A 93 year old lady sat on an ER stretcher Tuesday for 8 hours. She was evaluated by 0800, labs and xrays taken. She received NO medication, and NO treatments were ordered. Her daughter in law sat patiently by her side, asking a couple of times for a blanket, or a drink of water.

In another room, my 3rd patient in an hour in that room was having a heart attack. We were told of her arrival 2 minutes earlier, took her history and started her exam in the hallway, because the patient who was in that room had to be moved....to the same hallway where the heart attack was waiting.....It took 14 minutes from arrival to send the heart attack victim to the cath lab accompanied by the cath team and the cardiologist- that was slower than the ER usually averages on day shift......

We can accomplish a great number of tasks in the ER with speed and precision: that SAVES lives. That is one reason I work in the ER. But we are taking poor care of everyone else. Incomplete care = poor care. Uncharted care= incomplete care.

It took 14 minutes for a team to care for the patient....it took more time to clean and restock the room, after the patient left- restocking is my job (at $54 an hour), and cleaning happens......when housekeeping (the one person in our area) is made aware of the discharge (sharp eyes, notwithstanding, she didn't even know the previous patient had been moved) so, perhaps the ER tech can tidy, disinfect, empty trash, make the bed.....or maybe she is in the trauma next door, drawing labs or applying splints....or transporting....NO, the 93 year old is still there, the bed hasn't been assigned. So I or one of my teammates will tidy. Now, on to the charting of the activities of 5 or 6 people in the care of my patient- that, also, is my job. Initial assessment, vital signs, procedures and treatments provided, outcomes or effectiveness of those treatments, documentation of heart rhythm, medications ordered and given, time documented of each item above. The patient had no allergies. There was nothing else known about the patient, except for the smoke scent of the house by the EMS crew. No medication reconciliation, no time of last intake, no pain control was offered, no activities of daily living, no social status or family contacts, no advanced directives, no financial information. No one to say anything of comfort to the patient.

....OH, but what of the patient in the hall, you ask. The person who was sent from a clinic by private car because the heart rate was 230 beats a minute. It took 3 IV attempts, and medications to slow the heart rate, normal saline had to be obtained from underneath the team leader's desk, (don't get me started on the shortage of normal saline for the past year)and the rhythm was still in question, so the patient would be sent back to clinic for heart monitor placement. But the patient was placed in the hallway, ALREADY OCCUPIED BY A PATIENT ON A HEART MONITOR, and no monitor was immediately available to apply. Oh, by the way, all of her heart monitor information, and vital signs were erased when she was moved to the hallway. A monitor was found, now we we needed a pill to reinforce that her heart rate stay slower (at 120, it was slower, but not 'fixed'). The order was written, and flagged- a team nurse went to give it, the pyxis was empty, pharmacy was called.....the order was now not flagged....and not done.

Meanwhile, I was signing in a patient in the condos with a GLF history, who fell after dialysis, while transferring to a wheelchair. The chin was cut, the dentures were broken, the patient had to have a

bowel movement NOW. The pants survived, not the underwear or the sheet, the patient was cleaned up and vital signs were taken. There was not time for an initial assessment, there was no active bleeding, the chart would go in the rack and I would return to clean up, and assess.

The doctor wanted to know why the hall patient had not been discharged. (No discharge papers were written yet, I said) Was the pill given?.....The order was discovered, pyxis #1 still had no stock, and pyxis#2 (on the other side of the ER) had no stock, and an order was faxed to pharmacy. Pyxis #3 was checked, and it had none.

Meanwhile an EMS crew waited to give report...

I had two additional nurse team members signing in... miscarriages, dementia patients, abdominal pains, asthma- all requiring assessment, evaluation and monitoring. Way too busy to give excellent care, we were trying to put out fires- (the 93 year old still waited for an assigned bed),so we were put on ambulance divert.....Except that we still received 3 trauma patients and two suspected stroke patients....we don't divert them, we're certified to take them, no matter. A critical patient requires a team of caregivers. Sometimes the team is only the primary nurse, usually a respiratory therapist, and the physician.....all activities to be recorded by the primary nurse in accordance with Federal Law, and and all to be accomplished with little or no help if no help is available. Door to cat scan time is imperative, the golden hour waits for no one.

The GLF patient had a head bleed, a room was received for the 93 year old, and then taken away...the pharmacy sent the pill, but it was lost in the tube system, and found 2 or 3 hours later on the team leader's desk. A stray pill was found in a cardiac box, the patient was returned to a room to get dressed, and get road-tested- while another patient was being sent into that very same room. I had a nurse (not even on my team)offer me a lunch break- an actual person to cover my assignment- not just listen for alarms while I went to the bathroom.....when was the last time I did that???? I first sat down to finish my charting on the heart attack patient whose notes were scattered across paper towels, and backs of forms. I was then able to chart on the patient who had arrived claiming to be "intoxicated" and had struck a head falling downstairs- noting the medication reconciliation of MScontin, fast acting morphine, alprazolam, and valium for sleep. That patient declined lab tests or cat scan and eloped out the front door while I was assisting my team member in a trauma alert in the next room. It was now 1400, and I went to lunch. Report was called for the 93 yr old, and then the room was changed, after I came back from lunch, a new room assigned an hour later, and report attempted but I was told that nurse was on a break, and I would have to call back- I declined, and asked to speak to the charge nurse. By the time I spoke with the charge it was 1555, and the charge declined to take report, citing the upcoming bed meeting, that would remove said charge from the floor, and, unable to report to the primary nurse, would leave that patient without coverage and "that would put the patient in an unsafe care situation", so I could just call back later and speak with the primary nurse.....Team leader in the ER was then involved (who, I suspect, had been needed at the bed meeting as well) who called admin manager...

I still had 3 hours left on my shift.......

A nurse's emotional connection with her patients and her job begins well before the beginning of the shift. Flu season this year has hit everyone hard, resulting in increased census, which is already common in the winter. The last two shifts I worked had a shortage of 5 and 6 nurses in my area, on my shift alone, and we were encouraged to 'hang in there'. Staff is frustrated. Waiting times were long, and patients were frustrated.

Tuesday's shift was my first shift I'd worked since I brought my mom home from her local Peace Health hospital after a 9 day stay; complicated by medication errors, monitoring errors, chronic pain management errors, resulting in a visit to the ICU, a prolonged stay, and uneven discharge planning. I was not proud to be a Peace Health employee.

My first patient of the day had waited 6 hours in the waiting room for her complaint of hives, (her second visit in 36 hours). I discharged her, unable to help her- hives are tricky.....

My second patient was the previously mentioned 93 year old, vague symptoms, to be admitted, but caught in the busyness of the day, spent eight hours on the ER stretcher, waiting.....I couldn't help her...I didn't have the time to meet her basic needs, let alone give her excellent care.....

My next patient was the intoxicated patient of earlier (who didn't want our help), and then the heart racing patient, who had multiple experiences with this problem, and thought the corrective surgery performed 6 weeks before should have taken care of it. This heart racing patient and the multiple family members had numerous questions, including basic pathophysiology, side effects of medication being given, what to do on discharge, and follow-up issues- this patient I could help, and I tried as much as I could, even with the critical patient interruptions, bed changes, medication SNAFU's , and general chaos of the department.

Finally, after getting a patient upstairs, my next patient had suffered a stroke at home, 4 days earlier, and was just now seeking medical treatment.....so sad, so preventable, both of feeling helpless....

The next lady in the hallway, outside my rooms, was having trouble with her cell phone, was waving it about and asking for help- I could do THAT. Turns out-she was misplaced in the wrong hall bed, her chart was with the other team of nurses and a different provider, she had multiple requests for toileting, required assistance to walk, and was very verbal about how she was receiving terrible care. I found her chart, talked to her MD to see if I could get her to the bathroom, tried to find her nurse- I could not tell by the chart who that was, because of uncompleted charting.

That patient was still in the hallway, an hour later- got fed up- and began to leave the ER, using her walker, with an IV, in a patient gown. When she saw me she recognized someone, so came to me to loudly complain about the care, or lack of care- worse, the absence of care she had received in this facility. She spoke of medicare fraud, for charging for care not received, for inhuman treatment- she had no call bell, requests for toileting went ignored, no one cared about what happened to her. A visitor in the hospital, whose own family member was critically ill, recognized the patient, made a couple of phone calls, and arranged for transportation for her to be taken home. Her follow up was "see your doctor" although the patient had made it VERY clear that she had no provider, her first available

appointment was scheduled for 6 weeks out. The only thing we could advise was return to the ER if you think you need to......there was no help for her.

Soon after this encounter, I was called into the office to speak with a team member, who stated that earlier in the day, I had hurt her feelings, by my 'attitude', and made her feel badly. She was thinking of asking to no longer work with me.....I was thinking of quitting my job......

We are here to help others, we need to help others- it is our passion. I'm turning on my fellow nurses in my frustration, and they strike back....who is going to help us?