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Patricia Iyer
MSN RN LNCC

Near Fatal Patient Controlled Analgesia Pump Incident

Guest post by Matt Whitman

Amanda Abbiehl and I share a similar story. Both of us were on patient-controlled analgesia (PCA) pumps to manage our pain.

However, the difference is that, by the grace of God, an observant nurse who just happened to walk by my room when I stopped breathing, called a “Code Blue”, and that ultimately saved my life. I would have been just another statistic if it wasn’t for that nurse. Unfortunately, Amanda was not so lucky.

What are the odds of a nurse putting her head into a patient’s room just as that patient is experiencing respiratory depression? Slim. What are the odds of that same nurse putting her head into the patient’s room after she had just checked on him 15 minutes before? Almost none. Yet, that is what happened to me and I ask why.

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The injury

My story begins in 1990, when I was a state trooper. My squad car was struck by a car driven by a drunk driver. Although the accident left me close to being a quadriplegic, I went through 6 months of physical rehabilitation and returned to work. My doctors told me that I would always have trouble with my neck; I was able to function at my job despite the pain. I was even named a district Trooper of the Year in 2001 and prior to that in 1994 received a statewide traffic safety award for arresting the most drunken drivers per capita.

But, despite being recognized again in 2003 as Trooper of the Year in Bridgman, MI, my neck injury increasingly gave me problems. In December 2002, the neurologist who read my MRI told me that I shouldn't be a trooper anymore. He said, if I get hit again, I'd be a quadriplegic. In January of 2003, I met with Indianapolis neurosurgeon Dr. Henry Feuer, who was (and I believe still is) a consultant for the Indianapolis 500 and the National Football League. Dr. Feuer told me that my condition had worsened and that my neck looked like that of a retired football player with arthritis, bone spurs and spinal fluid unable to circulate effectively. Dr. Feuer gave me two pieces of bad news. The first was that I needed surgery. The second confirmed that I couldn't be a state trooper any more.

The surgery

So, I underwent neck surgery that year at Methodist Hospital in Indianapolis. Because of the pain that I was in, I was on a morphine pump after my surgery. The night after my surgery, a nurse had just checked on me and then continued to check on other patients on the very large hospital floor. Another patient she was caring for needed something. Although it was on her cart, she decided to go to the supply room and restock her cart. Fortunately for me, her path to the supply room led her passed my room.

The rescue

So, even though she had just checked on me 15 minutes earlier, she just so happened to be

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passing my room when she noticed I was not breathing and called a “Code Blue”. She would tell me later, while she was crying, that she did not know what made her walk past my room. While she continued to sob she told me that she had never seen anyone live after they had coded.

I remember feeling warm, calm and in a better place. There was a point where I had to decide if I wanted to fight back and live or stay dead and remain in that warm pleasant place. I chose to fight and recall being jolted back. I remember doctors over me, bright lights, and someone holding my hand. Miraculously, I survived. The doctors told me that 96% of Code Blue patients die; only 4% live. I remember later on that morning that I was somewhat of a spectacle for the student nurses. They would come into my room and stare at me to see the patient who had cheated death.

I had been without oxygen for 6 minutes. At 7 minutes, I was told, I would have been brain dead, if not dead permanently. I died at 4:11 AM, and for many years after I would wake at 4:11 in the morning remembering what happened to me.

I was never electronically monitored. There was nothing that would have indicated to a nurse that I was about to experience respiratory depression and almost die. I was 39-years-old and in terrific health. I was not a high risk patient. Had my PCA pump been integrated with a capnography machine, the pump would have shut off and alerted my nurse that I was not breathing. Instead, I am alive today because my nurse, who had checked on me 15 minutes earlier, just happened to be passing by my room when she didn’t have to. I say to Brian and Cindy Abbiehl – My deepest condolences. Know that your daughter died peacefully. Know that that she was not in any pain or under any stress.

I say to all hospitals that care about their patients’ safety and welfare — electronically monitor ALL your patients, not just the ones at

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high risk. A human life is too valuable for you not to. All hospitals need a technological safety net for their patients. All nurses and caregivers need that safety net too.

This blog post was shared by the Physician-Patient Alliance for Health & Safety.
About Physician-Patient Alliance for Health & Safety: Physician-Patient Alliance for Health & Safety is an advocacy group devoted to improving patient health and safety. Follow PPAHS on Facebook (www.facebook.com/ppahs) and on Twitter (twitter.com/mikeppahs). The PPAHS website is www.ppahs.org

PPAHS is currently developing a checklist targeting PCA pump use. For more on this initiative, please see this ASC Review article: http://wp.me/p1JikT-8O

We will share Amanda Abbiehl's story this month. Watch the Patient Education Safety Materials at avoidmedicalerrors.com for details.

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

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Brown Recluse Spider Bites – How Serious?

In the United States, reports of severe injuries by brown recluse spiders began to appear in the late 1800s, and today brown recluse spiders continue to be of significant clinical concern. These bites are common, and the complications that result are significant.

Of the 13 species of Loxosceles spiders in the United States, at least 5 have been associated with tissue death. Loxosceles reclusus, or the brown recluse spider, is the spider most commonly responsible for this injury.

Pathophysiology

Brown recluse spider bites can cause significant injury with tissue loss and tissue death. Less frequently, more severe reactions develop, including inability of the blood to clot, renal failure, and, rarely, death.

Brown recluse venom, like many of the other brown spider venoms, poisons cells and affects

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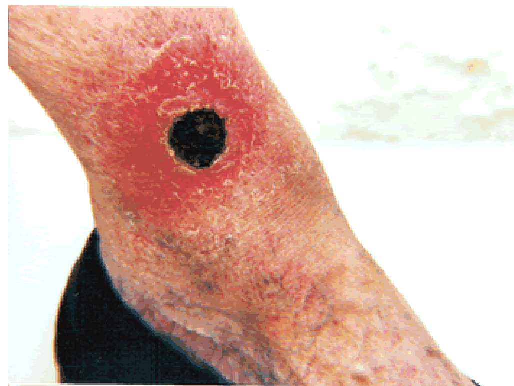
the blood. The bite causes intense inflammation.

Frequency
Although various species of Loxosceles are found throughout the world, the L reclusus is found in the United States from the east to the west coast, with predominance in the south. Recently, reports of persons with "spider bites" presenting to emergency departments have reached near urban legend proportions, prompting many physicians to question the diagnosis of a brown recluse bite in areas where the spider is not commonly found. The list of conditions that can present in a similar fashion to that of a brown recluse spider bite is extensive. A more likely explanation for this so-called "epidemic" of spider bites is probably community-acquired methicillin- resistant Staphylococcus aureus (MRSA) skin infections.

History
The brown recluse, living up to its name, is naturally nonaggressive toward humans and prefers to live in undisturbed attics, woodpiles, and storage sheds. Brown recluses vary in size, and can be up to 2-3 cm in total length. They are most active at night from spring to fall. Characteristic violin-shaped markings on their backs have led brown recluses to also be known as fiddleback spiders. The spider bite initially is mild and frequently goes unnoticed until several hours later when the pain intensifies. An initial stinging sensation is replaced over 6-8 hours by severe pain and itching.



Physical
Edema around the bite site produces the

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appearance of a halo around the lesion. The red margin around the site continues to enlarge peripherally, secondary to spread of the venom into the tissues. Typically, at 24-72 hours, a single clear or hemorrhagic blister develops at the site, which later forms a dark dead area. Tissue death is more significant in the fatty areas of the buttocks, thighs, and abdominal wall.

Treatment

Treatment of brown recluse bites is directed by the severity of the injury. General wound management consists of local debridement, elevation, and loose immobilization of the affected area.

Because the activity of the venom is temperature dependent, application of local cool compresses is helpful and should be continued until progression of the tissue death process appears to have stopped.

Dapsone frequently has been recommended by authorities to treat local lesions. However, because of the potential for adverse effects associated with dapsone use, appropriate caution should be exercised if using this medication. To date, no well-controlled studies have shown dapsone to affect clinical outcome in human brown recluse bites; therefore, it is should not be routinely recommended.

Other treatments, such as colchicine, steroids, antivenom, nitroglycerin patches, and surgical excision, have been reported, but insufficient data exist to support their clinical use today.

Some evidence indicates that hyperbaric oxygen therapy is beneficial for animals for reducing skin lesion size, but controlled human studies of this technique have not been performed.

Doctors should admit patients to the hospital who are exhibiting signs of systemic toxicity (illness) and evaluate them for evidence of lack of blood clotting, renal failure, or further progression of systemic illness.

Urinalysis can provide early evidence of systemic involvement (e.g.: hemoglobinuria,

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myoglobinuria) and can be performed easily at the bedside in all patients.

Additional treatment includes wound care and debridement as well as treatment with antibiotics of any bacterial infections complicating the bite. Wound cultures should be regularly obtained. Skin grafting may be necessary after 4-6 weeks of standard therapy. Aggressive treatment is necessary in order to avoid loss of fingers or toes or limb amputations.

Medical-Legal Considerations
The most common problem is the tendency for a physician to minimize the bite. Most spider bites are not serious and clear on their own. Unless the Brown Recluse bite is suspected and treated quickly and aggressively, serious injury may result. This could lead to litigation. If the patient is treated with Dapsone, close supervision is necessary as there are many side effects associated with the drug. Lastly, when systemic complications occur, they must be recognized and treated immediately. Delays in diagnosis and treatment have been associated with serious injury and sometimes death.

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

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.

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Elizabeth Bewley MBA

Hospital Staff May Only Fix Problems If You Speak Up

Richard and Karen, both in their early fifties, live in a suburb of Philadelphia. Karen was driving home from a visit with family when she went off the road in rural Pennsylvania. The nearest hospital identified a compression fracture in her spine, and sent her by ambulance to a major medical center in Philadelphia.

Karen could not recall what led to the accident, so to be safe it was decided to put her in a cardiac unit in case heart trouble had caused her to lose consciousness.

After she had been there two or three days, her cousin Jake called Richard to ask how Karen was doing and how her care was going. Jake worked in the Infection Control department on another campus of the hospital where Karen was being treated.

Richard said, “She’s okay, but I thought you worked for one of the top tier hospitals! I can’t believe some of problems she’s running into.”

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Jake asked for particulars, and Richard said, “Here’s one that should interest someone in Infection Control. Today a patient tech came in and Karen asked him if there was a way to redirect the air conditioning vent, because it was blowing on her. He had gloves on, and he took the cover off the AC unit. Then he lifted out a clump of debris and adjusted the vent. Guess what he did next?”

“What?”

“He came over and started to test Karen’s blood glucose level. She said, ‘Aren’t you going to change your gloves?’ He shrugged, and said, ‘If you want me to.’”

Jake groaned. Richard said, “That’s not all!” He listed half a dozen other situations in which it seemed that Karen was paying more attention to getting good care than were the people treating her. Karen is an insulin-dependent diabetic, and nursing practices interfered with her ability to control her insulin appropriately. People in the cardiac unit didn’t know how to move her to avoid injuring her spine further.

“Listen, Richard,” Jake said urgently. “Write down each of the problems she’s run into. Then call the Patient Relations department and ask for a meeting. When so many things are off, that’s the only way to get them resolved.”

“Patient Relations?” Richard said skeptically. “What’s that?”

“That’s the department specifically set up to help patients when they can’t get things to work right by dealing with the individual doctors and nurses directly.”

“Never heard of them.”

“The switchboard will put you through if you ask for the department by name.”

Richard did as Jake suggested. He was amazed at the results. Within 90 minutes, the Patient Relations representative called a meeting at Karen’s bedside. Several key people showed up. The first was the nurse

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manager of the floor where Karen was housed. The second was a resident (a doctor early in his career employed by the hospital). The third was an orthopedic specialist. The fourth was an endocrinologist. The fifth and sixth were Karen and Richard.

The Patient Relations representative had given everyone a copy of the list of problems that Richard had written. The list noted several issues. Two were problems with drug administration. Another was an ongoing problem with management of Karen's diabetes. The next was about a problem with keeping her spine from moving. In addition, he listed the concern about hand-washing described above and other issues.

Richard said, "We explained that they had forbidden Karen from using her own blood sugar monitor to track her blood glucose levels. She was dependent on the hospital staff to come and measure. But they weren't testing at the appropriate times, so she was left to guess how much insulin to inject herself with from her insulin pump."

The endocrinologist asked, "Who's your regular endocrinologist?

Karen told him, and he said, "Oh! Well! You've got the best possible person in the area!" Comfortable that Karen had an appropriate care program, he said, "We can arrange for you to test your own blood sugar levels."

And in 15 seconds, Richard reports, the problem was fixed. The other topics were also quickly solved. The whole meeting lasted only 15-20 minutes.

Karen was in the hospital for several more days. Nurses checked on her more often than they had before the meeting. Hospital staff who came into the room were clearer about what they needed to do. No problems arose for the balance of her stay.

Even long afterwards, though, Karen remained troubled. "After Richard and I met with the

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patient advocate, my care changed, but not the care of others. At one point, my roommate called several times needing help and they still did not come to help her. As soon as I rang for the nurse, one appeared. I told them she needed help, proving the squeaky wheel gets the grease."

Three key points stand out.

It often seems to be a well-kept secret that that many hospitals have departments titled Patient Relations, Patient Advocate, Patient Ombudsman, and the like. While not all hospitals have such organizations, it is worth asking about when you are admitted.

These organizations may be very successful in addressing problems that the patient or family member has been unable to get resolved.

The fact that these departments can help you doesn't mean that the underlying problems that led to gaps in your care have been eliminated. That is, the next time you or a family member is in the hospital, it will still be important to be vigilant.

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.

News

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

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Sarah Jean Fisher
MSN, RN-BC, BA

Pressure Sores: What Are They and How Do They Develop?

A woman used to visit her 37-year-old younger brother at a long-term care facility where he had resided for the past four years. He was dying. Multiple body systems were failing from malnutrition and dehydration, and poison was spreading throughout his body from an infected pressure sore.

The young man had suffered a spinal injury in a drug-related accident that left him paralyzed from the waist down seven years ago. He dealt with bouts of depression, prescription drug addiction, and personal loneliness since his girlfriend broke off with him last year. In the years since the accident, he learned to transfer himself from the bed to his wheelchair using a transfer board. He would sign himself out of the facility, visit a nearby tavern, and return hours later very intoxicated and high from street drugs purchased while out of the facility.

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The last few months he frequently refused to cooperate with therapies, activity/recreation staff, and nursing caregivers. He would not eat, and refused to bathe or be repositioned. He became verbally abusive to staff and would strike out at them physically if they came too close at those times; he would not even allow dressing changes to his sacral pressure sore which had degraded a Stage IV (worst kind) wound. Since he was awake, alert and fully coherent, he was allowed to make decisions for himself. He was unbelievably depressed with how his life had turned out, blaming himself and fate, and was now at the point of wanting to end it all through his own death. He got his wish.

I share this story with you to show that pressure sores are not only occurring in the elderly. They don't happen accidentally and that they can be a contributing factor to end of life. A certain chain of events is required to set the stage for a pressure sore to occur and worsen.

Pressure sores may develop at home, in the hospital or at a nursing home – wherever people receive care who are at risk for developing pressure. These include people who are immobile, incontinent, and have poor nutrition. Pressure sores are identified by the depth of the wound, the layers and type of tissue that has been damaged. Here is a breakdown used by many clinicians:

Stage I: There is no opening in the skin, but a color change noted on the skin, (red or darker) especially on that covering a bony prominence (heel, ankle, elbow, hip, sacrum, back of the head, around the ear). The darkness does not fade within 30 minutes of pressure being removed (non-blanchable). This area of skin can be painful.

Stage II: The skin is open to a shallow depth, and may drain a small amount of blood, or blood-tinged fluid. It can be very painful. Think of this like an open blister you would get at the back of your heel when you wear a new pair of tight shoes.

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Stage III: This is a wound that goes down though subcutaneous and fatty tissue but not including muscle. It is deeper than a Stage II. It may display tunneling (passages from the wound bed radiating outward toward healthy tissue) and can be extremely painful.

Stage IV: There is massive tissue destruction and drainage involved, can be deep and wide, and extend down to the bone. It is deeper than a Stage III. Surgery is frequently required to repair it.

Healing can only occur in a pressure sore if a series of four events happen regularly. These activities should be carried out by caregivers at home or by healthcare professionals caring for a patient in a hospital or nursing home.

- A wound must be assessed daily, and an appropriate treatment/dressing applied. If progress towards healing is not visible within two weeks of daily assessment and treatment application, a new treatment must be considered and tried. Then the pattern must repeat itself until the wound heals.
- Wound healing requires high protein stores in the blood which comes from eating an appropriate diet. Blood work can show if there has been ample protein intake to the body. If the patient frequently refuses nourishment or the right kinds of foods, it may be necessary to supplement Vitamins A, C, iron and zinc sulfate for 30 days, for example, to boost healing factors in the body. For effective and timely healing, protein levels need to be consistent. Diet can be assessed by calorie counts or 3-day meal monitoring to determine what the patient is consuming and an interview with the patient and/or loved ones can determine the patient's food preferences to assist with eating compliance.
- Body organs receive nourishment and dispose of some waste products through the blood circulating to all systems. If ample fluid intake does not occur

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regularly, the body does not receive the required fluids to disperse proteins to the wound site and carry away blood borne waste material like dead cells and pus. If the patient requires assistance to drink, caregivers must encourage and assist with fluid intake around the clock, not just on day shift. In a long-term care facility, residents are encouraged to consume 32 ounces of fluid per 8-hour shift plus what is on their meal trays. Attempts should be made to provide any specific desired drinks that are allowable.

- Wound healing cannot occur unless proteins and fluid can get to the site. Pressure must be removed from the wound site and rotated regularly to other areas of the body to allow healing at that site and to prevent pressure sores from forming at secondary sites. Regular turning and repositioning are essential. The patient cared for at home may need to be evaluated by a wound care clinic or home health nurse with expertise in the type of surface needed to relieve pressure. Nurses should evaluate the mattress, chair/wheelchair cushions and other pressure reduction appliances. Caregivers should use a draw sheet (half sheet laid across the bed) to reduce friction. They should use pillows, bolsters, positioning wedges, special-made chairs which allow comfort without pressure, and if possible, encourage some walking each day to boost normal circulation, strengthen heart muscles, and encourage calcium stores to remain in the bones.

Each one of these actions is vital to wound healing and if even one is missing or not complete and regular, wound healing cannot continue and the potential for another site to occur strongly exists.

About The Author

Sarah Jean Fisher earned a master's degree in nursing from Thomas Jefferson University with

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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 and 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.

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.

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Aila Accad RN, MSN

Nursing Leaders Can Reduce Medical Errors

When nurses focus on nursing care, medical errors can be reduced. As healthcare reform is charged with putting the "health" back in health care, nurses must take leadership. Nursing is all about restoring people to a healthier state.

Nurses have been working under the medical model, rather than the nursing model. Monitoring symptoms and delivering treatments is only a fraction of what nurses can do. The real power of nursing is in assessing all the aspects of what is happening with the person within her environment. This includes more than just what is happening in her body with a particular disease process. In addition to the body, nursing assessment includes the mind, emotions and spirit of the person, in relationship to environment, family and community. The nurse then works with the person to create a plan of care that will help restore her to a healthier state. This plan includes the person's unique perspective and values.

Properly assessing, planning and implementing nursing care with a person takes time. Nurses are increasingly forced to spend more time away from the bedside, especially in hospital

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settings. This does not allow enough time to interact with people in order to properly assess and integrate nursing care into their medical care. The less nursing's holistic perspective is available, the more medical issues, complications and errors occur.

When Florence Nightingale introduced nursing into hospital care back in the 1800s, she discovered that more people got well. It was not introducing more medicine or physicians into the care. It was the nursing model added to the medical care that improved health. Today, nurses must reclaim and assert a nursing care model in order for medical care to become "health care".

There is support for this in the Affordable Care Act, which requires more collaboration and coordination of care and an orientation toward wellness. The Institute of Medicine *Report on the Future of Nursing* also recommends that nursing be integrated into health care for improved health outcomes.

Even though the U.S. is spending more on than ever on health care we are not getting healthier. We are not the healthiest country in the world and our rank is dropping. Adding more medical care and technology is not enough to improve health. This has been proven in the past and is being proven today. We need a more holistic approach; a health approach. The nursing model focuses on health. This is the missing piece.

The trends, the public and the government are turning toward nursing to help solve the health care crisis. It's now time for nurses to heed the message. Nurses must lead this change by reinserting the nursing model, which is grounded in holistic observation, assessment, planning, intervention and evaluation back into human care.

Human beings are more than mechanical bodies that can be diagnosed and treated without consideration for the other aspects of being human. Nursing addresses these other aspects that contribute to human health.

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Health advocacy is a key role of nursing. This is why nurses must take leadership in adding nursing care to medical care in order to create a “health” care system that can turn the trends toward better health outcomes.

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.

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

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Dean Dobkin MD

Strange Folks

Some of the strangest folks come to the ER.

I'm just finishing up a 24-hour shift "moonlighting" in a small town in Southern Maryland. I got some sleep last night, thanks for asking. Working a 24-hour shift in a low volume ER is not all that unusual.

I think back over the last 24 hours and reflect on the patients I saw. Many were fairly typical, for me, but might be surprising to you.

The last patient I saw (5:45 a.m.) was a 54-year-old lady from New York who came in with a toothache. Why do people come in with toothaches? Isn't it pretty much common knowledge that most ERs don't have dentists? Can people not figure out how to use the Yellow Pages (or the internet) to find a dentist?

My patient earlier this morning hadn't seen a piece of dental floss since Carter was president. That was her first problem. Second problem ... arising, of course, from the first problem ... she couldn't figure out she needed a dentist, not an ER doctor. Sure, I gave her some antibiotics and a prescription for two days' worth of pain medication ... but that's not a substitute for dental care.

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She had some swelling over the tooth, an indication of an abscess information; otherwise, she would have fit the perfect profile for a "seeker." In our world, "seeker" means "drug seeker," indicating a person who goes to an ER (or goes to ER after ER) looking for a high from narcotics. A “seeker” is usually looking for either a shot or a prescription; or, of course, both. Such patients tend to arrive "outside of normal hours" and are from "out of town."

Most ER doctors handle such patients with medications other than narcotics. If we aren’t sure if someone is a “seeker,” we will give them enough medication for a day or two. At worst, they won't become addicted nor overdose on the small number of pills; at best, we're being compassionate since the patient's pain might indeed be real.

Sad to think there are people who go from ER to ER in search of a prescription "high." I recall one such patient I saw years ago while working in a hospital in Somers Point, N.J. He was from "out of town" and complained of pain from kidney stones.

His x-ray showed he had a "stent," a surgically implanted tube that would facilitate the drainage of urine from his kidneys to his bladder to help prevent any kidney stones from blocking the passage. The next day I saw the same patient while I was working in a hospital in Meadowlands, NJ. He clearly was going from hospital to hospital - likely moving further and further north - in New Jersey. Like most such "seekers," he denied having seen me before, denied, in fact, almost everything, even when confronted. He left the ER as an "unhappy camper."

Blatant abusers of emergency departments like him are far too common. Find them wherever you find people who enjoy narcotics.

Another patient I saw last night suffered from mild heart failure for decades, having had his aortic valve replaced three times. He was 60; he was talking, moaning, and screaming that he couldn't breathe. He expelled a lot of hot air

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with all the moaning and screaming.

HIs mother came in first (yes, that's right, he was 60 and his mother came in with him) screaming that her son had chest pains and was having a heart attack, and could someone please come out with a wheelchair?

The nursing staff was out of the door in a jiffy, wheelchair in hand. He had no chest pains. He wasn't having a heart attack.

What possessed the mother to say he had chest pain is beyond me. There was no wait for emergency services; we had no other patients. This man wasn't having a heart attack. With his moaning, screaming, tangential speech, and absurd mother, the picture painted would have been comical if not so pathetic.

The patient's son and wife arrived soon after he came. Everyone wanted to ask me why he was moaning and yelling. I thought the questions would better be directed to the patient. Saying he had a mental problem wasn't going to go over very well.

Nonetheless, even people who clearly have a mental ailment must be taken seriously. My job included investigating what might cause him to feel short of breath, whether or not he was moaning or screaming.

After a chest x-ray, lab work, an EKG, and an analysis of the oxygen content of his blood, his medical evaluation was almost complete. The final test, a CT scan, confirmed he had no blood clot on his lung, and no problems from heart failure.

He needed a wheelchair to get in but quickly found he could walk to the bathroom. Make sense? No. What to do? His medical needs were minimal. His psychiatric needs were overwhelming. There was no way he nor his family would accept the truth; his problems were psychiatric.

It was a shame, in a way, a man whose whole life was fixated on a problem - a real problem with his heart - that was totally under control, and probably had been that way for the last three decades.

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There are certain medications we use which calm psychotic patients. Psychotic patients, unlike neurotic patients, are removed from reality. That was the man I treated last night.

An hour after a single dose of haloperidol, a sedative, my patient was calm. I didn't lie; I told him I wanted to give him medication to calm him down. He had been, after all, moaning and screaming.

Our job in the ER is providing what the patients *need,* which often differs from what they want, or what they say they want. He said he wanted treatment for his "shortness of breath" from his "heart," yet his real need was for psychiatric care. My treatment will keep him calm at least until he sees his cardiologist (today); hopefully, the cardiologist will refer him to a psychiatrist for more definitive care.

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

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with his wife and family in Philadelphia. He testifies as an expert witness in emergency medical care. Contact him through patmedleague@gmail.com.

Order Bullying in Healthcare: How it Harms Patients at

www.avoidmedicalerrors.com/store/bullying-in-healthcare-how-it-harms-patients/

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

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Carol Kivler MS CSP

Take Time For Rejuvenation

After a hectic month of work and over committing myself with both volunteer and social activities, I found myself on a slippery slope of feeling drained of energy and spirit. During a discussion with a good friend, I realized that by giving so much of myself to everything and everyone, I needed to find a way to rejuvenate my mind, body, and spirit.

With the Internet at our fingertips we began searching for a place of peace and serenity. And as God would have it, not only did we find a spiritual retreat center, but there was a humor conference taking place that exact weekend. Laughter, Lake George, and a labyrinth all found in the same place—perfect!

Just making the arrangements and cancelling all my commitments for the weekend was a relief—I would have three days and two nights to take care of just me—WOW! The weekend was filled with glorious laughter, time in the chapel meditating, walking the labyrinth, praying for guidance, and meeting new friends. With each passing moment my spirits and soul were coming alive again. When I arrived at the retreat center, I felt like a flower wilting from the

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drought of self-care. Leaving the center, I felt centered, re-energized, and at peace. What a difference a weekend of self-care can make.

As I drove out the entrance of Silver Bay YMCA in Silver Bay, NY, I turned to read the entrance sign that I had overlooked driving in. The sign read, “We hope you have an inspiring experience.” I smiled and answered out loud, “I sure did!”

As I drove home, I thought about an experience I had on a plane to Chicago. I settled into my middle seat with two small books purchased at the airport—those two details in themselves are strange—I never select a middle seat, and I rarely purchase two books at the airport.

I began reading. From my peripheral vision I noticed the young woman sitting in the window seat kept opening and closing the shade and then cradled her head in her hands. She repeated the same routine every couple of minutes. I stopped reading for a minute, and she turned to me and asked, “Do you fly frequently?” “Yes”, I answered. She shared how petrified she was of flying; her anxiety was through the ceiling. BINGO—so that was why she kept opening and closing the shade. She said she was afraid the engines would catch on fire and we would crash. Anxiety sure has a way of wrapping us up in fear.

As a person, who knows anxiety well, I immediately became a friend to a stranger. I spoke to her about fears and anxiety as I held her hand and assured her we would land safely. Then it occurred to me that the other book I had purchased was a pocket guide on feeling secure. Wasn’t that interesting—I had no idea what made me even pick up that guide, I gifted her the pocket guide.

Then two days ago when I spoke to an executive from Mexico he shared a new term with me widely used in his country—“Godincidence.” It’s clear now why I had the middle seat and why I purchased the pocket guide.

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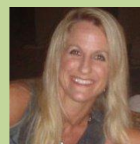
Reflective Question: What "Godincidence" have you noticed lately?

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.

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, and much more!

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

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Nancy Collins PhD, RD, LD/N

Vegetarian Athletes: What to Eat

It is a proven fact that diet can definitely impact athletic performance, and a vegetarian diet can certainly provide all of the energy and nutrients that individuals need to power themselves through their next workout or competition. However, just like all diets, a vegetarian diet takes some planning. Most vegetarian diets can meet the nutritional needs of athletes, if they include a wide variety of foods. The following tips can help ensure that you perform at your optimal ability.

Protein

- Protein requirement for endurance athletes:
  - 1.2-1.4 grams (g)/kilogram (kg)/day
  - Can increase to as much as 1.6-1.7 g/kg/day in times of intense exercise
- Protein in some plants is not completely digested:
  - Vegetarians and vegans may need to eat more to ensure that they are getting enough protein
- Even though most vegetarians easily meet the requirement for protein, vegans, strength-

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trained athletes, or athletes with very intense training regiments or low-food intake may want to:
  - Use nutritional shakes and protein supplements to meet their needs, or
  - Focus on improving their protein intake through careful dietary planning

Carbohydrate

- Carbohydrate requirements:
  - 5-7 g of carbohydrate/kg/day for general training (usually)
  - 7-10 g of carbohydrate/kg/day (likely)
- Most athletes should aim to have 60%-65% of their total caloric intake from carbohydrate, although the total amount can vary depending on body weight
- Most of the calories that athletes consume should come from complex carbohydrates, such as:
  - Whole-wheat breads
  - Whole-wheat pastas
  - Whole-wheat cereals
  - Oatmeal
  - Brown rice
  - Fruits
  - Vegetables

Fat

- A diet with too much emphasis on carbohydrates can crowd out necessary fat consumption
- Good sources of fat include:
  - Nuts
  - Seeds
  - Nut butters
  - Avocados
  - Olives
  - Olive oil

Vitamins and minerals

- **Deficiencies:** Vegetarian athletes are most likely to become deficient in the following vitamins and minerals (deficiencies more common in females):
  - Vitamin D
  - Riboflavin
  - Calcium
  - Vitamin B_{12}
  - Iron
  - Zinc
- **Nonheme iron:** Most plant foods contain nonheme iron, which is not as well absorbed as heme iron:

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- **Iron and vitamin C:** Pair iron-rich foods with foods containing vitamin C, such as citrus
- **Iron and calcium:** Do not pair foods containing iron and calcium, which interferes with iron absorption

- **Phytic acids:** The absorption of zinc from plant foods is hindered by the presence of phytic acids, making the zinc less absorbable than the zinc found in animal-based foods
- **B_{12}:** This vitamin is found only in animal foods, making fortified foods necessary for vegetarians and vegans
- **Vitamin D**: This vitamin exists naturally in animal products and is synthesized from exposure to sunlight
- **Spinach**: Although high in calcium, spinach is not a good source of calcium because of the presence of oxalates, which makes for poor absorption of calcium

Nutrient	**Vegetarian/Vegan Food Sources**
Calcium	• Milk and milk-based foods (if lacto-vegetarian) • Kale • Collard greens • Mustard greens • Broccoli • Bok choy • Legumes • Figs • Currants • Almonds • Chickpeas • Oranges • Tofu • Fortified soymilk • Texturized vegetable protein • Tahini • Calcium-fortified orange juice • Flour • Bread
Iron	• Pistachios • Cashews • Chickpeas • Dried apricots • Sesame seeds • Tahini • Black molasses • Spinach • Wholemeal bread
Zinc	• Legumes

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	• Hard cheese (if lacto-vegetarian) • Whole-grain products • Wheat germ • Fortified cereals • Nuts • Tofu • Miso
Riboflavin	• Enriched whole-grain cereals • Enriched breads • Dark-green leafy vegetables • Broccoli • Avocados • Nuts • Sea vegetables • Dairy products (if lacto-ovo vegetarian) • Eggs (if lacto-ovo vegetarian)

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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.

Spread the word. Who do you know who would enjoy reading Avoid Medical Errors Magazine? Encourage them to sign up at www.avoidmedicalerrors.com. Share the news on Facebook, Twitter, and LinkedIn.

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Kay Rice MEd CN

Four Weight Loss Tips

Tip 1 – "Real food is always better than fake food!"
This has become my signature statement for choosing healthful and nutritious foods. Mother Nature knew what she was doing when she created our food supply! The closer you can get your food to the way Mother Nature created it, the more nourishing and healthier it will be for your body. This means whole grains, locally grown fresh fruits and vegetables in season; foods that come without packaging or barcodes, and only have one ingredient in them. Refined, processed and packaged foods, foods that have ingredients that you don't recognize and can't pronounce, foods that have additives and preservatives, or have been genetically altered or irradiated are not the best choices. Going by this statement will also eliminate the need for substitute foods, such as diet sodas, low-fat dressings, processed cheese food (not real cheese). Generally they have taken something out and replaced it with something even less healthy. So, whenever you have a question about the healthiest choice, or the latest fad, just remember: "Real Food is Always Better than

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Fake Food", and ask yourself how close to the way Mother Nature created it that food really is.

Tip 2 – Don't ever eat anything that you do not like or truly enjoy!

Don't waste calories by eating something think you "should" eat, or feel guilty because you think you ate something you "shouldn't". Make the healthiest choice from the most nutritious and highest quality foods, but you can skip the diet substitutes, artificial sweeteners, and any other food that you do not like, that does not genuinely satisfy you, or that you do not enjoy. We have so many delicious food options and so long and you make your choices from high quality foods, and keep your nutrient ratios and portions in line you should never "have to" eat anything you do not enjoy.

Tip 3 – Make a decision and know your "whys"

Regardless of whether you are trying to lose 10 pounds, 100 pounds, become a fitness model, build wealth, or achieve any other worthy goal you need to start by making a defining decision to achieve your goal. Make your decision, write it down, and then list all of the reasons why that goal is important to you. This simple exercise alone will significantly improve your odds of success in any endeavor.

Tip 4 – We do not plan to fail, we fail to plan.

Once you have decided on your goal, choose a plan to follow. Learn as much as you can about that plan and how it works by reading a book or speaking to a nutrition coach, or whatever works best for you, and then prepare to implement your plan. By "prepare to implement" I mean do the necessary shopping and food prep, have a backup plan for when you travel or are away from home for a while. You may start packing a cooler for the day, or keep a meal replacement bar in your purse or briefcase. A plan will give you a map to your goals, and a little weekly and daily planning will ensure you stay on the right path.

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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.

Couch Potatoes: Secrets of Getting Fit

This program is an interview between Pat Iyer, President of Avoid Medical Errors and Mike Schatzki. When you purchase this program, you will receive the interview in audio form, transcript and a bonus.

What you will learn

Mike Schatzki shares some surprising information about getting fit, just for us couch potatoes. If you are already fit, you'll find out the two things you need to do to stay fit. Mike's content is NOT "warmed over stuff you already knew". You will

- learn what you need to do to reduce by 50% your risks of prematurely dying from anything.
- how you can avoid being in the 90% of people who do not keep weight off permanently.

Buy this at http://www.avoidmedicalerrors.com/store/couch-potatoes-secrets-of-getting-fit/

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Faye Levow
President and CEO of
Launch Pad Publishing Inc.

Preventing Elderly Abuse Part 2 – What To Do If You Suspect Elder Abuse or Exploitation

In part 1, we covered the four types of abuse: financial, physical, mental/emotional, and neglect, and discussed how to recognize them. We also discussed some ways to prevent them.

If you suspect that your aging family member is being abused, neglected, or exploited by someone, first look for proof, so you can explain your findings to the authorities. If your parent can speak and is willing to talk, get her to tell you how things are going. Leave the questions very open and see what she has to say. How does she seem? Has her mood changed over time? Does she seem nervous or anxious, where she was not before? Do you notice any bruises or complaints of unusual pains?

Check her medications (if you know what she are supposed to be taking and how much, you can see if the amount in the bottles appears correct.)

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Is she bathed and wearing clean clothes? Do you detect unpleasant odors from her or in her living space?

Has she recently changed her will, powers of attorney, or other legal paperwork recently? If she has, find out from the attorney if your parent seemed competent at the time. Also find out if the caregiver was present for these changes or if your parent seemed rushed or under pressure. Most attorneys will not admit to seeing anything amiss because they could lose their license if they suspect someone is not competent and proceed anyway. But it is still good to ask, so the attorney knows that someone is concerned.

Are the bills paid? Is she suddenly living below her means and not enjoying former pleasures, yet should be able to afford these things? Keep an eye on the bank accounts and investment accounts, too. Are there any large, unwarranted withdrawals from her accounts or large checks being written to caregivers or other service personnel?

Pull her credit reports from all three credit bureaus (use www.annualcreditreport.com) and check the information against bills, credit cards in their wallet, actual mortgages, etc. I met a woman whose elderly grandmother had her identity stolen and someone had bought a couple of houses in her name.

These are all bits of evidence that you can identify to give to an investigator.

One elderly man, whose children all lived far away, had a caregiver who was selling off his belongings and going to take him back to her home country with his money. One of his adult children took some time off work to make a surprise visit and found his father packing up to leave the next day without a word to his family. Can you imagine? The caregiver had the man convinced that she was his family and no one else really cared about him. Needless to say, the son called the police, got an attorney, and went to court to stop them from being able to leave. Do you think this man's father was competent?

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Once you have gathered evidence, most states or counties have a Department of Protective Services that focuses on elder abuse. That is usually the best place to start. You can also contact National Adult Protective Services Association www.apsnetwork.org or National Center on Elder Abuse – Administration on Aging 800-677-1116 www.ncea.aoa.gov. Both of these can groups can give you local numbers to call for help.

If you are suspecting a caregiver who has been hired through an agency, contact the agency directly. Most agencies will take action immediately. If they don't, call the authorities and work with a different agency.

The moral of the story is: Be involved with your aging parents!

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

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discuss branding, future products, and other opportunities that can bring greater success and satisfaction to an author. www.LaunchPadPublishing.com

Killer Cure by Elizabeth Bewley

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

What you will learn

Patient safety expert Elizabeth Bewley exposes the sources of errors in the healthcare system. Health care kills more than 600,000 people every year, the equivalent of the population of Boston.

Get details at **http://tinyurl.com/ch9dgch**

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Patty Rose
Founder and CEO of
Step Away From The Desk
Wellness Programs

Find The Pockets For Fitness

Are you overwhelmed by life, too busy to fit in a workout, or too busy to even *think* about doing some exercise? You are not alone. This is a chronic issue for people in today's high pressure, busy world. Yet, it is crucial to our general health and wellbeing. So, how do you find your way out of what can seem like a never ending cycle which continuously ends the day with you thinking, "I'll try to exercise tomorrow?" It's in the "pockets". By finding small pockets of time in your day, you can begin to implement very doable moves that will raise your heart rate, increase your energy level and help with flexibility. Here are some very easy to do moves that can be done virtually anywhere with no equipment and very little space.

Increase your cardio: Raising your heart rate is what this is all about. What this essentially means is that you are asking your heart muscle to work and as a result get stronger and perform better.

Raise your arms above your heart. By raising your arms above your heart you immediately expect the heart to work harder.

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For even more advanced version you can raise your arms above your head.

Periodically do knee lifts. This is in addition to raising your arms above your head. As you bring your arms back down, reach one knee up to your chest. Shoot for bringing your knee as close to your chest as possible brining your hands or your elbows to meet the knee. Repeat to the other side. Repeat the sequence.

Note: If you need balance assistance, simply hold on to a sturdy surface with one hand while doing the above exercise one arm and alternating the legs.

Do interval training. Interval training is the process of raising your heart rate for a short duration of approximately 2 minutes followed by a cool down period approximately 30 seconds. You will repeat this several times in a row. The purpose of this is that is requires your heart muscle to function optimally by going faster and then regulating itself. It then meets the demands of your body and adjusts its rate.

Here are some activities varied from basic to more advanced you can do to use the “interval training method for your heart health.

While walking, increase your heart rate by doing jumping jacks or going up and down a set of stairs.

Try jumping rope. If you don't have one, just pretend. A person lifting her own body weight from the ground and resisting gravity is a very powerful stimulus for the heart.

ALWAYS remember “safety first”. I encourage you, as the student of your own body to become aware of its functions the best you can. This way, you'll be able to determine if you are working hard enough as well as if you are working too hard. These are a few simple tools you can use to “self-monitor” your activity level which will help you to progress in the safest and most efficient way for you.

Talk Test: The Talk Test can help you monitor what you expecting of your heart muscle. While performing a movement activity you should be

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able to converse within a full sentence or two without huffing and puffing. If you are unable to speak a full sentence, you may be working your heart too hard for its capability. On the opposite side of the talk test, you can monitor if you are challenging yourself enough. If you are able to chat away, having a full blown conversation with ease, you are most likely not moving far enough beyond your comfort zone to make progress.

Song Test: The Song Test, is much like the Talk Test. It helps to determines if your heart is stressed and no longer able to function on a basic level.

This is how to use the Song Test: We all have those songs that we can sing off the top of our head. Think of a song that you have always loved, just recently heard, or that you can't seem to get out of your head. If at any time during your workout, you are unable to recite the words with ease it's a signal that you may be working your heart too hard. Slow down, rest, and let your heart rate decrease. Do not completely stop; maintain your rhythm while decreasing the intensity and or speed.

There is so much that you can do to use those little pockets in your day. You have the power to be your own safety advocate, understand your body and learn what to give it to be as healthy and vibrant as you can. I've always loved the quote, “Slow and Steady Wins the Race” because I believe it's important to be realistic and safe, while doing your best to leave your comfort zone and live a healthy happy life.

Mini Workout Videos and 7 Day Workout Plan are two workout plans you can follow with ease that can support you in filling those pockets of time with healthy activity for you.

Dance. Move. Live!

About the Author

Patty Rose is the founder and CEO of Step Away From The Desk Wellness Programs and StepAwayFromTheDesk.com. She created these programs when she saw a need for

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realistic, mindful approach for women to become empowered, live their best lives and find the source of well balanced happiness – a path that is individual and unique to every woman.

Patty Rose has over 20 years of extensive experience with teaching, performing and creating fitness and motivational programs as well as a B.A. in dance from Hofstra University and several dance and personal training certifications. Teaching happiness through wellness and fitness, Patty is passionate about helping individuals find their own unique power to implement health and fitness and live their best and happiest life. This is a mission that is close to her heart and brings her great joy and satisfaction. She is also the creator and owner of PattyRose.com, DanceMeetsFitness.com, and DanceFitnessPro.com.

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Layout: Jessica Wilson

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