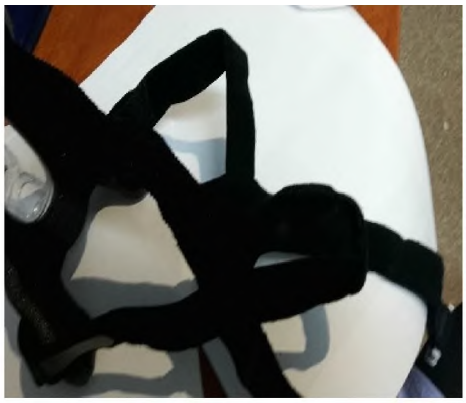
COVID RESPONSE FEEDBACK:

- Dangerous work practices like bed to bed transfers should be stopped by placing patients into electric beds that they remain in from Emergency. Bed to bed transfers add to nursing neck, disc, back, shoulder and hip injuries and are entirely unnecessary, with battery operated electric beds. Unnecessary bed to bed transfers continued during Covid, which was dangerous, as somebody was at the head of the bed, supporting the patient's head and neck. Wardies transferring patients on hydraulic trolleys place the 220kg capacity of these trolleys onto single knee and hip joints. No safety improvements occur after health worker injuries, as despite 80% of their working life spent lifting, bending and twisting around medical equipment, 74% of injuries are fraudulently dismissed as "degenerative" (Safework 2013 stats). WorkCover as an insurer misuses the medical term "degenerative," as this term also refers to the inflammatory mediators that flood to trauma sites after injuries. Degenerative means that the inflammatory deposits are visible on medical imaging to Radiologists and the medical definition cover post traumatic arthritis.

- Most bed to bed transfers are done without hovermats, and no disposable hovermat sheet covers are purchased, so that the hovermats can be left under patients, to keep the patient's skin free of moisture, unless they are used in theatre, where patients over 90kg are routinely transferred over narrower trolleys to theatre tables. When wider bed to bariatric bed transfers occur, where the greater risk occurs, the hovermats are not available to clinical areas.

- Health workers sustaining respiratory infections receive no compensation for pneumonias, when these infections are dismissed as "community acquired". Many health workers looking after people with respiratory distress have the infective bugs aerosolized by BiPAP and CPAP machines, when the cause of the respiratory distress is initially considered to be of cardiac origin. The most dangerous time for health workers is during intubation for ventilation, but nurses needing to get PICC lines in for their own antibiotics, after assisting with the intubation of infected patients, got their infections dismissed as "personal". CPAP and BiPAP machines aerosolize bugs 1.2 meters from the patient's head, so that even wardies pushing beds were placed at risk.



- The purchase of dangerous non-stitched head bands for CPAP and BiPAP masks satisfies the budgets of business managers, while maiming Nurses. Nurses are repetitively bending and leaning over bed to prevent the strapped masks from migrating into patients' eyes. The non-stitched head bands of the masks should be stitched to prevent the straps sliding in hair causing patient eye and health worker bending injuries.
- SafeWork do not provide feedback to workers sustaining serious injuries or infections. The SafeWork and WorkCover emphasis is on rejecting compensation and dismissing injuries and infections as personal, as the sleep deprived health workers are financially strained and vulnerable. With unfair AIRC processes permitting Interlocutory Applications to be filed to pervert the course of justice, like:
  (1) Onus of Proof 1995 legislation that cannot be satisfied with consultant opinions and MRI;
  (2) unscientific precedents like the Blackwood vs Toward 2015 decision that ignores the medical science around post traumatic arthritis and fraudulently exploits the medical term "degenerative", all costs are deflected to the workers, with no safety improvements required.
  (3) Workers on $25/hr cannot fund Lawyers costing $690/hr to challenge unfair AIRC processes, since they get no Legal Aid and are financially strained funding work injuries.
  (4) The Bundaberg Nurse was accused of being a "vexatious litigant" for an Interlocutory Application to be filed, to force her to withdraw her AIRC Application for re-instatement. Unless she withdrew her appeal, she would be liable for the legal fees of herself and the Respondent, as IAs are deployed to force the injured to impossibly defend that their injuries are not "degenerative", in a legal system that fails to recognize medical science. How can she be a vexatious litigant when her 4 serious permanent injuries were all substantiated by 4 MRIs. The Bundaberg Hospital was never held accountable for

leaving her on full 12 hour clinical duties with a MRI diagnosed disc tear, on a 3 month spinal surgeon waiting list, until unable to walk. 7 medical requests for risk mitigation and rehabilitation support from the Spinal Surgeon, Pain Consultant and GPs were then ignored, subjecting this nurse to 27 surgical injuries, a significant risk of quadriplegia, and $20,000 medical gap fees she was left to self-fund with no compensation.

(5) You cannot look at the Covid issues without looking at the fraudulent maltreatment of health workers, left maimed and bankrupted just from going work in a bullying toxic culture, hideously referred to as a "health" system. Using health funds to increase the lawyers employed by hospitals, employing Media Liaison and HR to generate propaganda, is not looking after health workers. In Australia, only Teachers get compensation, not the manual handlers, labourers and tradies, who are not willing to engage in corrupt insurer driven AIRC systems.

- Nurses got 3mm kidney stones and severe headaches from dehydration when stuck in the Covid suits for 6 hour intervals, the duration of entrapment in Covid suits should not exceed 4 hours.
- 50% of slide sheets used to shift patients should be different colours. Those on either side of the bed cannot determine if they are all lifting with the same sheet, when slide sheets are folded under bariatric patients. When staff on either side of the bed lift, are unaware they are lifting with different slide sheets, the patients move unpredictably causing nursing and wardie back, shoulder, neck and disc injuries. For the patients moving unpredictable, they are subjected to unnecessary procedures, when intravenous accesses, chest tubes and feeding lines become dislodged.

- Many health workers who have injuries but are not infected, are denied their right to transition back to work on reduced hours. Those nurses and wardies wanting to transition back to work on light duties could assist their colleagues by answering phones, photocopying documents for aeromedical transfers, getting medications out to check, preparing infusions etc. However, the Qld Government denies all the risk mitigation and rehabilitation support in their Rehabilitation Guidelines, and prefers to have nurses and wardies remain home using accrued sick leave, rather than contributing to reducing the work of colleagues. Many nurses having to rest for minor injuries like to boost the morale of colleagues, by answering the phones, photocopying for transfers and reducing their paperwork. Instead they can only fraudulently return to work using "annual leave offered as flexible working arrangements", instead of accrued sick leave. Marking return to work staff on rosters as being on suitable duties plans would prevent unrealistic expectations. Instead suitable duties plans are denied altogether. Veteran nurses on return to work arrangements, could buddy with novices, until they gain their confidence, but instead they are denied suitable duties plans, and can only return to stressful full clinical duties full time during their injury recovery, or take "annual leave offered as flexible working arrangements" instead of sick leave to transition.
- Work injuries are being deliberately extended by returning an aging workforce to non-ergonomic workplace designs, products, equipment and policies (bed to bed transfers), until they are left with chronic pain and disability. There is no sane reason why ventilators should be purchased with humidifiers 30 cm from the floor, for an aging gender diverse population, needing to chronically bend low to turn off alarms.

There is no reason why, the culturally and gender diverse, aging nursing workforce should have to chronically hyperextend over these infusion pump stations, to turn off alarms on ceiling mounted monitors, when the average nurse is 153-157 cm tall. When reporting injuries, the issues will be ignored by male OH&S Officers over 180cm tall, who will determine the needs of an aging female workforce without consultation.

Why does the Government consider it reasonable for nurses to shunt furniture from bay to bay, just to get admissions? This hospital passes accreditation and OH&S issues with blocked fire doors for the most vulnerable critically ill patients in the hospital, by shunting furniture to external buildings when pre-warned. In November 2018, they actually got the ACHS award for quality and safety due

to their spreadsheet illusions that do not translate to safety, for patients or staff as per blocked fire door on left.

Imagine being pregnant having to get the equipment on the far wall in the bay below. This unit was evacuated 2 times for mold, then more OH&S attention was paid to the removal of cork notice boards, than the 4 areas where the floor scould not be cleaned.

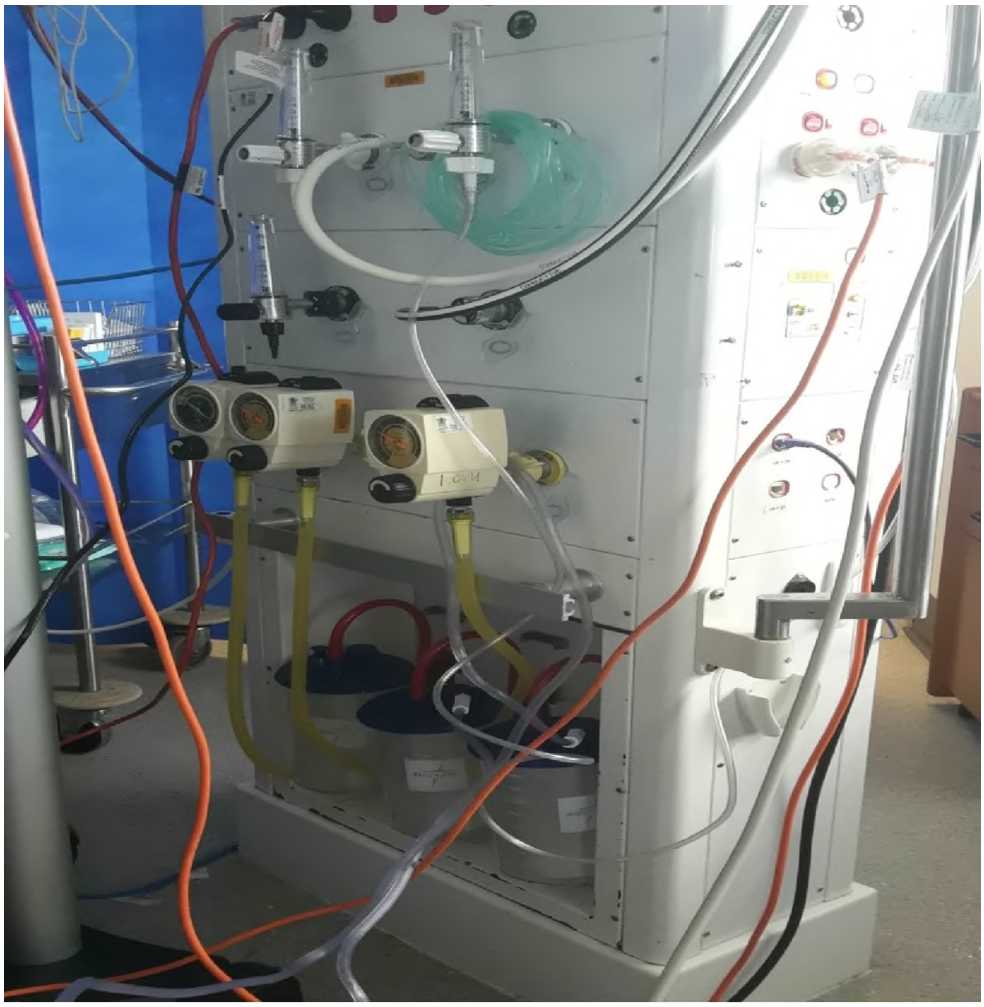
To get this transport monitor from the above bays for a patient to go to Xray, CT Scan or theatre, that pregnant bellied nurse would need to navigate all the equipment in the above bay, then leave carrying the transport monitor obscuring her view of her feet, with all the leads and cables to trip over.

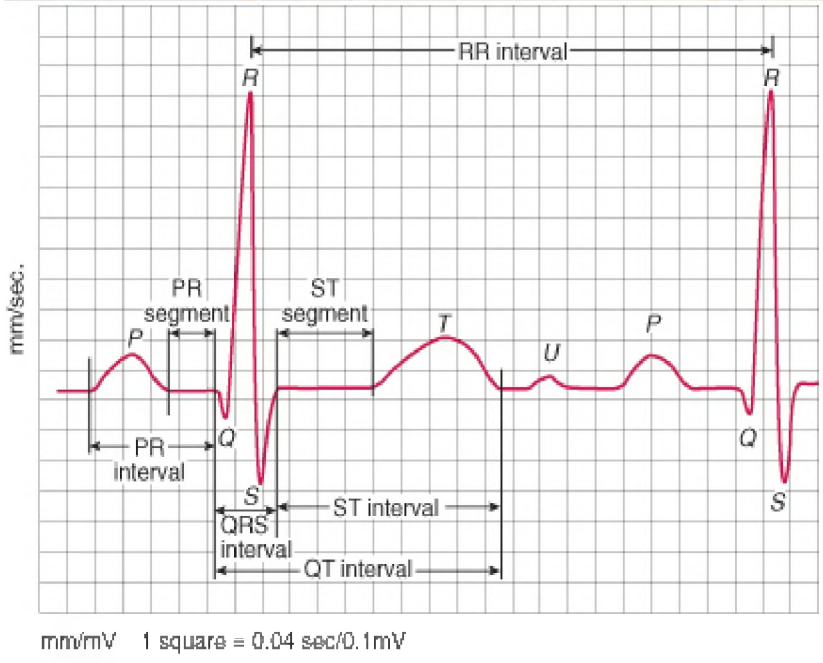
1000 nurses, wardies and auxillary staff sacked during the pandemic was a disaster. Novices were panicking other novices, with no-one with experience available to show them what to do when sick leave spiraled.

The skill mix of the work force is being dangerously diluted with university/hospital contracts. When hospitals commit to taking 100 new grads for placement in the next year, the veteran nurses are denied access to long service leave. If they want their long service leave, they are forced to resign, so that all their sick leave entitlements are wiped. This makes a full time position available for novices, with no experience or skills, to satisfy the university and hospital contracts. Experienced nurses with full patient loads, needing to accept admissions or facilitate discharges, are then stressed and missing meal breaks, when the novices dilute the skill mixes and need support.

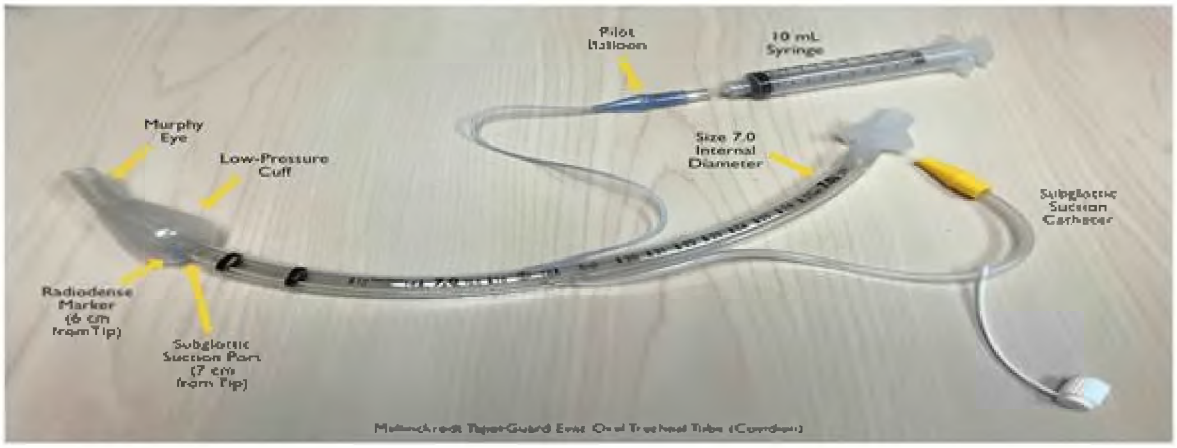
The aging work force is chronically maimed deliberately by non-ergonomic workplaces, as viewed below. To change these canisters daily, those aged 60 years have to get to floor level at the back of beds, twisting around ventilators, dialysis, echo machines and cables! Then chronically hyperextend to silence monitor alarms, but their injuries will be self-funded when dismissed as “degenerative”.

The only personal aspect of these injuries is the cost. Nurses and Wardies do not go to work to negative gear self-funding work injuries, fraudulently dismissed as personal.





Despite the Credible Meds pharmacy list being available for patients with long QT syndrome, to prevent fatal arrhythmias, many hospitals are not putting in age and gender when doing heart tracings. When the risk of fatal arrhythmias and patients on anti-coagulants falling are entered on risk systems, the risks are dismissed because the "doctors can calculate the QTc". The doctors are ¼ of the team here. The Pharmacists checking medication charts cannot calculate the QTc; the nurses giving out medication need to check the heart tracing QTc measurement to withhold medications like common antibiotics if the QTc exceeds 500ms. The risks to patients having sentinel events will not be reduced if this risk is chronically dismissed.



Subglottic suction catheters for endotracheal and tracheostomy tubes should be used to reduce the risk of lung aspiration of saliva. Only the Mallinkrodt brand is safe as the Portex ones get cuff leaks causing lung white outs.