My name is Diana Bijon, I've been an ED RN for 16 years and have been at OHSU for 13 years. I often work as the charge nurse for the OHSU ED, and have lived countless dangerous situations where patients lives are teetering and I have not had enough staff to care for them. I have also lived through many situations of patient violence where I was alone in the Emergency Department lobby with violent patients and had not ONE staff member present to help me.

Please know that I have an excellent ability to compartmentalize the horrific events that unfold in the ED. It's why this specialty nursing practice is perfect for me. However, in the last few years the OHSU Emergency Department has turned into the largest inpatient hospital unit, with admitted hospital patients occupying up to 47 patient care spaces in our 31 bed ED. There are many shifts where we are not provided any additional nurses to take on this burden, and we continue to try to function as an Level1 Trauma Center, a STEMI Center, Stroke Center and Tertiary Center absorbing the most complex difficult high risk medical patients in the state.

As our health infrastructure continues to fail our communities and the ED continues to be the safety net and the only option for patients, the lack of staff in addition to lack of space and failing infrastructure forces me to watch my patients suffer - while I KNOW exactly what to do, what they need. I have the knowledge, skills and experience to help every single patient. But I cannot do it alone and I cannot do it with a short staffed team in an overburdened ED.

The transection of failing outpatient infrastructure, lack of hospital space and short staffing has led to truly life threatening situations.

One example is from a couple years ago. I was the charge nurse, we were short staffed, had a completely full department with hallways stacked with patients and I was working hard to keep a code bed open in my resuscitation bays. Three 'full activation' traumas arrived at the same time, and I moved critically ill patients from those bays into the ED hallway. One was a teenager who was severely head injured after being ejected in a car crash. They had an altered in level of consciousness, was naked and restrained to the bed. I only had time to throw a blanket over them before moving them to the hall.

I then had one nurse for each trauma arrival, when I should have had 3 RNs for each of those trauma arrivals. Plus the head injured teenager warranted a 1:1 RN and she had no one but my Unit Secretary to keep
an eye on her while she waited to go to the OR with Neirosurgery.

I had to be the bedside trauma RN for a trauma returning from CT with my nurse, because one of the other 2 traumas was about to die and needed 2 RNs to keep him alive. The patient I jumped to manage became unexpectedly critically hypotensive and suddenly also

altered. I was doing my best alone in the room when one of my favorite trauma surgeons walked in and saw that things were going badly. He asked for things I am VERY capable of when I have staff to help. But I could not all the things, as the only RN in the room. I could see my longtime colleague through the door to adjacent trauma bay. He was struggling too and couldn't help me.

I had to tell this surgeon who I have worked with for years, "I can't". And it wounded my soul. I had to look at this patient and know I was failing her. The trauma surgeon understood our short-staffing in the ED and let me take her to the crash bed in the trauma ICU. To do what we should have been able to do in the ED. What we absolutely would have been able to do if I'd had safe staffing that morning.

When I ran back to the ED I found my head injured teenager still in our hallway, and her parents were horrified. I have still years later not been able to compartmentalize their horror. Or the look on my trauma surgeon's face. Or that my long time RN colleague from that bay next door quit the ED along with TOO MANY of our very best nurses.

The Emergency Department is an amazing place full of great people. It is a place that should NEVER be short staffed, especially during our new normal of failed healthcare infrastructure. The answer to this failure IS safe staffing in the ED.