Australian nurse speaks out about worsening conditions on the front lines of the pandemic

Our reporter
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The rapid and continuing surge in COVID-19 cases across Australia has exacerbated a systemic crisis in the country's chronically underfunded and understaffed public hospitals—the result of a decades-long assault by Labor and Liberal-National governments. The attacks have been enforced by the trade unions, including the health unions, through sell-out enterprise and industrial agreements.

There is growing anger and opposition among health workers to the harrowing conditions they face. Recent weeks have seen protests of nurses, including ICU nurses at Westmead and Liverpool hospitals in Sydney, New South Wales (NSW). In NSW alone, there are currently 2,068 COVID-19 patients admitted to hospital, with 132 in intensive care, 61 of those on ventilators.

To contain the growing anger, the NSW Nurses and Midwives' Association has been compelled to call a ballot on a state-wide nurses strike for February 15. The union is seeking to limit the action, isolate the nurses and direct them to plaintive appeals to the very governments responsible for the crisis.

The World Socialist Web Site *(WSWS) and Socialist Equality Party(SEP) are calling for workers to establish rank-and-filec ommittees in every workplace and community, independent of the unions, to fight for the resources needed to respond to the pandemic.The SEP has announced a public meeting this Saturday, entitled: "Join strike action by nurses! Form rank-and-file committees. Lives over profit." We urge health workers to attend and to contact the SEP. Let us, and other workers, know what is happening in your workplace.*

The WSWS spoke with an Enrolled Nurse, based in south-western Sydney, about her experiences, which echo those of nurses and other health workers across Australia and internationally, as healthcare systems are pushed to breaking point. The working class suburbs of the southwest have recorded the highest infection rates and deaths in NSW.

WSWS: Can you explain what has changed in your hospital since the upsurge in Omicron COVID infections?

EN: A lot has changed in how we deliver care. We are grossly understaffed on every shift and we have been told by our Nursing Unit Manager (NUM) that we need to get used to working short staffed with one or two nurses each shift, although this has already been happening every shift. There are always two Registered Nurses (RNs) missing and they are replaced by Assistants in Nursing (AINs). They are very rarely replaced with another RN or Enrolled Nurse (EN). The RNs are either on sick leave or they have contracted COVID or are waiting for a PCR test. An AIN can't dispense medication; they only assist with personal care.

Recently my boss told us that the model of care will potentially be changing, which means that the priorities of doing personal care will change. We won't be showering patients or getting them out of bed as much because we don't have enough staff. There is the possibility that patient observations, which should be performed every 4–6 hours, will change. It appears at present that this won't proceed but as everything changes every day, we don't know from one shift to another what will happen.

WSWS: What is the normal nurse-to-patient ratio?

EN: It is supposed to be 4:1, that is, one nurse looks after 4 patients. But even prior to COVID that wasn't the case. It was 5:1, but now we are seeing 6:1 and sometimes 7:1. We have had patients waiting to be discharged, sitting in the corridor. At times for RNs, it is 8:1. Many RNs are paired with AINs, with eight patients they have to give medication to, and they have to do it by themselves because AINs can't do it.

WSWS: So really there are no ratios?

EN: Yes, and my manager told us in a meeting that potentially there will be times you will have four staff with 28 patients. That is what we have on night shift which is different to day shift because we don't have to do Activities of Daily Living (ADLs), which includes showers, meal setups, getting patients out of bed. It is still very tough on night shift with only four staff but mostly manageable, but it will be mayhem if we have four staff and 28 patients on a day shift. They either can't fill the staff who are missing because there are no staff to fill or they have been deployed to other wards. Increasingly, NUMs and after-hours managers are putting a lot of pressure on staff to do overtime and if we refuse there is a guilt-trip: "your fellow nurses will be short staffed." We are called from the after-hours office saying: "if you don't find another staff member you won't get anyone else."

There is pressure on the nurses to call all our colleagues to

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ask them to come in and do overtime, because there are only 5 of us with 28 patients. The majority say no. I rarely do overtime because it is so difficult to manage doing 16 or 18-hour shifts, then coming in the next day at 7am. It is very tough on our mental health. At one point the kitchen staff were refusing to hand out meals and were going to leave it on the trolleys because they don't want to be in touch with infected patients. That would have meant the nurses would have to hand out the meals too, adding another job onto our lists. At this stage that has been overruled but we're ready for that to change also.

Next week, speech pathologists, physiotherapists, Clinical Nurse Consultants who carry out different specialities will be brought onto the ward to help with the ADLs—showers, meal setups, getting patients out of bed—because the nursing staff can't manage the workload. We have high acuity patients who have heavy care requirements. Our ward is urology/colorectal specialty, but we are now getting patients from other wards which have been changed to COVID wards, so their patients were transferred to us. This means our ward is catering for an array of patients outside of the urology/colorectal speciality.

We are all wearing a lot of PPE—masks, goggles, then face shields and plastic gowns—when in infectious wards which is very difficult and also we can't take them off to have a drink or go to the bathroom. The only time we can is on our breaks so it is very difficult if the breaks are missed or delayed, which happens.

WSWS: You have been informed that they were looking at deploying positive asymptomatic nurses into the COVID ward. Who told you that?

EN: The NUM (Nursing Unit Manager) at a meeting—this has not yet been implemented because the directors are looking at the data from the UK and US, where they have carried out this practice, as to how successful that was. If they think it is beneficial to the running of the hospital then it will be implemented.

The rules for close contacts isolating have changed. The rules change every couple of days because they can't sustain nurses being absent so they alter the close contact rules.

Prior to this, if a nurse was positive and was in the vicinity of a patient or staff without a mask—like in the tea room—you would have to isolate. You would be paid but if you developed symptoms you would have to call the manager to say so and you wouldn't be paid COVID leave but you would have to use your own sick leave (if you have any left). COVID leave doesn't come out of sick pay.

WSWS: What is the feeling among nurses about all the changes?

EN: Shell shocked. We are dealing with situations that are like something out of a movie. We sometimes look at each other and are gobsmacked and ask, is this really happening? Do we really have three patients on trolleys in the corridor right now with no beds? What if a medical episode happened with that patient? There is no equipment to use to assist that patient.

Nurses are becoming fed up—especially senior nurses, who have seen the hospital turn from when they started, to now. They don't understand how nurses can be treated so badly by the hospital management, that we are expendable. The management doesn't listen to us or our concerns. Or if they do, they say, "we understand but we can't do anything about it, it is out of our hands." They say, "we understand you are stressed, burnt out, emotional at times but we can't do anything about it." You have to deal with it.

Our hospital didn't use to be a COVID hospital, but now it is. It used to be that COVID patients were transferred to a larger south-western Sydney hospital, but they can't take any more so other hospitals have become COVID hospitals.

In my hospital there are now five COVID positive wards with around 28–30 patients in each ward. All those wards had specialties—geriatrics, orthopaedics or upper GI (gastrointestinal)— and those patients have had to be transferred to other wards or discharged. Around 140 patients have been shipped to other wards.

We are also discharging patients that are not ready to go home, like patients who have drains and we have to teach them how to look after the drains at home. Before, we rarely taught patients to manage their own drains, but organised community nurses who would go into patients' homes to do them. I'm assuming community nurses are run off their feet too.

With all the changes to the hospital and our routines, nurses are struggling to keep up and manage their day-to-day workloads. It's now trickling into personal life as we're all too tired to engage in activities with family or friends.

WSWS: What do the patients think?

EN: Sometimes they think we are too slow. Most are lovely and understanding and know we are run off our feet. Families can't come onto the wards now so we have to assist the patients much more.

WSWS: How many extra nurses do you think are needed?

EN: Enough to sustain the 4:1 ratio.

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