

Supplementary Table 1.

Theme	Illustrative quotes
<p>Work health and safety issues including policies/guidelines</p>	<p>“We don’t want to be heroes. We just want protection in line with OHS standards”. (GP, VIC)</p> <p><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><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><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><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.”</i> (Emergency Medicine Doctor, NSW)</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.”</i> (Nurse, VIC)</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.”</i> (Surgeon, NSW)</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.”</i> (Anaesthetist, VIC)</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.”</i> (Anaesthetist, VIC)</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>“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)</i></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>
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“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)