Pharmacy Fakes: Protect Your Family

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Part 2

Condition: Critical

A burnt-out nurse blows the whistle

7:15 A.M. We're short-staffed again. I find this out as soon as I arrive for work. I've been assigned three patients, even though the safe ratio for my intensive care unit is two patients per nurse. I'm in for a tough 12 hours.

The night nurse fills me in on Patient 1. He's in critical condition with alcohol withdrawal—delirious, agitated. For his own safety, he's restrained at both wrists. The man is at risk for seizures, stroke, heart attack and death, so I'll need to check him for complications every 30 minutes. Treatment is sedation. He's getting that, but obviously not enough.

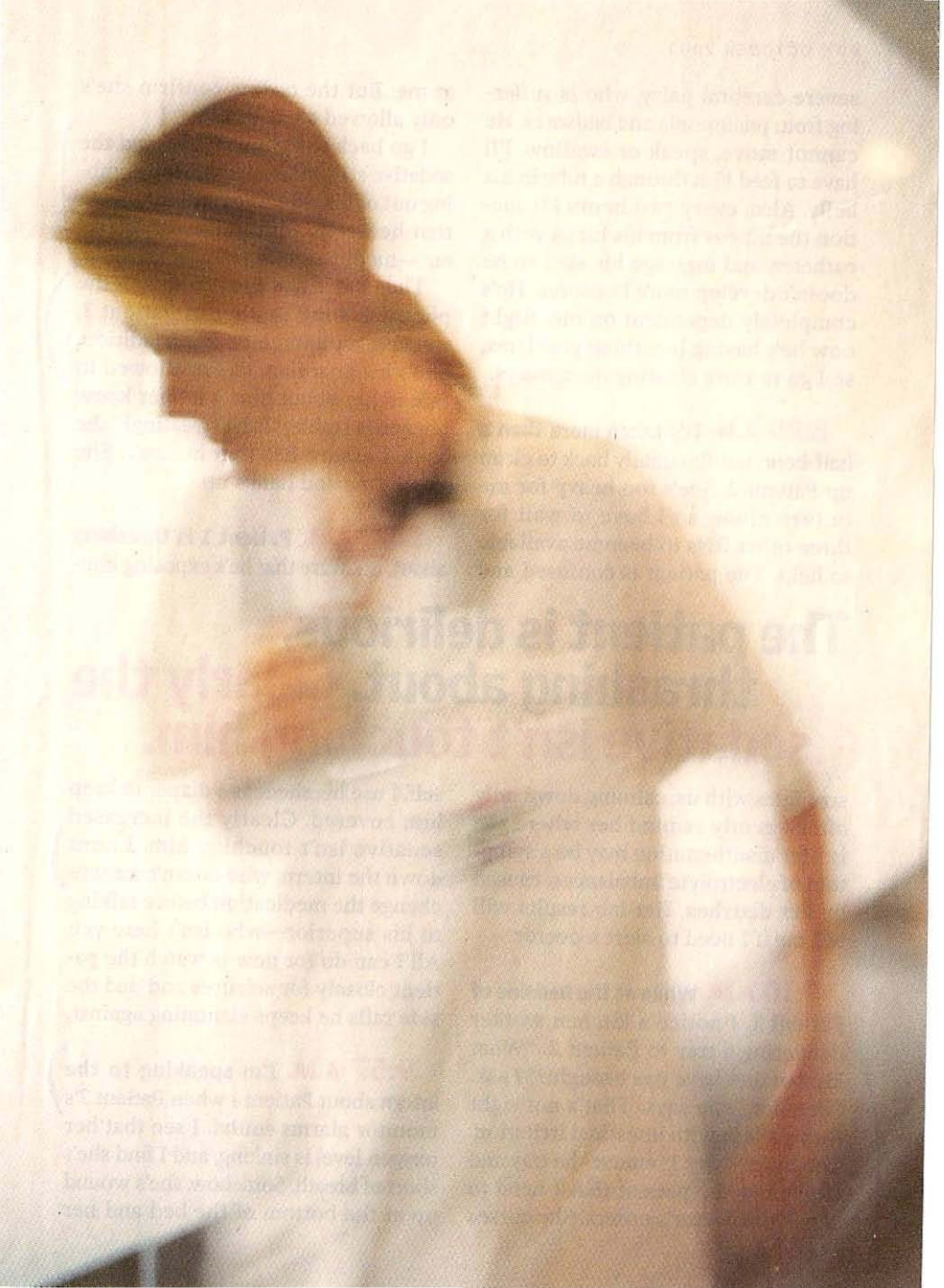
Seeing that his vital signs are normal, I decide it's safe to increase the sedative dripping into his vein. Once I'm sure he's handling it without side effects, I move on to Patient 2.

She's a 66-year-old, 300-pound woman with a serious blood infection. Her antibiotics are causing frequent diarrhea, such as right now. Thanks to "cost-cutting," I don't have a nurse's aide to turn to for help, so I place a towel over the soiled sheets, intending to return momentarily.

Patient 3 is a 26-year-old man with

Part One in this series, a report on America's nursing shortage, appeared in the September 2003 issue. This piece was written anonymously.

PHOTOGRAPHED BY ERIKA LARSEN/REDUX



severe cerebral palsy, who is suffering from pneumonia and bedsores. He cannot move, speak or swallow. I'll have to feed him through a tube in his belly. Also, every two hours I'll suction the mucus from his lungs with a catheter, and massage his skin so he doesn't develop more bedsores. He's completely dependent on me. Right now he's having breathing problems, so I go to work clearing his airways.

8:20 A.M. It's taken more than a half-hour, but I'm finally back to clean up Patient 2. She's too heavy for me to turn alone, so I have to wait for three other RNs to become available to help. The patient is confused and struggles with us, calming down only after I gently remind her where she is. Her disorientation may be a symptom of electrolyte imbalances, caused by her diarrhea. Her lab results will tell me if I need to alert a doctor.

9:10 A.M. While at the bedside of Patient 1, I notice a kitchen worker delivering a tray to Patient 2. "What kind of diet have you brought?" I ask. "Regular," she says. That's not right for a patient with intestinal irritation. Too much dairy. I remove the tray and explain to the patient that I need to check the doctor's orders. She curses at me. But the orders confirm she's only allowed clear liquids.

I go back to Patient 1, and find the sedative still isn't helping. He's climbing out of his skin. I remind the intern that he needs additional—or different—medication as soon as possible.

Then I'm called away to answer the phone. It's the mother of Patient 3, wanting an update on his condition. She's his guardian, so I'm allowed to talk to her about him. I let her know her son is stable. "Is he sweating?" she asks. I assure her that he isn't. She thanks me and hangs up.

9:32 A.M. Patient 1 is thrashing about, unaware that he's exposing himself. I use his sheet as a diaper to keep him covered. Clearly the increased sedative isn't touching him. I hunt down the intern, who doesn't want to change the medication before talking to his superior—who isn't here yet. All I can do for now is watch the patient closely for seizures and pad the side rails he keeps slamming against.

The patient is delirious, thrashing about. Clearly the sedative isn't touching him.

9:57 A.M. I'm speaking to the intern about Patient 1 when Patient 2's monitor alarms sound. I see that her oxygen level is sinking, and I find she's short of breath. Somehow, she's wound up at the bottom of the bed and her

big belly is sitting on her chest. I corral three other nurses to help me pull her up to a better position. She yells at us and slaps our hands. But her breathing soon improves.

10:10 A.M. The interns discuss Patient 1 with their senior MD, and I also give the doctor my assessment: We aren't treating the man's symptoms adequately. He needs better sedation or he's going to have complications. The doctor agrees and instructs the interns to pay attention when an experienced RN tells them something about a patient. Then he orders an antipsychotic drug to be given immediately. It's taken three hours to properly treat Patient 1's symptoms.

10:55 A.M. I'm hanging an IV antibiotic on Patient 2 when Patient 1's ex-wife telephones. She has heard he's here and wants information. I tell her that state confidentiality laws prevent me from discussing his situation. She could try calling his mother, who is listed as his next of kin. This is hardly what she wants to hear, and she snaps at me angrily. I offer to transfer her to my supervisor. She hangs up on me.

11:05 A.M. I'm administering Patient 2's meds when I'm told that the sister of Patient 3 is at his bedside and wants to see his nurse. I call over that I'll be there as soon as I can.

When I finish with Patient 2, I go introduce myself to Patient 3's sister. She curtly states that it took me 15 minutes to get to her. Then she says that she wants me to turn her brother. I inform her that I just did that an hour ago. She insists that he doesn't look comfortable. He's sleeping and I don't want to disturb him, so I tell her that I'll reposition him when he wakes up. So she wakes him.

12:15 P.M. The unit secretary is at lunch, and the phones are ringing off the hook. All the RNs are busy at their patients' bedsides. The doctors, meanwhile, are complaining loudly that no one is answering the phones. We remind them that RNs are here to take care of sick people, not phones.

1:35 P.M. The elderly mother of Patient 1 is standing silently at his bedside watching him sleep. She looks exhausted and drained. I introduce myself and ask if she understands what has happened to her son. She hesitates, and then says he must have been on a binge. I explain that, actually, he tried not to drink but this made him ill because his body had become so dependent on the alcohol. Suddenly she tells me his whole 25-year history with alcohol—recoveries, relapses, the effect on his family, and all she has done to try to help him.

When she is finished, I ask if she's taking care of herself, and she begins to cry. She worries about her son so much that she can't sleep, she says. I assure her there is nothing she could have done to prevent or fix this problem. Then I encourage her to attend a meeting of Al-Anon, where she'll find support from others who have

felt the same pain. We talk for 20 minutes. As she leaves, she gives me a hug and says, "Thank you so much for understanding."

2:30 P.M. Having just given the latest round of medications, I'm at the desk reviewing charts. The RN next to me is going to lunch, and I'm assigned to cover one of her patients. She tells me if his blood pressure falls, I'm to increase his IV medication. I am now responsible for four ICU patients.

2:50 P.M. Three hospital workers show up with gurneys and announce that they're here for Patients 1, 2 and 3. I know nothing about this. An intern says that Patient 1 is going for a CT scan of his head, Patient 2 for a CT scan of her abdomen, and Patient 3 is being transferred out of the ICU.

I've been here all day, and no one mentioned any of this to me. None of these patients has been prepared to leave the ICU, and none of the documentation is completed. The transporters are angry because their shift is ending in 20 minutes and they'll be delayed. I'm feeling stressed, but if I rush I'll make a mistake. They will just have to wait.

The secretary calls me to the phone, but I ask her to take a message. It's Patient 2's daughter, wanting an update. She'll have to call back later.

3:30 P.M. The other nurse is back from lunch so I'll take my break now, before my patients are returned to the ICU. The charge nurse tells me to empty the linen hamper I've filled with patient 2's soiled sheets. I tell her to call housekeeping for that sort of thing, and I go outside to have lunch—eight hours after starting my shift. Only four more to go, I say to myself.

4:30 P.M. I return from my break, and Patient 2 returns from her scan, with her daughter following her. I introduce myself and ask the daughter if she would wait in the family room until her mother is settled in bed. She steps aside, but stands just behind the curtain. I feel the tension in the air.

Glaring at me, she wants to know if I'm the RN who wouldn't take her call.

When I finish with the patient, the daughter comes back in and glares at me. She wants to know if I was the RN who would not speak to her when she telephoned. I explain that I could not leave another patient to take her call. She demands to speak to the doctor about her mother, in effect dismissing me. Then she allows me to overhear her say to her mother that she will report me and my "attitude" to my supervisor.

5:45 P.M. I am about to prepare for the 6 p.m. meds when I see that a doctor has ordered an EKG for Patient 2. There haven't been any cardiac or respiratory changes, he tells me; he just forgot to order the routine exam earlier.

We used to have an EKG technician, but the position was cut to save costs. So instead of giving my patients their medicines on time, I have to stop providing nursing care and function as the EKG tech.

6:30 P.M. The intern tells me he needs more blood work done on Patient 2. I just can't do it now: I only have an hour left and too much paperwork to do. So he'll have to draw the blood himself.

The intern also hands me an order for a new sedative for Patient 1. Unlocking the narcotics cabinet, I find we don't have this medicine in stock. Since the hospital pharmacy no longer has the staff to deliver narcotics to us daily, RNs must go themselves to pick up whatever is needed. I rush off to the pharmacy, asking another nurse to "keep an ear out for my patients."

7:15 P.M. The night shift is arriving and they begin to make their assignments and count narcotics to ensure the controlled drugs are accounted for. I turn my patients over to one of the RNs, telling her about their history and the details of the day. We also go over the orders and medications together, check all the IVs to make sure everything is correct, and do a quick assessment of each patient.

8 P.M. Finally finished. But my shift ended a half-hour ago. Since I'm leaving late, I'll have to pay the hospital parking garage the regular fee plus an extra six dollars ... again. Then I'll pick up my kids at my mother's house, drive home, check their homework, and get them ready for bed. I won't be having any dinner tonight.

My back is killing me, my neck hurts, my ankles are swollen, and my head is pounding. How much longer I can work like this, I just don't know.

HOOK, LINE AND STINKER

"Fish is the only food that is considered spoiled once it smells like what it is."
P.J. O'ROURKE

"You know why fish are so thin? They eat fish." JERRY SEINFELD

"Why does Sea World have a seafood restaurant? I'm halfway through my fishburger and I realize, 'Oh, my God, I could be eating a slow learner.'" LYNDA MONTGOMERY