How Royal Bournemouth Hospital management put patient and staff safety in jeopardy: A frontline nurse explains

5 January 2021

The following letter was sent to the WSWS from a frontline nurse at the UK's Royal Bournemouth Hospital.

I want to add my voice to my colleagues who spoke out here in Bournemouth, Poole and across the country. The response of our [National Health Service] Trust management to the coronavirus outbreak and recent surge of cases is pathetic, if not outright criminal. They have put both patients' lives and staff safety and well-being in jeopardy during this pandemic. They have a lot to answer for.

I am sure that their actions are bound up with the wrong policies and strategies of the government in response to the pandemic.

After several days of horrendous and tiring shifts during and after Christmas and leading up to New Year, I was listening to Prime Minster Boris Johnson last Sunday on the Andrew Marr show with disgust and anger. He vomited up lie after lie, evasion after evasion, encouraged by the kid-glove treatment of Marr. "We've got to keep things under constant review but we will be driven entirely by the public health," he said.

What nonsense! 2.6 million people have contracted the virus and 75,000 people have needlessly died (even according to official highly massaged figures). This happened because the Johnson government defied science, scientists and public health experts and put the profits of corporations and financial markets before lives.

Johnson then claimed, "This government has taken every possible step that we reasonably could to prepare this country for the consequences of winter." What a lie! I work at a hospital in the South West which is not in a worst-hit area. Yet our normal services have buckled under enormous pressure from a surge of Covid-19 cases, staff burnout and large numbers of staff becoming victims of the virus.

Then, on Monday, Health or more properly Death Secretary Matt Hancock appeared on ITV's Good Morning Britain. He repeated bogus claims that nurses had a significant pay rise and that the government had addressed the staffing issues in the NHS.

In October, Royal Bournemouth and Christchurch Hospitals Foundation Trust (RBCH), where I work, and Poole Hospital Trust (PHT) merged to become The University Hospitals Dorset Foundation Trust (UHD). Although the UHD management and media outlets like the BBC and ITV try to paint this amalgamation in rosy colours, it was a part of a plan drawn up by the Dorset Clinical Commissioning Group (DCCG) to save £153 million. This would see the closure of the Accident and Emergency Unit and Maternity Unit in PHT as well as the shutting down of several community hospitals in Dorset, losing 120 beds for good. At the heart of the overhaul is further privatisation of services. Opposition to these plans, from clinicians and people across Dorset, was ignored.

If the hospitals merger was supposed to enhance the health services in Dorset, it has failed the first test during the second wave of the pandemic. We now have 178 positive patients across more than two dozen wards and units in the trust, in contrast to the first wave of the pandemic where there were two separate zones—Covid and Non-Covid. Hospital management pretended that they could look after Covid and non-Covid patients along with other elective patients, without adequate staff and resources. This has failed miserably, with severe consequences for patients and staff.

Blue Intensive Care Units (ICU) which treat Covid-19 patients have exceeded their 13-bed capacity as 15 patients need intensive care. These patients have to be admitted to Green ICU beds, causing disruption for intensive care for other patients. Sadly, I heard the news last week that a colleague who works at PHT had been admitted to ICU.

RBCH and PHT has had 1,292 cumulative cases of Covid-19 since the start of the pandemic and 282 of them have died. However, it will be impossible to determine the scope of the patient suffering and deaths as a result of not having adequate staff, lack of necessary equipment and resources, and the wilful neglect of management.

We had an awful and relentless several days since Christmas Eve. While we were at work, we also heard with horror the situation in London with ambulance services receiving more than 7,000 calls. Those who work in Covid wards here are struggling to fulfil the multiple treatment and care needs of frail and poorly patients. Colleagues in other wards and units are also running without the full staff template because every day starts with matrons going around to those places to find health

care assistants and nurses to help wards overwhelmed with Covid patients.

Every day and night is a struggle. We have to look after around 20 patients. Night shifts are scary and horrendous. We have patients who are gasping for breath and need oxygen therapy. Some are incontinent and need their pads changing. Other frail patients need their positions changing and then we have to administer their medication and antibiotics on time. Observations need to be completed timely and accurately.

Imagine doing all this with two or three staff down. It's impossible. We are here to look after our patients, but we can't fulfil their needs. This is mentally draining.

In November, a colleague in the East Wing of the hospital described how a specialist in Older Persons Medicines had written to the matron flagging the perilous situation. He wrote, "Yesterday, for example, I witnessed a bay in which a patient was having a severe GI [gastro intestinal] bleed, another had pyuria [infected urine with puss cells] while a third was having central chest pain, all concurrently. Despite this the nursing staff were efficient, resourceful, and it was clear that they were doing an excellent job. They are to be commended. However, I do wonder how sustainable this situation is, with high acuity on a ward not usually staffed for this. I was particularly concerned when I heard that a ward with such acuity was initially planned to be staffed with only 2 trained nurses overnight…"

During the day, we sometimes get help when we insist on extra support. But during the night shifts we seldom get adequate support despite requests to the clinical site [duty managers].

Adding more pressure to staff, the swabbing team was dissolved several weeks ago. So we have to carry out patient Covid swab tests despite being up to our eyeballs in work.

We had several meetings with management but none of the issues patients and staff face have been resolved. The situation has gone from bad to worse. In some Covid wards more than 75 percent of staff have contracted the virus. Some are/were suffering from severe symptoms and dozens of others are facing long Covid and PTSD. 265 colleagues in our trust are currently absent due to self isolation or having Covid-19 symptoms. This is largely thanks to the wrong PPE guidelines. We are still not allowed to wear FFP3 masks and gowns even when going to a bay full of patients with Covid-19.

One colleague said, "Staff in the hospital now are like leaves falling off from a tree one by one but still no concrete plan from the top."

Adding insult to injury, the hospital management and infection control unit pass the blame onto us. They say there are high infection rates among staff because we have a biscuit or a cup of tea in the ward during a break!

After exposing the staff and the patients to danger, Chief Executive of the UHD Debbie Fleming, whose salary is above £200,000 a year, wrote to us in December shedding crocodile tears about our fate! One of my colleagues was blunt. She said, "We don't need love letters from the CEO. We need proper PPE and enough staff to look after patients."

If a nurse makes a mistake under duress or pressure, they lose their pin and licence to practise. But where is the accountability for people on top?

Mid December, we received self-testing kits to test for Covid bi-weekly. This was too little too late. Hundreds of staff have already contracted the virus. I remember that the government voted down a motion to do regular weekly testing of NHS staff in the spring.

Lack of planning was apparent when Covid wards were opened adjacent to surgical wards and cardiac wards. Ward 21, which was closed for several years and does not have wall oxygen for several bed spaces, was opened as a Covid ward in the autumn. There was no continuity in care as there were no permanent staff.

A bank (staff resource pool) health care assistant who did a night shift in that ward said it was "chaotic" and felt sorry about the patients. He said, "I had to go out looking for oxygen cylinders each time they ran out."

Mixing of Covid and non-Covid patients has resulted in a disaster. Many elective procedures and investigations have come to a halt due to not planning ahead and the disease spreading in wards and units. The number of patients waiting more than 40 weeks for elective surgery and treatment has reached 8,246 compared to 786 in January 2020. A mere 64.5 percent of patients have had their treatment started under 18 weeks after a referral. Only 57.3 percent of patients who came to Emergency departments of the trust were treated, admitted or discharged within 4 hours on December 20. As health professionals, we know that these conditions will have long-lasting and catastrophic consequences.

One of my colleagues was thinking of writing to her union and then to the Care Quality Commission (CQC). But in my opinion the unions are useless. They do not raise a finger amidst the unsafe and dangerous conditions we are forced to work under. The CQC has not given a damn about patient safety and the well-being of either the staff or patients. The National Institute for Health and Care Excellence (NICE) is not there to determine safe staff levels. The Health and Safety Executive provides a cover for the government's homicidal policies instead of enforcing workplace health, safety and welfare.

I think we, the health workers, should organise independently to combat these issues.