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Patricia Iyer
MSN RN LNCC

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Stroke Risk in Women

If you are a woman, you have a one in five chance that you will have a stroke. One out of six men will have a stroke. Early reaction to the signs of a stroke may prevent much of the damage that can occur. Here's what you need to know. You could:

- have sudden numbness or weakness of the face or your arms or legs
- have trouble walking
- lose balance or coordination
- have difficulty speaking
- develop trouble seeing in one or both eyes
- become suddenly confused
- become dizzy
- develop a severe headache without a known cause

You might experience only one symptom. The key point is that this is a sudden change. Women are more likely to have confusion, headache and dizziness. Only 25% of women who have a stroke will fully recover.

ACT FAST:

Face: Does one side of the face droop when you are asked to smile?

Arms: Does one arm drift downward when asked to raise both arms?

Speech: Is the speech slurred or strange when asked to repeat a simple phrase?

Time: If you observe any of these signs, call 911 immediately.

Source: National Stroke Association, Act FAST, http://www.stroke.org/site/PageServer?pagename=symp

Which women are at highest risk for a stroke? Black women have the highest risk of stroke, followed by whites and then Hispanic women. Other risk factors include getting older (the risk rises with age). High blood pressure, excessive alcohol drinking, depression, obesity, diabetes, excessive sodium intake, elevated blood lipids, smoking, and drinking diet soda. Also, women who take estrogen supplements after menopause are at higher risk. There is also an association between women who have migraines with an aura (warning signs) and strokes. Atrial fibrillation, which can cause small blood clots to travel to the brain, can cause a stroke.

What can you do to reduce your risks? Maintain a normal body weight. Eat a diet lower in sodium and cholesterol. Learn more about nutrition by reading http://choosemyplate.gov. Snack on fresh fruit and vegetables instead of cookies, white bread, and cakes. Control your blood pressure if it is increased. Drink less diet soda, which helps to decrease sodium intake. Stop smoking. (Smoking doubles your risk of stroke.) Ask your doctor about taking a baby aspirin a day to reduce your risk of a stroke.

You can reduce your risk of stroke by choosing a healthy lifestyle. Start today.

Source: Susan Simmons, Acute Stroke in Women, Nursing 2012, March 2012, page 30

About the Author

Patricia Iyer MSN RN LNCC is coeditor of the newly released 4th Edition of *Nursing Malpractice*, available at www.patiyer.com. She is President of Avoid Medical Errors, LLC.

Challenges of Caring for Elderly Parents

Alicia VanBuskirk RN discusses challenges of caring for elderly parents. The elderly are at risk for injury from safety hazards, as well as medical errors due to their typically complex medical problems and medications regimens.

This program is an interview between Pat Iyer, President of Avoid Medical Errors, and Alicia VanBuskirk. When you purchase this program, you will receive the interview in audio form, as a transcript and 3 bonuses.

You will learn

• that the person over 65 years old goes on average to the doctor 8 times a year and thus has more opportunities for medical errors.

• concrete and practical suggestions for helping your parents communicate with their physicians (and much more).

Get more details at http://tinyurl.com/d7vnwyl

Skilled Nursing Facility Falls

Falls among patients in Skilled Nursing Facilities (SNF) are an all too common occurrence. Causes can generally be classified into 4 broad groups:

1. Patient characteristics
2. Medical care planning by physicians
3. Nursing care
4. Environmental factors

Prevention entails:

- A detailed medical evaluation and plan upon admission including diagnostic tests to identify patients at an increased risk for falls with special attention to medications or combinations of medications.
- Assessment by licensed nursing staff to create an ongoing care plan, follow-up meetings by members of the care giving team, efficient and readable chart systems which facilitate communications between shifts and regular team meetings to generate progress reports and make changes in the plan when indicated.
- Facility maintenance, strict adherence to applicable codes and effective and

efficient response to deficiencies when found by State or Federal inspectors.

Patient Characteristics

Almost all patients who require SNF care have significant difficulties performing their activities of daily living (eating, grooming, dressing bathing, toileting, and walking). Many of the conditions that cause the need for care in a SNF create significant risks of falling. These conditions include dementia, weakness, stroke, visual disturbance, night-time confusion, orthopedic limitations that produce difficulty walking and balance problems. Many of these can be worsened by medications such as those used to treat high blood pressure, which can cause dizziness and momentary decrease in consciousness due to a drop in blood pressure on arising. Pain medications are commonly associated with falling. Many drugs used to treat behavioral outbursts due to dementia as well as diabetic medications can cause excessive lowering of blood sugar.

Treating physicians have the responsibility to take these potential risks into account when planning care for their patients upon entering a SNF. Periodic visits to the facility to reassess patients' progress are essential. Physicians must either be available themselves or provide on-call 24/7 coverage to respond to urgent or emergency situations or concerns of nursing staff.

Nursing Care

The nursing care plan must provide for ongoing assessment to evaluate risk factors. The facility should have clear protocols for reducing fall risk and use individualized plans for each patient. These could include such things as bedrails, lowering the bed so that if a patient does fall out of bed the possible injury will be lessened, properly functioning walkers, geriatric chairs and other equipment.

Environmental Factors

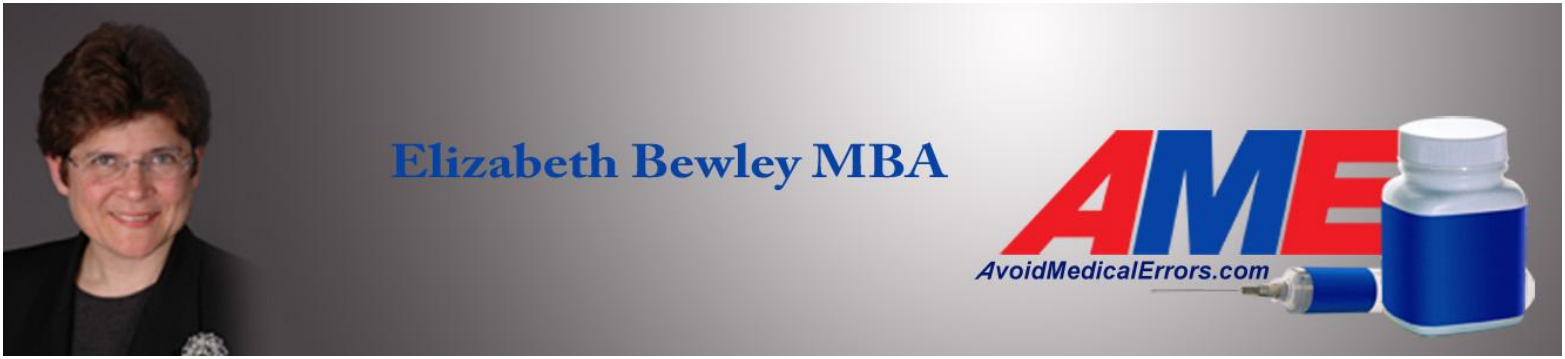
Floors must be kept dry and non-slippery. Corridors and rooms must be well-lit during the day. High toilet seats and grab bars in bathrooms and halls help to prevent falls.

Patients who can walk must have appropriate footwear.

Medical-Legal Considerations

Falls in SNFs are an important factor in causing lawsuits. An injury to a person who is already weakened by significant illness and dysfunction may start a chain of complications that leads to worsening of his condition and possibly early death. This frequent series of complications often occurs even if the specific injury caused by the fall is successfully treated. What may seem to be a relatively trivial injury in a well person can be catastrophic to a SNF patient.

See www.amfs.com for details of our services.



The Good Patient: Bedsores are Preventable

Don was newly retired at the age of 65. He was looking forward to traveling with his wife Elaine. Then a series of medical problems landed him in the hospital. He declined rapidly. He became so weak that he was unable even to lift his head off the pillow.

Many years later his wife, Elaine, recalled, “They told me he was going to die.”

One day, about a month after Don arrived at the hospital, there was a sudden flurry of activity. He was moved to a gorgeous corner room that he had all to himself.

The new room was large enough that Elaine could stay when Don was being treated.

She said, “I peeked through the curtain while they were turning him and I saw the bedsore on his lower back. It was four inches long and I could see down to his bone. Then I find out that he’s got them all over. He had four of them.”

Bedsores are also known as pressure ulcers or decubitus ulcers. Don’s were all Stage IV, the worst possible. This means that much of the

tissue from the skin down to the bone has been damaged or even has died.

Bedsores develop because of unrelieved pressure on bony parts of the body. This pressure can happen when someone lies in bed without moving for hours at a time. Don did that because he was too weak to move. Bedsores can arise when a patient slips out of position or drags himself in bed. They can arise if caregivers drag patients instead of lifting them.

Most experts agree that bedsores can start to develop in as little as two hours. Drew Griffin, a Certified Wound Care Nurse with eighteen years of experience, notes that in some cases, they start to develop even sooner. Often, this is the case if the patient is at high risk. Patients may be at high risk if they don't eat or drink enough. They may be at high risk if they have more than one medical problem.

The Mayo Clinic reports that even Stage I and Stage II pressure ulcers can take months to heal. Stage III and Stage IV pressure ulcers may never heal. As Elaine pointed out, "The skin may grow over it, but you're missing the muscles and tendons and nerves. All that tissue that was destroyed and had to be removed because it was dead never comes back."

After Don had been in the hospital for nearly three months, they finally diagnosed and addressed the illness that had put him there. He was soon well enough to move to a rehabilitation facility. A month later, he was sent home. However, he still had four Stage IV bedsores.

For six months, nurses including Kate Suchmann, R.N., came twice a day, seven days a week to change his bandages and clean the wounds. Towards the end of that time, Suchmann trained Elaine to do much of this critical, painstaking work.

Now a Professor of Nursing at Vermont Technical College, Suchmann commented, "Elaine is probably the only reason he's alive.

She is very gifted, focused, and precise—and she was always asking questions."

For years, Don's and Elaine's lives revolved around dealing with his bedsores. And Don is not alone in his experience.

According to HealthGrades,189,315 Medicare patients developed pressure ulcers as a result of hospital care in 2008, and those bedsores were the cause of death for 17,611 of them.

Griffin, the Certified Wound Care Nurse, noted, "Pressure ulcers are preventable 100% of the time." Medicare, the federal health insurance program for the elderly and disabled, agrees.

Medicare calls pressure ulcers "never events," meaning that they are so preventable that they should never happen. In fact, Medicare typically won't reimburse hospitals for treating Stage III and IV bedsores that develop in the hospital. The hospitals should have prevented them in the first place.

Today, more than 10 years later, Don is still suffering. He said recently, "I have tremendous pain." Elaine rattled off a list of medicines Don takes to treat the pain and the nerve damage.

If you or a family member or friend is in the hospital, what can you do to avoid an experience like Don's?

Learn about the risk. Go to bradenscale.com. Click on Products. Then click on Braden Scale for Predicting Pressure Sore Risk. This one-page quiz is widely recognized as a useful tool to tell how likely it is that a specific patient will develop bedsores.

Ask the patient's doctor to help you understand the patient's risk and to explain what the doctor and the hospital staff will do to prevent pressure ulcers from developing. For example, one critical step is to reposition patients every two hours if they are immobile.

Ask what the patient and family can do to reduce the risk. Suchmann, the nursing

professor, notes that when patients refuse to shift position and/or refuse to drink or to eat, they can dramatically increase their risk. "It's not their fault. When people don't feel well they often don't want to do these things. But the biggest risk for bedsores besides pressure is poor nutrition. And people don't want to drink enough fluids. Fluids are essential for tissue function. So patients need to move, drink, and eat."

Follow up to ensure that planned actions take place. Ask to see the results of assessments of the patient's skin. Check to make sure that the patient is in fact being repositioned. If you see that the patient is not eating or drinking, ask for an assessment by a dietician.

About the Author

Elizabeth L. Bewley is President & CEO of Pario Health Institute and the author of *Killer Cure: Why health care is the second leading cause of death in America and how to ensure that it's not yours*. She is also the author of a weekly newspaper column called "The Good Patient." To tell Elizabeth your story or to ask her a question, write to: thegoodpatient@pariohealth.net.

More than the Blues

On the surface Carol Kivler had it all: a beautiful house, successful attorney husband, healthy children, and a fulfilling part time job as a college professor. She began having racing thoughts, weight loss, joint pain and headaches. Doctor after doctor told her that her test results were normal. Then she saw a psychiatrist, who diagnosed her with clinical depression. Carol became psychotic and required hospitalization. In this gripping interview, Carol explains how she went from the successful wife to a woman who contemplated killing herself and her children.

Read more here: http://tinyurl.com/6v92j8f

Sarah Jean Fisher
MSN, RN-BC, BA

AME
AvoidMedicalErrors.com

Eloping From a Long Term Care Facility…It's Not Gardenias and Wedding Cake

To the uninformed, elopement is not a case of Mom being spirited off by some geriatric Romeo to "tie the knot" with white gardenias and wedding cake. It is a serious and potentially deadly situation. The definition of elopement used by the American Health Care (AHRQ) is "when a resident's location is unknown" (1). Here are some examples:

Example 1

A nursing home sounded the Code Grey alarm for "missing resident" at about 4 PM when a resident could not be found for dinner. No one had remembered seeing the resident since approximately 2 PM. Protocol was followed but the resident could not be found. In the midst of the search, the facility elevator locked between floors and they waited for an elevator

mechanic. By 7 PM, staff were hearing a banging sound. Someone said, “It’s coming from the elevator”. The elevator mechanic brought the car to the first floor, opened the door and found the missing resident. She had wandered in on her way to 2 PM bingo, then the elevator locked. She sat down and fell asleep. When she awoke, she was hungry and knocked on the door to get out. She suffered no permanent or serious injury.

Example 2

One cold morning in February, the security officer at a center city nursing home opened the door for a woman who worked at a nearby newspaper. She had with her one of the male residents of the facility who was wearing the woman’s coat over a hospital-type gown, a diaper, no shoes or socks and a facility bracelet with his name on it. She stated that when she arrived at work that morning, she found him huddled in the corner of the building entryway. When the security guard had let the cook in earlier, he had used the rest room right afterward and left the lobby area unattended. Apparently, the lock on the front door had not engaged as the cook entered, and when the resident got off the elevator, he was able to go right out the door to the street. He had wandered across the street and around the corner to the sheltered doorway of the newspaper office where he was found. Although he waited on the doorstep possibly for an hour, he suffered no permanent or serious injury.

Example 3

Several years ago in January, a woman with dementia and several other health issues was taken to a nursing home by her children because they were unable to care for her any more at home. The new resident was very unhappy there, refused to eat, and frequently yelled that she wanted to go home. Several days after she was admitted, she went missing at bedtime and could not be found. The facility initiated its elopement protocol and exhausted all recovery efforts unsuccessfully. At 10 AM the next morning, the woman’s body was found in the dumpster of a shopping center near the

nursing home. She had left the facility with the visitors, wandered to a nearby mall and climbed up boxes to get into the dumpster. She died from exposure to the elements and dehydration.

The elopement of a resident from a long term care facility is one of the ”never events” that nursing homes dread. The term, first coined by Dr. Ken Kizer in 2001, was used when discussing serious medical errors which are clearly identifiable, measurable and preventable, including fall with injury, pressure ulcer, dehydration, constipation and elopement. No facility wants one of its residents to successfully wander or elope from its safe confines, yet all should be prepared with an emergency protocol to initiate should it occur and a prevention policy to reduce the number of occurrences.

Emergency response protocol for elopement usually includes first searching every conceivable space of the unit (behind doors and curtains, under beds, in showers, closets, and cabinets). Then the search extends to the entire building, and then the neighborhood. Generally, administrators and the police are notified. One person is assigned to call all family members/friends the resident may contact and also all local hospitals with a description of resident. It is a good idea to fax a recent picture to hospitals if possible. If the search must extend to the neighborhood, teams are assigned to grids on a map and they should have a picture of the resident and a cell phone to check in every 15 minutes.

There are numerous interventions a facility can implement to prevent resident elopement. Here are some of them:

- Perform elopement assessment on each resident who is new, readmitted, experiences any significant change, and regularly throughout the year, e.g. quarterly.
- Have pictures taken of all residents and a photo of known wanderers/elopers.

Place these on each unit and at doors to the outside, and large gathering spaces.

- Don't place residents at high risk for elopement on the first floor of the building.
- Put wallpaper over doors that matches walls so the door is not obvious as an exit.
- Paint a black circle (hole) on the floor in front of emergency doors to deter crossing.
- Provide planned activities for shift change and close of visiting hours, when a high number of people are moving in and out of doors. The activities will take place in rooms away from the doors.
- Provide some identification label or badge to visitors that must be turned in before they are able to leave the facility.
- During a "Code Grey", call all elevators down to the first floor and check them.
- Provide supervised moderate exercise for potential elopers to discourage wandering.
- Some facilities have a locked unit for extreme cases.
- Perform visual face to face checks every 15-30 minutes on known elopers when they are agitated.
- Provide regular "drills" like fire drills, to all shifts, to rehearse staff and to sharpen their response time and understanding of emergency procedures. A former president of the American Medical Directors Association shared how he did this. He took a resident into his office and closed the door. Then he waited to see how long it would take for the staff to realize the resident was missing. In some cases, it was hours.
- Alert staff to closely monitor stairway entrances and doors to the outside (including loading docks) during fire

drills when alarms may be off. Do a head count after every emergency "drill."

- Anticipate physical needs (pain management, food, toileting) of dementia residents who are able to move about on their own to deter purposeful wandering.

Hints for family and friends when visiting a nursing home:

- Be careful whom you hold a door for; you may be facilitating an elopement
- To those asking how to leave the facility, direct them to a dead-end corridor;
- Reply to questions about exits by involving staff;
- Offer ignorance to questions regarding leaving, "I'm from out of state";

Here are some resources for further information and statistics on elopement:

(1) http://www.portal.state.pa.us/portal/server.pt/community/hospital/14149/chapter_51_questions_and_answers/558509

(2) https://www.guideone.com/SafetyResources/SLC/Docs/cs_elopement02.pdf

(3) www.nccdp.org/wandering.htm

About The Author

Sarah Jean Fisher earned a master's degree in nursing from Thomas Jefferson University with emphasis on education and has been certified in gerontology for over 13 years. She has end-of-life training certification by ELNEC (End of Life Nursing Education Consortium) and her bachelor's degree in English is from Bucknell University. Sarah Jean has been a nurse for over 18 years. Long-term care has been her only focus. She has worked as a charge nurse, shift supervisor, and has been specializing in staff development/infection control for the past

Sarah Jean has also worked for four years as a geriatric nursing expert witness with Med League Support Services reading and evaluating medical records for attorneys related to potential litigation. She is a widow with 4 grown children, 11 grandchildren and

her first great-grandchild. She can be reached at SFJ94@comcast.net.

Reducing Risks in Nursing Home Care

Sean Doolan Esq. has developed expertise in representing the victims of nursing home and assisted living malpractice. He shares his lessons learned in this interview, and provides specific information you can use to advocate for a loved one in the nursing home.

Visit http://www.avoidmedicalerrors.com/store/reducing-risks-in-nursing-home-care for more information.

Why Health Care is Broken and How That Affects You

Join Dr. Larry Cohen and Pat Iyer in this edgy and controversial interview. You will get a broader perspective of health care and how its failings can affect you – and what to do about them.

Visit http://www.avoidmedicalerrors.com/why-health-care-is-broken-and-how-that-affects-you for more information.

How to Reduce the Stress of a Worrying Mind

"In every life we have some trouble, but when you worry you make it double. Don't Worry. Be Happy." Bobby McFerrin

When I was speaking at a conference last month, I went to the hotel gym the first morning. The TV on the wall flashed one horrendous news story after another at me in rapid succession. My body started tensing up. I couldn't stay there even 5 minutes. I had to get out!

I don't have a TV at home but this is not a problem. I can see TV everywhere – restaurants, the gym, even in the elevator of a local office building. If you are not a worrier, there are lots of people in the world, who will help you find something to worry about. All the talk about the world ending in 2012 finally got to one of my coaching clients. It started with anxiety and built into full blown panic attack.

If you are a worrier, your mind tends to focus on the future. Your mind is designed to keep you safe; to keep you alive. Stress is all about not feeling in control. Since your mind can't come up with a way to control the future, any future event is fertile ground for the stress of worrying.

A worrying mind goes around and around the same thoughts with no solution. It builds a case for fear, anxiety and ultimately panic! This raises your cortisol level. Cortisol negatively affects blood sugar and blood pressure, and deteriorates your overall health. Struggling not to worry doesn't work because you are fighting against your natural tendency.

What can you do? Here are three tips:

1) Focus on images of what you want. Your mind thinks in images. When your mind worries, it's imagining a future that is out of your control. Turn that future oriented mind around. Focus it in a positive direction by creating a vision of the future you want rather than worrying about the future you fear.

Take the first step in making your future vision real by putting images of your goals and desires on a poster board. Focus on these images every morning, at times during the day and before bed. You can read an article about how to make a vision board on my website. When you envision what you want, your unconscious mind actually helps you get what you want. It does this through a system in your brain which is triggered by images.

2) Ask a positive question. When you find yourself worrying, make a decision to think about one thing you are grateful for in that moment. Your mind likes to solve problems and answer questions. It doesn't care if they are positive or negative. So, when your mind is working on the impossible task of figuring out how to control the future, give it a positive question to work on. Ask, “What‘s right in this moment?” You will be amazed at how once you "prime the pump" with one thing, your mind begins to make a list of other things you can be grateful for. In no time you will begin feeling joy instead of fear.

3) Hang around with positive thinkers. You have heard the adage, “Misery loves company”. Unfortunately, when you are thinking negatively, your tendency may be to share those complaints with others who feel the same way. While this seems to take the

edge off at first, you actually feel worse in the long run. Misery multiplies.

Make a list of people you know who tend to see the brighter side of situations. Talking to someone with a different perspective can improve your outlook too. You may find it hard to agree with their point of view at first, yet within a few minutes you may find you are feeling better.

Summary

When you find your mind in a state of worry about what might happen in the future, stop! Imagine the future you want. Think of one thing that is right in the present moment or talk to someone who is seeing a brighter picture. You cannot change the outer world. You *can* change the way you see it.

About The Author

Aila Accad, RN, MSN is an award-winning speaker, bestselling author and certified life coach, who specializes in quick ways to release stress and empower your life. A health innovator, futurist and member of the National Speakers Association, she is a popular keynote speaker and radio and television guest. Her bestselling book *Thirty-Four Instant Stress Busters: Quick Tips to De-stress Fast with no Extra Time or Money* is available at www.stressbustersbook.com. Sign up for *De-Stress Tips & News* at www.ailaspeaks.com and receive a gift, *"Ten Instant Stress Busters"* e-book.

News

Our Inner Circle educational materials are now available for purchase as either through the monthly subscription or individually. See the Educational Materials tab at www.avoidmedicalerrors.com

High Blood Pressure and Stroke: Medical Malpractice?

When I go to a fine restaurant, I expect a pleasing experience. I expect little variation from perfection in the quality of the food, atmosphere, and service. If my expectations are not met, I can simply decide not to return. When I go to a fast food restaurant, I expect my order to be completed, and to receive reasonable, polite service. If my expectations are not met, I can simply decide not to return.

How does this differ from a visit to the emergency department?

While it is your *expectation* to have a type of experience *you believe* is appropriate - meeting your expectations - it is our *obligation* to provide you with the service you *need,* whether or not that is the service you want.

Neither the fine dining restaurant nor McDonald's will try to talk you out of a high-salt, high fat and nutritionally deficient meal. They will both be happy to serve you. It doesn't matter if you're a heart patient and want all the cholesterol you can eat, or if you're a diabetic and want to consume a few hundred grams of

sugar in your Coke with your processed, fried potatoes.

Some patients want to have what they *want,* and often don't want to hear what they *need.* Patients in pain often want pain relief; they often can't focus on the underlying problem of what is causing the pain. Our obligation is to treat the underlying cause and try to convince the patient the underlying condition seriously requires urgent attention. Some patients don't want to hear it.

On my last shift, one such patient who had a headache with a blood pressure through the roof, exclaimed, "Doc, every time I come to the ER with one of these headaches, you guys treat my pressure and discharge me."

I asked, "And do you follow up and take your medications?"

He said, "Every time I take my medications, they don't work, so I don't take them." *Why would you expect your blood pressure to be controlled without taking medication?*

Fast-forward to a potential scenario months from now. Consider the same patient, same headache, but with different symptoms. Now he has blood leaking from a blood vessel inside his brain. Blood compressing his brain from a cerebrovascular accident (stroke) is caused by uncontrolled high blood pressure. He is unable to speak, unable to move half his body, doomed to a life in a long-term care facility, incontinent of bowels, drooling … well, let's say, "unpleasant" is an understatement.

Fast-forward again, months later. The family seeks an attorney to investigate the circumstances of that first emergency room visit. The family and the attorney representing the patient (now called p*laintiff)* want to know why he wasn't admitted to the hospital the day he explained he did not take his medications. Why didn't someone ensure he took his medications? *We don't admit patients so they can be handed pills to swallow.*

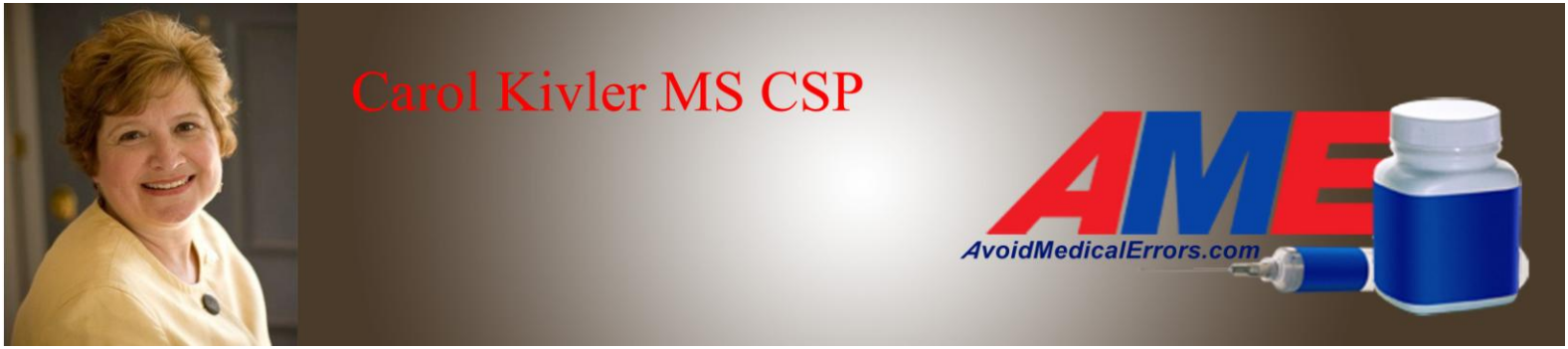
Is this an example of emergency medicine "malpractice"? Was there an error committed

by the doctors or nurses? No, not in this instance. The patient is responsible for following the instructions of his physician. His devastating injuries could be avoided had he followed up and taken his medication. A couple of pills a day, that's all; that's everything that would be required. But the pills have to go down the throat, not sit in the pharmacy bottle.

Next month we'll examine how other incidents of medical "negligence," both real and imagined, raise their heads in an emergency department.

About the Author

Dean Dobkin, M.D., is a practicing emergency physician at the Philadelphia Veterans Affairs Medical Center. A graduate of Albany Medical College in 1976, Dr. Dobkin completed residency training in Emergency Medicine at the University of Illinois while the specialty was in its infancy. He has been certified and recertified three times, as a specialist in Emergency Medicine by the American Board of Emergency Medicine. He has experience acting as faculty for an emergency medicine residency program, has held academic appointments at two Philadelphia medical colleges, and acted as an emergency department director at a variety of different hospital emergency departments. He has been honored by being named a Life Fellow of the American College of Emergency Physicians (ACEP), after serving with distinction for that organization. Dr. Dobkin chaired the Pennsylvania Chapter's membership committee, represented the Chapter at the National Council, coordinated their one day seminar series, and was elected as Officer of the Board of Directors for six years. Dr. Dobkin has acted as a consultant for PEER Review organizations, the Jefferson Health System, the Commonwealth of Pennsylvania, and the United States government. Dr. Dobkin lives with his wife and family in southern New Jersey. He testifies as an expert witness in emergency medical care. Contact him through patmedleague@gmail.com.



Self-Discipline – Aids in Recovery

"Commitment—the more you have invested in something, the less likely you are to let it fail."
--Rory Vaden

During the last month I found myself intrigued by the book, *Take the Stairs—7 Steps to Achieving True Success*, by Rory Vaden. I began reading the book with the international executives I coach in mind. However, the more I read about the seven steps, the more I realized how aligned these steps are with the recovery model for sustained wellness in dealing with a mental health disorder.

The overriding theme for the seven steps is: **Self-Discipline.** Rory contends that "Discipline creates freedom—freedom to do anything". WOW—what an empowering declaration! Since depression and anxiety steal your power, this statement caught my attention; and I trust it will capture yours.

These seven steps, if used consistently, can assist you in remaining in recovery for longer periods.

1. **Sacrifice** – set aside short-term discomfort for long-term results.

2. **Commitment** – changing from the question "Should I?" to "How will I" is the mind-set that makes all the difference.

3. **Focus** – keep your mind on recovery and minimize distractions.

4. **Integrity** – states that all of creation follows a simple and powerful pattern: "You think it, you speak it, you act it, it happens."

5. **Schedule** – learn that focused effort is amplified by appropriate timing and regimented routine.

6. **Faith** – choose to believe that all that is happening today – good or bad – is part of an ultimately greater plan.

7. **Action** – realize the right mind-set preceded proper movement, but the bottom line of seeing change and results in our life is your need to ACT.

Recovery seldom comes to individuals unwilling to hold up their end of the work needed. So get started making changes today—you might be pleasantly surprised what self-discipline can do!

Reflective Question: What steps have you already mastered?

One thing we can be assured of is change. We change every single day because of our experiences—whether it was a person we met, something we heard or read, a feeling that surfaced, or just another day lived—change is inevitable. All you need to do is look in the mirror--I mean really look at yourself. Staring back at you seems like a stranger. I often find myself saying, "And who are you?" The face of time has a way of creeping up on our faces quicker than we would like to admit.

But when I step back and appreciate the

changes of time, especially during my mental health journey, I marvel at how far I've come. The journey wasn't easy, pleasant, or fair. My four depression and anxiety episodes changed me in ways no other experiences could have. Not only have I accepted the changes those experiences provided, but I embrace the person I am today.

Until you live through your darkest and scariest moments, you cannot relate to others who have also traveled a similar journey. It is in those shared experiences that we develop empathy and compassion for others. And I don't know about you, but this world needs more empathy and compassion. That's a change we would all enjoy seeing in our world today!

Reflective Question: What changes have you allowed to occur on your life journey?

About the Author

Carol Kivler, MS, CSP, is a passionate consumer advocate, speaker, author and the founder of Courageous Recovery. She speaks to consumers, their loved ones and healthcare professionals to raise awareness, instill hope and combat stigma surrounding mental health diagnoses and treatments. Along with Courageous Recovery, Carol is also the founder and president of Kivler Communications, which provides executive coaching and customized workforce development training.

Carol lives in Lawrence Township, NJ and is the proud mother of three grown children and five grandchildren. She is an avid reader, life-long learner, gardener and amateur baker.

Kathleen Cunningham CMLC

Mammography, Dental X-Rays and Thyroid Cancer Risk Myth versus Truth

Recently, a flurry of controversy took place regarding a telecast made by Dr. Mehmet Oz. He warned women that radiation exposure during mammography and routine dental x-rays could elevate the risk of thyroid cancer. Dr. Oz advised patients to request a lead "thyroid shield" or "thyroid guard" prior to having a mammogram or dental x-rays. There was concern that women might chose to defer mammography because of the fear of thyroid cancer. No one really disputes the fact that with breast cancer, early detection saves lives and it is generally agreed that the benefits of mammography far outweigh the risks. Experts in the field have said that the issue of radiation exposure during these x-rays has been studied extensively and that the risk of thyroid cancer from these procedures is negligible.

Following the broadcast, there was a firestorm of backlash from the medical community, particularly from radiologists and dentists, who defended the tests and offered information regarding the amount of radiation exposure from mammograms and dental x-rays and the

lack of evidence to support any causative link to thyroid cancer.

Medical Radiation

Exposure to radiation is cumulative. That is, it builds up over time. Radiation exposure is measured in millisieverts (mSv). The amount of radiation exposure during a mammogram is approximately 0.2 mSv. During mammography, the thyroid is not exposed to direct radiation, but rather "scattered" radiation in very minimal amounts. Of the 0.2 mSv, only 0.002 mSv goes to the thyroid.

To give an idea of what these levels really mean, an average person is exposed to approximately 3 mSv of background radiation from the sun and from other natural sources in a year. The amount of radiation exposure from a mammogram is approximately equivalent to 30 minutes of background radiation that we are all exposed to every day in our daily activities.

Mammography

A multitude of studies have affirmed that mammography has lowered breast cancer mortality to a significant degree. Women who have been screened with mammograms have a 25% to 44% decrease in mortality than those who do not undergo mammography. Early detection is the key to a better outcome and a higher survival rate.

Daniel D. Kopans, MD is the Senior Radiologist in The Breast Imaging Division at Massachusetts General Hospital and is Professor of Radiology at Harvard Medical School.

Dr. Kopans states that, "A woman could get a mammogram every year for the next forty years and her thyroid would receive less radiation than it receives in one day from background radiation. He also states, "Over the course of a year, our thyroids receive 17,520 times as much radiation from the background as they would from a mammogram."

The American College of Radiologists and The Society of Breast Imaging do not recommend the use of a thyroid shield and state that the

shield may actually interfere with complete visualization of breast tissue and could possible result in additional mammograms having to be done because additional views might be needed.

Some women who wish to avoid mammograms can be screened using MRI imaging or ultrasound, neither causes exposure to radiation. Other methods, such as Breast Specific Gamma Imaging (BSGI), still require the breast to be compressed and do expose the patient to radiation. Radiation is also present with Positron Emission Mammography (PEM) and in Digital Breast Tomosynthesis (DTS) imaging techniques.

Leonard Wartofsky, MD is a thyroid cancer specialist with the Washington Medical Center in Washington, DC. Dr. Wartofsky states, "The doses associated with mammography have been well studied and well calibrated. As long as it is done with modern equipment, women should not be concerned. That degree of radiation is not consequential.

A family history of breast cancer in a first degree relative (parent, sibling, child) is definitely a consideration, but 75% of breast cancer cases occur in women with no family history. It is recommended that women begin to get annual mammograms starting at age forty and continue that frequency throughout the lifespan.

Dental X-Rays

Dentists claim that the amount of radiation exposure during dental x-rays has decreased significantly over the years as a result of evolving technology. Routine dental x-rays usually consist of four "bitewing" views.

The American Dental Association (ADA) recommends the use of a thyroid shield during dental x-rays. ADA guidelines from 1987 have suggested that perhaps routine x-rays do not need to be done as often as once thought. The ADA recommends that children without high risk for cavities be x-rayed every one to two years. Children are more susceptible to damage from radiation because of their small

size and the fact that their cells divide so rapidly. Teens without a high risk of cavities should be x-rayed every year and a half to three years and adults without a high risk of cavities should be x-rayed only every 2-3 years. Some critics have suggested that dentists continue to order x-rays more often than the guidelines recommend because of the financial incentive.

Thyroid Cancer

As cancers go, papillary and follicular types of thyroid cancer have over a 90% cure rate and in general carry an excellent prognosis.

The incidence of thyroid cancer has been rising over the last 30 years. A possible cause of this, surmised Dr. Oz, is radiation exposure during these tests. Other practitioners have offered the fact that during women's routine gynecologic exams, most practitioners now check the thyroid as a matter of course.

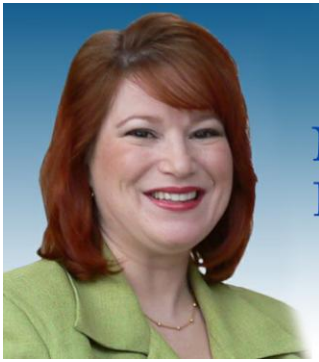
It is widely known that there was a marked increase in cases of thyroid cancer following the Chernobyl nuclear accident. Prior to that, it was found that when patients received radiation to treat acne, they had increased rates of thyroid cancer and the practice was eliminated.

Some experts have proposed that the real reason behind the increasing rate of thyroid cancer is due to increased levels of nitrates in food and drinking water. The nitrates are the result of run-off from the use of fertilizers.

The thyroid cancer risk from a routine mammogram is said to be less than 1 in 17.1 million.

About the Author

Kathleen Cunningham is a Medical Investigator /Certified Medical Legal Consultant with 20 years of experience in her field. Ten of those years were spent as the full time in-house medical investigator for Gerry Spence's nationally recognized law firm in Wyoming. For several years she functioned as the in-house medical legal consultant for the law firm of Meyer and Williams in Wyoming.



Nancy Collins
PhD, RD, LD/N

Lifestyle Improvements: Four Weeks of Small Changes

First week

Sunday	It only takes 2 ounces (oz) of dark chocolate/week to help prevent heart disease.
Monday	Getting 8 hours of sleep/night helps to prevent weight gain, diabetes, and heart disease. Go to bed early tonight!
Tuesday	Measure food out, and immediately put leftovers into the refrigerator.
Wednesday	Eat soup or salad before your main course to help fill up and avoid overeating.
Thursday	Eat 1 oz of nuts five times/week to help decrease the risk of developing coronary artery disease.
Friday	Try whole-grain pasta tonight for more fiber, vitamins, and minerals than enriched pasta. If

	you want, an easy way to get started is to mix part of your regular, enriched pasta with whole-grain pasta to get used to the taste and texture.
Saturday	Buy your produce weekly, and prepare it in advance, whenever possible (cutting melon, etc). Keep your fruits and vegetables in very visible places in the refrigerator, so that you will reach for them first.

Second week

Sunday	Try to have a blend of protein and carbohydrate at every meal and snack. For example, choose reduced-fat cheese, peanut butter, nuts, lean meat and poultry, or an egg for protein; and any whole-wheat grain product or fruit for carbohydrate.
Monday	Get into the habit of always keeping snacks in your purse, glove compartment, or desk at work. Consider a snack mix made of dried fruits and nuts, individual peanut-butter packets with crackers or an apple, or vacuum-packed tuna.
Tuesday	Aim to consume 25 grams (g) of fiber/day. If you currently fall short, work your way up slowly to avoid becoming constipated and drink plenty of fluid.
Wednesday	This week, track what you eat, the time of day you eat, the people that you are eating with, and how you are feeling. Look for patterns and clues to how you could improve. Rate your hunger on a scale of 1-10, and decide how much to eat based on this

	rating. Generally a 4 or higher warrants a lite snack, and a 7 or higher warrants a full meal or a more substantial snack.
Thursday	Experiment with fresh herbs. Many contain as much or more antioxidant power than fruits and vegetables.
Friday	Try to eat two vegetarian meals/week. Think of the possibilities—a hearty lentil stew, a spicy black-bean burger, a lite veggie wrap, or a seasoned Portobello “burger.”
Saturday	Do not worry about breaking the rules by having dinner leftovers for breakfast or a traditional breakfast food for dinner. Everyone’s appetite is different. If you like to have your biggest meal in the evening, do not worry about gaining weight because of

	this. Studies repeatedly have shown that it does not matter what time you eat. What matters is how much you eat within a 24-hour period.

Third week

Sunday	This week, take the time to plan menus. Write out a grocery list before heading to the store. When you are hungry, you will not need to eat whatever is most convenient, because you will have a plan.
Monday	Make “variety, balance, and moderation” your mantra, and believe it. Promise yourself that you’ll never “diet” again, but will always strive to eat a diet that provides many different types of foods from all of the major food groups, and that you will eat

	enough—not too little and not too much.
Tuesday	Check out your kitchen. Is it full of “fat free,” “sugar free,” or “lite” foods that you purchased because you believe they are “good for you,” even though you do not truly enjoy them? Sometimes it is more satisfying to have a small portion of a regular version of a food than it is to have a large portion of its nutritionally altered alternative.
Wednesday	If a food contains three or more ingredients that you have a difficult time pronouncing, do not eat it.
Thursday	Sneak fruits or veggies into your diet by adding them to casseroles, soups, ground-meat mixtures, breakfast cereals, smoothies, etc. This week, aim to try two fruits and two vegetables that you do not eat often, if ever.
Friday	If you do not exercise regularly, try doing four 5-minute spurts of activity every day this week, or wear a pedometer and try to walk 10,000 steps every day.
Saturday	Take the time to sit down and enjoy your meals. Set the table, play some light music in the background, and focus on the food before you.

Fourth week

Sunday	Look for hidden sources of sugar this week. It might surprise you to discover how much is in your favorite pasta sauce, flavored yogurt, breakfast cereal, etc.

Monday	Eat fish twice this week. Salmon, tuna, mackerel, sardines, and halibut are some good varieties to try. These types of fish are all high in omega-3 fatty acids, which are good for you.
Tuesday	Wear a rubber band around your wrist. Snap it any time that you think of a food, or of yourself, as "good" or "bad."
Wednesday	List the people who you consider crucial to help you as you continue on your journey of a change in lifestyle. Who will you call or visit when you are discouraged? Who will you talk to when you are excited about your success? Who will you count on when you need someone to provide sensible advice?
Thursday	Try a new recipe this week. You do not have to become a chef to prepare your own meals. If you live alone or with one other person, invest in a good "cooking for two" cookbook.
Friday	Get out the scale. Find the measuring cups and spoons. For 1 week, measure or weigh out your food until you are able to "eyeball" a proper portion size. We are so used to "supersized" portions in America than many of us have no idea what a serving should look like.
Saturday	Make a list of ways that you can reward yourself—none of these should involve food! Keep your list handy. It is good to recognize your efforts and accomplishments.

About the Author

Dr. Nancy Collins, founder and executive director of RD411.com, is a registered and licensed dietitian. Dr. Collins has over twenty years of practitioner experience in clinical nutrition and consulting to the health care industry. She is nationally known as a medico-legal expert dealing with the issues of malnutrition, wound healing, and regulatory compliance and has served as an expert witness in over 400 legal matters.

Dr. Collins is a frequent speaker at medical education symposia and a prolific author. Dr. Collins is an editorial advisor to the journal *Advances in Skin and Wound Care*, a contributing editor for *Ostomy-Wound Management,* and a columnist for *Today's Diet and Nutrition*. She is also the member of many medical advisory boards including the American Professional Wound Care Association, which granted her Fellow status Dr. Collins is a Past President of the Florida Dietetic Association and a past Chair of the Nutrition Entrepreneurs DPG. Currently, she holds the position of Delegate to the American Dietetic Association. In 2003, Dr. Collins was awarded the Dietitian of the Year Award for her longstanding contributions to the profession of nutrition. In 2009, she was awarded Nutrition Entrepreneur of the Year for her visionary projects and forward thinking.

Charlotte's Story: A Life Cut Short by Medical Errors

Barbara Levin shares her perspective about patient safety from two viewpoints: as the daughter of a woman who was a victim of medical errors, and as a registered nurse who is involved in day-to-day care in taking care of patients in the hospital.

Learn concrete strategies you can take to keep records of medical care, share information about medications, communicate with your physician, and be your own advocate.

Invest in your safety: http://bit.ly/t9edgR

Do You Have Computer Eyeballs?

Computer Eyeballs: A look at Computer Vision Syndrome. In the past couple of years I've begun to spend a lot more hours in front of my computer monitor. This is just a part of the modern workday for many of us, but I've found it can put a real strain on my eyes.

I began to notice that after several hours working at my computer, I'd take a break to run errands and I'd get into my car to drive. Everything at a distance seemed blurry. So I asked my friend and expert, The Eye Guy, what might be happening! First, he reminded me that driving when my eyes were having trouble focusing was dangerous and told me I should take this seriously. He diplomatically told me that part of what was happening was that my 'older eyes' were having a difficult time adjusting to distance vision after focusing on the computer for a long periods. My experience isn't uncommon. Not just adults, but kids who play video games or use computers at school can experience eye problems, especially if the lighting is less than

ideal. This even has a name, *Computer Vision Syndrome* or CVS.

It turns out that working on a computer is harder on your eyes than reading a book or reading words off a sheet of paper. This is because the computer screen adds contrast, flicker and glare. These problems can be more severe if you have an eye problem like nearsightedness, astigmatism, or just 'older eyes' like I do.

A Few Simple Suggestions from The Eye Guy:

Give your eyes a break. Every 20 to 30 minutes, look away from the computer and look out the window, around the room, or even close your eyes for a few minutes. Even better, get up and stretch!

Use a wetting solution. Use some saline eye drops to help your eyes after focusing on something at the same distance for a time.

Cut the glare. Change the lighting, move the monitor or close the window shades until the glare disappears.

Re-arrange your desk. The optimal position for your computer monitor is slightly below eye level, about 20-28 inches away from your face.

Tweak your computer settings. Adjust the brightness, contrast and font size until you find the best setting for your vision.

Get an extra pair of glasses. If you wear glasses talk to your optometrist about getting a pair specifically for working in front of the computer. I have a pair of glasses that I use exclusively for computer work which helps me focus at the 20-28 inch distance from my eyes. Using them makes a huge difference.

About the Author

Kay is a Primordial Sound Meditation Instructor and Vedic Master, certified by the Chopra Center for Well-Being. Primordial Sound meditation is a mantra-based meditation process in which individuals receive personal

mantras based on their birth information. If you would like more information about meditation or Primordial Sound Meditation, please contact Kay at kay@kayrice.com or visit her website at www.kayrice.com.

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Bullying in Health Care: How it Harms Patients

This program is an interview between Pat Iyer, President of Avoid Medical Errors, Dr. Alan Rosenstein, and Beth Boynton MSN RN. When you purchase this program, you will receive the interview in audio form, transcript and 6 bonuses.

What you will learn

Bullying does not occur just in the playground or corporate setting. It also happens in health care where people's lives are at stake. Bullying in the healthcare environment can have serious consequences to patient care. Beth Boynton RN and Alan Rosenstein MD share their expertise about this potentially very dangerous behavior.

Faye Levow
President and CEO of
Launch Pad Publishing Inc.

Where to Live When Assistance is Needed

While moving/uprooting oneself in the elder years may be a challenge, there are some very important things to consider when assistance is needed with activities of daily living, such as dressing, bathing, and cooking.

The three most common options are:

1. Continue to live in the home and hire outside assistance through an agency or privately.
2. Move in with adult children who then provide care (usually at a big price to the personal lives and relationships of all concerned).
3. Move into an assisted living community.

Each of the three choices has benefits and drawbacks.

Most people have their minds set on living in their home until they die. Yet, continuing to live at home with hired caregivers can be both expensive and isolating. It is your parent and the caregiver at any given time. Hired caregivers may or may not be attentive. If you

hire privately, you must do a full background check and even then, you must maintain a certain vigilance to protect your parent from abuse or exploitation. This is less likely when hiring through an agency, but still requires some awareness.

The home may need modifications to accommodate physical needs, such as railings in the bathrooms or along hallways. Stairs may be difficult to navigate, so a bedroom may need to be situated on the first floor if it is a two-story home. Area rugs may need to be removed, along with other potential obstacles, and so on.

Moving in with adult children can often put a strain on relationships. Depending on the space available in the home, it can be cramped quarters for everyone. Modifications may be necessary there, also. Usually, family members have jobs or school and the elderly parent can find herself left alone for most of the day. A remedy to this is bringing in a hired caregiver or, better still, connecting with an adult day program, which helps cure the isolation problem and gives the elder opportunities to enjoy activities with their peers. Many day programs also offer various therapies to assist participants with any medical, physical, or cognitive issues.

The option of an assisted living community is often overlooked because many people still remember the days of the “nursing home.” This is very different. Many states have facilities where elders have their own apartment with privacy. Meals are usually taken in a group dining room and there are activities available for enjoyment, socializing, and physical exercise. Most assisted living communities offer transportation to doctor appointments and shopping. For those able to drive, they are free to come and go as they please.

The further benefit of assisted living is that family members can visit and enjoy each other’s company without having to be in the position of caregiver. As the elder’s needs increase, assistance is readily available. One

can also hire additional help in many facilities, if needed. In a quality community, it can offer the best of all worlds.

In addition, when one spouse is in the position of caregiver to the other, assisted living can be a great relief. There are no more worries about meals, transportation, and other daily issues. For women caring for their husbands, who probably retired long ago, it is finally a chance for them to retire, too!

Although many people think that the ideal is to remain in the original home, moving to a new one within an assisted living community may be a far better option for living out a happier life.

About the Author

After two years of being in a crazy whirlwind of managing her mom's care, caregivers, and finances, Faye Levow knew that she had to do something with all that she had learned. Knowing that millions of people deal with similar situations on a daily basis, she decided to create the upcoming book *OMG! My Parents are Getting OLD!* scheduled for release in 2012.

A comprehensive resource book, *OMG! My Parents are Getting OLD!* weaves her story among chapters from over 50 professionals who work with seniors daily in a wide range of fields, and the lessons from nearly 70 family caregivers who have "been there."

President of Launch Pad Publishing, Faye has been writing and editing for over 30 years and coaching authors for the last seven. She has been a features writer for magazines and newspapers, a contributing author in several books, and has edited magazines, newsletters, and numerous books in a variety of genres, including a Washington Post best-seller.

From coaching to editing to publishing, Faye Levow's passion is to help authors get their books out of their heads, and get their message, in their voice, to their audience. She specializes in going Beyond the Book™ to discuss branding, future products, and other opportunities that can bring greater success

and satisfaction to an author.
www.LaunchPadPublishing.com

Inner Circle Interview

Kay Rice speaks about Mind Body Medicine.

Kay Rice is skilled in understanding Aruvedic medicine, or the mind body connection. In this interview, she shares practical suggestions for harnessing the power of your mind to help in your healing process and to increase your enjoyment of life.

Get this interview at http://tinyurl.com/cekhu6t

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