failure. They also appear to be disproportionately the HCWs exposed and dying in the UK.” (Anaesthetist, QLD)

“I’ve had PPE failure with an N95 mask that initially fit well but mid-intubation in cardiac catheter lab on a patient who had suffered a cardiac arrest the mask developed a major leak and fogged up the face shield which meant I was exposed to viral aerosol and had poor visibility during the time critical procedure thereby endangering my patient’s safety and management and my health. It is incredibly stressful. Make fit testing mandatory and provide us state of the art PPE.” (Anaesthetist, VIC)

“The Australian standard stipulates that fit testing of N95 is mandatory. The ICEG advice is that it might not be possible to fit test everybody quickly enough in this pandemic. This is taken by hospitals as advice that they do not need to make any effort in this regard.” (Anaesthetist, QLD)

Paying for our own PPE and fit testing

“I have been asking for several months to have my mask fitted. I have escalated to my manager and my CEO. I have been expected to examine patients as the team leader for possible covid patients without an N95 mask. It is expected that the more junior staff stay out of the room. That means the patient could cough etc. with below standard PPE for me. Around Easter time I had to go to Bunnings to buy my own PPE for operating on “possible covid” patients. After threatening to go to my union I was finally fit tested for an N95 mask months later - but there was no sticker provided for me to put on my ID with the correct brand to fit me. Surely

the healthcare system can get those printed when we have been planning for PPE for the last 3 months? As an obstetrician labouring women do not wear a mask - they breath heavily all over the obstetrician who is between their legs.” (Obstetrician, NSW)

“None of the N95 masks fit my face and my hospital won't let me wear my own 3M respirator, so how do I minimise my risk?” (Anaesthetist, NSW)

“We have had multiple HCW infections despite adhering to the current policy for PPE. My hospital has refused to have us fit tested citing supply issues as the reason.” (ED doctor, VIC)

“The national guidelines on PPE for HCWs has failed us in Vic. The situation is deteriorating rapidly. We need urgent intervention by occupational health and safety experts to remedy the weak guidelines on respiratory protection and years of neglect in hospitals. I have not been sleeping well for a long time. I am likely to be called up for active service on the COVID wards and this fear is playing on my mind. I purchased an elastometric P3 filter mask but would be disciplined if I wore it to work despite it likely being superior to a non-fit tested N95/P2 respirator.” (Doctor, VIC)

“I am increasingly concerned about the poor quality PPE that is being provided including ill-fitting level 3 masks with ear loops and the paucity of disposable hoods/caps even for ICU staff who are caring for COVID19 positive or suspect patients. Due to these negligent, near criminal deficiencies in PPE, I have been forced to personally fund the purchase of full face elastomeric respirators, face shields and other items of PPE for my personal use as well as for nursing staff.” (Anaesthetist, QLD)

Reusable respirators

“I am an Anaesthetist with beard. I have been fortunate enough to have access to a Powered Air Purifying Respirator (PAPR), which will give me protection against Covid19. I would like health care workers in Australia to have easy access to PAPR as it likely provides superior protection in those who cannot achieve adequate seal with n95 or P2 masks due to beard or other facial features.” (Anaesthetist, NSW)

"I was previously involved as a frontline physician during the Singapore SARS crisis looking after SARS cases which were transported to a designated SARS hospital in Singapore. I owe my life to the wearing of the 3M Jupiter Hood System with ventilatory filters and waxed gowns/PPE issued by the Hospital Administration at that time. Prior to this SARS had already claimed the lives of a prominent Cardiothoracic Surgeon and almost killed a dear medical colleague who was an ICU specialist before its lethality was considered." (Physician, WA)

"I have been offered 4 types of disposable N95 masks at 2 different hospitals, none of which fit me without a detectable leak around the mask. Getting any hospital to agree to provision of objective fit testing for its staff has been impossible. That I have had to purchase my own respirators (2 Sundstroms and 1 3M 7500) and negotiate with hospital infection control to implement cleaning protocols just so I can use something that subjectively fits me, is ridiculous." (Anaesthetist, VIC)

"I failed my fit-test with the N95 mask that is used in my hospital. Managed to pass the fit-test using the Clean Space Halo PAPR." (Anaesthetist, NSW)

PPE fit for purpose

"Working outside in sometimes extremely windy conditions, the required face shield blows up and down providing no protection at all. N95 masks should be available in these conditions." (Nurse, COVID screening clinic)

"We desperately need a mandated minimum standard of PPE specific to prehospital care and the environment that emergency ambulance Paramedics work in. We do not function in a controlled environment like other health care workers. We face wind, weather, manual handling of infected patients, difficult extrications, patient lifts, carries, and sit centimetres from patients in confined spaces. Gowns are a completely inappropriate item for us, given to billowing in the wind, spreading droplets, contaminating faces and surfaces, as well as providing no protection to legs when bending, lifting, sitting" (Paramedic WA)

"NSW ambulance protocols were recently changed to instruct paramedics to lessen their precautions by downgrading to surgical masks for all droplet precautions, including confirmed COVID cases. Paramedics are expected to juggle between different masks based on the interventions we use to treat patients (reserving P2/N95 for patients requiring O2 therapy, airway management,

	<p><i>compressions, certain medications, etc), however are not able to predict these decisions until we are already on scene. This often means we have inadequate PPE at the time we have to rapidly treat critical patients, often in front of family who may not appreciate the need for us to stop and change our PPE before intervening.” (Paramedic, NSW)</i></p>
<p>Fear for self and others, bullying and censure.</p>	<p>“I have not been sleeping well for a long time. I am likely to be called up for active service on the COVID wards and this fear is playing on my mind” (Physician, VIC)</p> <p><i>“Given over 1/3 COVID19 patients are asymptomatic and that patients are infectious prior to the onset of symptoms, anyone can have this virus and not know it. Working in general practice where I often do extended consultations for pregnancy and gynaecology issues I am frequently in close proximity to patients for over 15 minutes. Understanding the aerosol spread of the virus and the poor ventilation and size of consultation rooms in my practice I feel optimal protection is with an N95 mask, yet current advice is just for a surgical mask. I therefore do not feel safe at work. Like most GPs, I work as a sub-contractor and so have no sick leave or work cover. If I am not seeing patients I do not get paid.” (GP, VIC)</i></p> <p><i>“Returning from mat leave and was disappointed to see that our PPE for covid patients was just a surgical mask, glasses, a plastic gown and gloves. I have young children and my husband at home I want to keep safe. My [parent] in law who lives with us has compromised health and my [parent], who looks after my children so I can work - has cancer.” (Nurse, WA)</i></p> <p><i>“I feel threatened coming to work and seeing COVID suspected patients with inadequate PPE. It affects our well-being. Many of us have isolated away from our families to avoid putting them at risk. Coming home to 4 walls away from my family and my pets is hard emotionally, but I do this so I can serve my community and protect my family. I have done this for months as I don't have the luxury of moving out and my family members have chronic diseases that put them at high risk of severe COVID.” (Doctor, WA)</i></p> <p><i>“General practice is my job, I did not consent to risk my life. I would like government to stop playing with my life and the welfare of my children. Give us adequate protection as you push us forward to that frontline to do our jobs.” (GP, VIC)</i></p> <p><i>“Seeing infection control “specialist” nurses at a different hospital coming and chastising front-line ED nurses caring for suspected COVID-19 patients for wearing N95s, saying they should only use surgical masks.” (Trainee doctor, TAS)</i></p>

“Despite the assurance of the guidelines, I did not feel safe. We are not volunteering to be sacrificial lambs to this disease, potentially spreading it to colleagues and family.” (Trainee doctor, VIC)

“Senior nurse managers wanted me to do this work without a P2 mask, and my own consultant said that “I am not happy about this. If you use up all the supplies, what will I use when I have to intubate? You won’t be the one taking that risk. You are not a team player.” ...Because of my concerns regarding PPE I have been shunned by many in my workplace. Excluded and victimised. I believe my formal end of term work assessment has been affected by this. I believe that my chances at successful application to work next year are very poor.” (Emergency doctor, NSW)

“I’ve been bullied by admin staff who don’t want us to ask for appropriate PPE, and lied to (apparently we don’t need to fit test masks).” (Anaesthetist, QLD)

“Constantly downgraded quality and little reassurance by hospital management that they will make sure we have adequate PPE. “People need to toughen up” from Medical super at the time of maximal anxiety.” (Emergency doctor, QLD)

“I look forward to a time that I can go to work without being bullied into risking my life, and those of my family, friends, and community” (ED Doctor, NSW)

“In March and April clinicians at the front line and middle managers who reported concerns about the lack of PPE to cope with a pandemic were bullied and undermined. Thank God for unions, Safework and campaigns such as this one.” (Nurse, NSW)

“Work in the community setting including through the pandemic we are actively encouraged not to wear masks when seeing clients. I have provided my own personal mask when I have felt vulnerable (i.e. taking a client to their GP). My workplace has actively tried to silence me.” (Allied health, QLD)

“My employer refused to provide N95/P2 masks, or droplet precaution gowns to Covid swab symptomatic new receptions arriving ...each day. New cases were sitting at 600-700 a day [in Victoria]. I tried to have a clinical meeting to discuss the risk

	<p><i>given the vulnerable situation ...in which we were performing the swabs, but I was told to “do what I was told and stop causing trouble, or leave”. I left. (Nurse, Victoria)</i></p> <p><i>“I expect to be able to return home at the end of my shift without risking my family’s health.” (Nurse, NSW)</i></p>
<p>Self-disclosed HCW infections</p>	<p><i>“I was denied N95 masks, informing me they are “unnecessary” when caring for COVID19 positive patients. I am now COVID19 positive, and won’t see my baby for weeks. All because of trying to care for people, when no one cared for me.” (Nurse, VIC)</i></p> <p><i>“It is too late for me, and many of my colleagues. I am isolating at home with COVID, after likely exposure while wearing recommended PPE in an Emergency Department. The risk is real and it is too great not to act.” (ED Doctor, VIC)</i></p> <p><i>“Health care workers are essential. It has been proven that p95 masks are the requirement to ensure protection from COVID and without this, we are unnecessarily being exposed to a much higher risk of contracting COVID. If someone tests positive for COVID in our emergency department, the amount of potentially exposed staff that would require to go into quarantine would be astounding and something we cannot afford” (ED nurse, WA)</i></p> <p><i>“I tested positive for COVID because my workplace did not have basic PPE available for me.” (Trainee doctor, VIC)</i></p> <p><i>“I have COVID-19, almost certainly contracted in my workplace.” (Doctor, COVID clinic, VIC)</i></p> <p><i>“I am performing aerosol-generating procedures on an almost daily basis, and using a surgical masks instead of an N95 to do this as a result of hospital policy that is lagging behind, and not in the interest of health care workers. Every time one of us is exposed to a patient who later tests positive, we are quarantined for 2 weeks. All hospitals in Victoria should upgrade their PPE policy to include use of an N95 for all AGP’s, and for those working in high risk roles not performing AGP’s.” (Trainee doctor, VIC)</i></p>

	<p><i>“Having 62 fellow healthcare workers at the same health network with confirmed COVID is 62 too many. Please give us adequate PPE - with effective eye protection (not just a 10cm x 5cm piece of flimsy plastic) and at least N95 masks (not just a poorly fitting surgical mask) when we have contact with suspected or confirmed COVID patients. Since when was it acceptable for miners to die from preventable OHS accidents? Never - so don't make it acceptable for healthcare workers.” (Trainee doctor, VIC)</i></p> <p><i>“Staff becoming sick is unacceptable, Where are Workplace Standards? Where is the outcry that staff don't have the appropriate equipment to stay safe at work? We give everything for our patients, but we don't expect to have to give our lives.”-(Nurse, TAS)</i></p> <p><i>“I had to go into isolation for 2 weeks because of exposure to a patient during an endoscopy who had NO covid symptoms and had been swabbed at a time there was confusion about pre-op mandatory testing. It came back positive AFTER the list concluded. I had been wearing just a 3 ply mask. No N95 available.” (Anaesthetist, VIC)</i></p> <p><i>“I contracted covid-19 whilst working on the covid-19 ward, whilst caring for covid positive patients. This was whilst wearing the correct PPE, and yet it still wasn't safe enough. More needs to be done.” (Nurse, VIC)</i></p> <p><i>“My partner is locked away from her family for 2 weeks... She was confronted by wards with patients with pending COVID-19 tests, coughing and spluttering over her through her shift. She requested patients wear masks, and was advised this wasn't policy, whilst every other Victorian in any other setting has to wear one. She requested an N95 mask, and was denied. She now has COVID. I can't work. She can't see her daughter or myself. And not everything was done to prevent this. Sooner or later, health care workers will die if this problem isn't fixed.” (Doctor, VIC)</i></p>
<p>Poor consultation, loss of trust in leadership</p>	<p><i>“We have the knowledge and skills required to sort this out. The bureaucracy is getting in the way of safety. (Anaesthetist, NSW).</i></p>

“Regarding infection control, “they have been very poor in backing up the healthcare workers of the hospital and it seems like they toe the executive line rather than evidence based practice.” Throughout the pandemic thus far, there is one thing, which is constant, and consistent which is no transparency and no honesty reflected in the leadership’s policies.” (ED physician, NSW)

“As a family of healthcare workers we made a decision to wear a higher level of PPE that what was recommended initially (due to aerosol spread) of COVID. NSW Health, Australian Government regulations and WHO have had it wrong and have been TOO SLOW to react putting our lives at risk. Healthcare workers are putting their lives at risk to care for COVID patients. We don't want 'lip service', we want action and we demand change. Nurses demand a greater voice, more pay and greater respect. I am seriously thinking of leaving nursing due to the lack of leadership, support and respect within the system. It was hard work for us as nurses before COVID - now it is just worse, there is emotional distress, distraction (over potentially contracting COVID and infecting loved ones, worry about illness and job security), increased errors at work and injuries due to the higher level of anxiety that people are feeling. Don't call us heroes and don't celebrate the International Year of the Nurse unless you are going to dramatically change practice and look after healthcare workers with ACTIONS, CULTURE CHANGE, IMPROVED LEADERSHIP and APPROPRIATE PPE and TRAINING.” (Nurse, NSW)

“Many of us have realised that COVID 19 is airborne months ago. I’m personally sick of trying to persuade administrators that they need to protect our nursing staff and doctors correctly. We’re supposed to risk our lives when there are better precautions available. We’ve had months to prepare and yet we still don’t have negative pressure theatres and the correct PPE. Too expensive. Well it will be interesting to see what happens when we’ve infected all our staff and don’t have adequate staffing levels to provide care. We have the knowledge and skills required to sort this out. The bureaucracy is getting in the way of safety.” (Anaesthetist, NSW)

“We have had very poor leadership in this area from executive, they have cut corners with our safety at every turn. We have had N95 masks taken out of our hands before going into positive COVID patients. We are the only hospital now in Melbourne not mandating face shields for all clinical contacts. They are so short sighted to the both personal and professional costs of this inadequate practice.” (Physician, VIC)

	<p><i>“I raised masking with senior staff at work and was rebuffed repeatedly and told we were following DHHS Guidelines. We then had an outbreak across the hospital with >90 staff infected and hundreds quarantined. Administrators were forced to change hospital policy, but still DHHS guidelines lagged until there were >600 healthcare workers infected across my state. I feel the department is out of touch and not taking adequate precaution with the lives of those on the front line. I have lost faith in leadership that sees risk to my safety at work as acceptable.” (Trainee doctor, VIC)</i></p> <p><i>“I have been asked not to wear a surgical mask when seeing patients. A colleague was threatened to be stood down for requesting an N95 mask. Lack of transparency around health care worker infections, this reduces trust in the system and does not allow us to learn timely lessons to protect other staff.” (Paediatrician, VIC)</i></p> <p><i>“The first letter on the Basic Life Support algorithm is D for danger: check for danger before you approach the patient. To approach a known or suspect COVID 19 patient with anything other than the best appropriate PPE is absolutely foolhardy. We are always having to use our judgement and analyse situations as part of our daily work. Do not lie to us and gaslight us when we assess the situation to be unacceptably risky for us.” (ED doctor, WA)</i></p> <p><i>“In the early stages of the pandemic affecting Australia, the lack of consistency in health advice resulted in significant anxiety within the workplace and I feel it is essential an adequate committee is established to avoid our lack of preparedness again and adequate PPE is readily available within Australia at all times.” (Nurse, WA)</i></p> <p><i>“Ever since March, the infection control people keep chipping and chopping the policy on PPE which is often dodgy. They keep justifying the non-justifiable with no evidence, it has created a very bad taste in our department.” (Emergency Medicine Doctor NSW)</i></p> <p><i>“Some hospitals have been quite proactive in responding to evolving evidence and increasing PPE availability and mandating extra precautions, while others have been slow or not responded at all (despite repeated requests and lobbying). The latter has made it hard to trust leadership and feel that healthcare workers' well-being factors into decision-making. This makes already low morale, even lower.” (Physician, VIC)</i></p>
--	--

“After all these years of nursing, I have never felt so disappointed with my industry as I do now. It’s a disgrace - I have lost all trust with the people making the decisions.” (Nurse, WA)

“I have no faith in my department’s PPE policy and flippant attitude to staff’s concerns about changing mask stock and PPE concerns. Each week there is a different mask to use, with limited information available and only fit checking (not fit testing) available to us. Not good enough!” (Nurse, VIC)