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On Behalf Of:

Committee: House Committee On Behavioral Health and Health Care

Measure: HB2697

I was asked by my Charge Registered Nurse (RN) at around 1500 to take care of a patient she had accepted from the Emergency Department (ED) who had generalized complaints. Our Obstetric MDs requested that we try to see her on our Labor & Delivery unit (L&D) since the South Operating Room unit (SOR) didn't have the staff to remain open for potential traumas in addition to caring for this patient until 1800. If the SOR admitted her right then they'd have to go on trauma divert, sending potentially high earning surgeries to one of the several other very equipped trauma hospitals in Portland.

The Obstetric MDs thought the patient was probably suffering a gynecological complication. Upon hearing this report I immediately voiced my concerns that this patient was not appropriate for our floor, highlighting that this would be utilizing scarce resources by tying up one of our three L&D Operating Rooms (ORs), our one Scrub Tech (ST), our one OB anesthesiologist, and an RN. Our unit was already short staffed/almost filled to capacity and we had patients that may need to be delivered via emergency cesarean at the drop of a hat. While I did not feel this was an appropriate assignment, I felt I didn't have an option to decline.

The ED called, and after receiving report, I asked them to keep her in the ED until we could take her directly to one of our ORs.
However after hanging up that phone call, around 1530, the patient rolled onto our unit in a stretcher, the ED was short staffed and needed to move patients elsewhere. We were forced to placed her in our L&D post-anesthesia care unit (PACU) for the time being.Around 1630 we were finally able to move the patient into our OR where she was put under general anesthesia. It took, however, another whole hour to obtain additional equipment, troubleshoot that equipment, and get the correct instruments that the team hadn't realized we didn't stock on our unit. The procedure finally began around 1730 and the OB team quickly figured out that it was not a gynecological complication and that Emergency General Surgery team was going to need to take over. At this point I called the charge nurse and told her that I felt unsafe and that I needed a SOR team to come up and replace our ST and myself immediately. Finally at 1830 the SOR team arrived. They began opening new trays of instruments before our ST and I could do our final counts stating that they would have to X-ray her at the end of the case because our way of counting was not in line with the way they counted. I gave report and relinquished care to the SOR RN and left the OR around 1845, at which point General Emergency Surgery was discussing performing a bowel resection and stating how "unideal it was to be on L&D."
By the time I left work at 1930 there was a laboring patient in pain requesting a C/S

due to hours of pushing with no progress and no estimation on when our OB anesthesiologist would be available to leave the L&D OR. Instead of MacGyvering an unideal situation on L&D, OHSU should have centered the patient and gone on trauma divert in order to care for her in the appropriate setting of the SOR. I understand that the intentions from staff were good and patient centered by stretching our resources in order to achieve multiple outcomes. However this patient ended up receiving subpar care including being under general anesthesia for longer than necessary, exposed to avoidable radiation (x-ray), in an environment unequipped for the care she needed, and care administered by staff who were unfamiliar with the care she required. This situation also resulted in delayed care for the L&D patients. OHSU has been exploiting its staffs' good nature by putting them in situations where moral injury is unavoidable. Passing this bill is the first step in holding them accountable for their profit over patient mindset and increasing retention/recruitment of more staff.