Snow Day: A Nurses’ Narrative
by Harriet Vincent (MSN 2017)

In my eight years of nursing in emergency departments, I’ve weathered some big storms. After the hype of anticipation and the initial chaos of the first few inches, the emergency department in a blizzard can in some ways mirror the quiet and peace of a new fallen snow. Motorists grow wise and bunk down at home for the duration. The unlucky ones who were trapped on the road are delivered by ambulance. You never see patients as happy or as grateful to see the inside of an emergency department. Walk in traffic slows to a stop. The ambulances continue to roll in, but they bring only the sickest, the most desperate.

In February of 2015, the weatherman was calling for record snowfalls. Heeding his warning I walked to work. It was bitterly cold as I traversed the two blocks to the hospital, but no precipitation was falling. I carried my snow boots in my bag. I love walking to work and the opportunity for reflection and focus it offers.

The emergency department was buzzing with expectancy when I arrived. The frenetic energy was palpable. I was pleasantly surprised to find myself assigned patients’ rooms. Years of experience and a two evening a week schedule routinely lands me in the triage chair. I was introduced to Nia, a seasoned nurse with years of cardiac post op care under her scrub belt. Nia was new to emergency nursing. It was her first shift orientating to our department. The nurse she had spent the morning with was being sent home ahead of the weather, and she’d spend her final four hours under my direction. We strategized and agreed she would assume primary responsibility for one of our beds while I served as her guide for locating supplies and navigating the documentation system.

Nia proved competent and resourceful. A few hours later the snow was steadily falling. I accompanied Nia to her room to triage a new patient, Charles, a sixty eight year old African American male. Charles arrived by ambulance with no friends or family. EMS reported that the initial call had been for confusion. He had been brought to the ED earlier in the week for a similar complaint and diagnosed with a urinary tract infection. Medicines for diabetes and hypertension had been noted at his home. The paramedic reported that the woman who called them stated that Charles wasn’t taking his medicines and had been acting strangely for the past couple weeks.

Charles was six feet and two hundred pounds of poor historian. He was oriented to person and place, but he wasn’t sure why he was in the emergency department. His affect was flat. He was slow to follow commands. It took five of us to move him from the ambulance gurney to our stretcher. We started his IV, drew blood, and placed him on the cardiac monitor. His vital signs were stable and his blood sugar was within normal limits. I activated standing order sets, and Charles was promptly on the way to CT for a brain scan.
CT called for lift assistance. As we walked to radiology, Nia and I discussed the differential diagnosis for confusion. Standing orders to rule out stroke, cardiac event, and sepsis were in progress. Charles stared blankly and was dead weight as we hoisted him to and from the scanner. When we returned to the emergency department, the doctor arrived to Charles’ bedside. Nia expressed that she was comfortable with Charles’ care, and I left to check on my other patients.

The rest of Nia’s shift passed in a blur. The rush of car crashes from the early hours of the blizzard lined the hallways. A small pneumonia was noted in Charles’ left lower lobe on x-ray. The rest of his work up was unremarkable. I helped Nia mix IV Rocephin and Zithromax. The attending was paged, and orders for Charles’ admission for pneumonia and confusion were arranged. At seven that evening, Nia handed Charles’ care over to me. She reported that Charles was resting comfortably and had been assisted to eat a dinner tray. His admission was pending a room assignment on the floor. I had just checked on Charles fifteen minutes earlier when I heard his IV pump alarming signaling the completion of his second antibiotic. At that time, I asked him if he was in any pain or if he needed anything. “No”, was his one work answer to both queries.

The arriving night shift reported that four inches of snow had accumulated. The roads were getting bad. I told Nia that in light of the weather and the fact that I had just laid eyes on Charles, we could skip bedside handoff. She smiled with relief and hurried to get home before the weather got worse.

Twenty minutes later a paramedic sauntered through the ambulance doors. He casually called: “You’ve got a runner out here; there’s a guy in a robe with his bare bottom hanging out headed across the parking lot”. The charge nurse and another nurse ran out the doors. I grabbed supplies to discontinue an IV and followed. I wasn’t expecting it to be a patient from our department, and I definitely wasn’t expecting it to be my patient.

I didn’t recognize Charles initially. He was barefoot save a pair of blue skid proof hospital socks. A coating of heavy wet snowflakes covered his shoulders and colored his hair white. My charge nurse was pleading with him to return inside. He kept shaking his head and repeating: “I got to get out of here”. I took him by the arm and whispered reassurances. I pointed out the snow and his dress. It was not a night for walking. In fits and starts we slowly made our way across the parking lot back into the warmth and light of the emergency department.

I was shocked that Charles who earlier was incapable of standing and transferring from a stretcher to the CT scanner could run across a parking lot so quickly, so deftly. His gait was slow and stubborn now. It took me ten minutes to coax him back up the hallway to his room. It
took another fifteen minutes to persuade him to sit down on the stretcher. I sat beside him and reoriented him to his place and situation. He replied: “I got to get across town”. I asked him where he had to go. He didn’t answer. I stared into his eyes and tried to see Charles. After several minutes of silent eye contact, Charles’ manner calmed slightly.

I asked Charles to lie back on the stretcher, and he finally complied. I returned him to the heart monitor and placed a bed alarm. I spoke with the doctor about Charles’ agitation and confused attempt to flee the facility nearly naked into the white darkness of the blizzard. Charles’ history didn’t include dementia, but his actions were a classic example of the sun downing behaviors exhibited by Alzheimer’s patients. The doctor ordered Haldol 10mg IV. As I slowly administered the drug, I tried to comfort Charles with active listening and reassurance. He relaxed and began to doze. I covered him with warm blankets and rechecked the bed alarm before leaving the room. Charles was comfortable; I was not.

As I sat at the nurses’ station composing an epistle on the dangerous situation that had just transpired, the phone rang. The woman on the other end of the line identified herself as a friend of Charles. I told her that he had admission orders for pneumonia, and that we were waiting for a bed to transfer him to the floor. I barely finished my statement before she launched into her story of what had been going on with Charles and what she hoped would happen. She told me that Charles had been living with her and her mother, an old girl friend of his, for the past two years since his house burned down. She enlightened me to the fact that Charles was bipolar schizophrenic with a history of numerous institutionalizations. She said that Charles had not been behaving normally for several weeks: “He keeps taking off all his clothes and wandering around outside and hiding stuff like his oxygen tanks”. This was good information, pertinent information. This is information I could have used when I triaged Charles seven hours earlier.

The woman continued to say that she had psychiatric problems of her own, and Charles wasn’t welcome to return to her home. In her opinion, Charles needed to be admitted again for inpatient psychiatric treatment. I hung up the phone disheartened. I envisioned Charles’ slow slip into dementia written off as his psychiatric problems. Did he forget to turn off the stove and burn down his house? I imagined his future: years in a nursing home before dying there alone. The health care system was failing Charles, and I was dissatisfied with my inability to help him.

Finally, Charles’ room assignment came through. After a lengthy report to the nurse on the floor, I stayed late to transport and to settle Charles into his new room. Back down in the emergency department, the waiting room was empty save a few patients stranded when the Medicaid taxis stopped running. I handed out warm blankets and sandwich trays before leaving for the night. The quiet and peace of the snow had finally landed on the emergency department.
There were no tracks in the snow as I walked up the hill towards home. The fat flakes fell thickly, and it was difficult to see more than a few feet ahead. I thought of Charles. He had no resources, no family, and no way to express the fear and disorientation of his daily life. In my eagerness to rule out medical causes for his confusion I’d almost lost Charles. What if that paramedic hadn’t seen him leaving? Would I have stumbled over him on this silent walk home? I’ve weathered a multitude of scary, life threatening, adrenaline pumping situations in my work, but there is a lesson in the reticence of Charles.