

August 10, 2026

### **Experience of Suzi Eichinger, RN — COVID Hospital Protocols**

My name is Suzi Eichinger. I am a registered nurse with nearly four decades of experience in multiple clinical areas, including critical care, PACU, and leadership.

During the 2021 Delta surge, I volunteered from the PACU to assist in the Cape Canaveral Hospital ICU. The dates were from August 2, 2021, to September 22, 2021. I served as an ICU helper, assisting with direct patient care, medication administration, hygiene, repositioning, and prone-positioning protocols.

One case illustrates a clear example of COVID hospital protocol overriding clinical judgment.

In early September 2021, during the peak of the surge, a patient arrived in the ICU after coding on the floor. He was profoundly unstable on maximum vasopressors and ventilated on 100% oxygen. His blood pressure was very unstable, but his oxygen saturation was hovering at a manageable 93%, which gave the staff some time to stabilize his cardiovascular status. The pulmonologist knocked on the glass door. I opened it and he said, "Prone him." I said, "He's too unstable. If we prone him, he will arrest." The physician replied, "That's the protocol." The order did not match the patient's clinical condition. We proned him. He coded about 20 minutes later and died shortly thereafter.

The staffing shortage made it deadlier. In this 12-bed unit, it was routine for a single nurse to care for three mechanically ventilated patients (1:3). This severely deviated from the accepted standard of two ICU patients per nurse (1:2), a ratio that is mandated in some jurisdictions. In nearly 40 years of nursing, I had never witnessed ICU staff so overwhelmed that they could not provide the constant assessment required for critically ill patients. I witnessed these conditions daily.

During a shift in early September, two of four nurses were pulled to hospital-wide codes, leaving two nurses for twelve critical patients (1:6), a ratio leaving most of the patients effectively unmonitored.

Throughout my deployment, patients remained in the prone position for dangerously long periods. Proning required an entire team, including a respiratory therapist. With only four nurses on the unit, every nurse entered one isolation room, leaving no one to monitor the remaining critically ill patients.

Consequently, patients were either not proned when indicated or remained prone for up to 48 hours. This was far beyond the recommended 16–18 hours. Due to critical staffing shortages, nurses could not provide essential care, including skin assessments, pressure relief, eye and mouth care, catheter care, bowel care, and airway management.

Because of my role as ICU helper, I assisted with every patient, providing a unit-wide perspective. What I witnessed was not an isolated incident, but a recurring pattern throughout my deployment.

Approximately the third week of August, executive leadership toured the unit. I introduced myself as an RN with leadership experience and explained that unsafe staffing was compromising patient care. About three weeks later, I raised those concerns a second time. Leadership blamed the national travel nurse shortage, ignoring that experienced Florida nurses were leaving for higher pay, and travelers refused Florida assignments due to non-competitive rates.

Within 15 days of returning to the PACU, I was under an HR investigation and told I would be terminated. I resigned to protect my unblemished career. I cannot prove retaliation, but the sequence is clear: I spoke up, and within weeks, I was removed.

In summary, the protocols I witnessed replaced individualized clinical judgment with rigid, top-down mandates. Severe understaffing made patient advocacy impossible, forcing nurses into perpetual triage. Consequently, unmonitored protocols led to predictable, avoidable outcomes.