I was in the hospital for the birth of my daughter, my first child. My husband, mother in law and doula were with me, as was my OBGYN. The birth had complications, so my daughter was raced over to an NICU as the doctor took care of me. With the worst over, I was taken to a recovery room. My husband and mother in law left to check on my daughter and have dinner. The doula went to take a break, too.

I was nauseous, though that wasn't certain if it was from the pain killers, the 13 hour labor or other matters. A nurse dropped by and recorded this. She asked me if I wanted medicine for the nausea. I said yes. She asked me if I could take a specific medicine, for which I said I wasn't certain. She gave me the medicine. Then the nurse left. I had a bad reaction to it and the nausea became violent vomiting, less than an hour after child birth.

The doula returned and asked what had happened as I was throwing up. I said I couldn't understand why I was throwing up; I'd asked for and received something to receive the nausea. It turns out that the medication I was given was one I did not tolerate well. The doula checked my chart and said I was given X, but she knew from my medical history I couldn't tolerate it. She called the doctor, since I was indisposed, and had me given a shot of something to control the nausea and counter act what I was given.

Nurses should not rely upon a disoriented or unwell patient to properly recall medical information. Nurses should review patient's charts before giving medication. If someone is reporting unusual symptoms like nausea after child birth, it would be better to have closer supervision in case there are greater problems.

When in labor with my first child, I was given an epidural by someone who was very nervous and maybe new on the job. The procedure resulted in a "wet tap." I think the injection went into my spinal fluid? The pain from the contractions was relieved, but when it came time to push, all the pain was concentrated in one area. I felt like someone was stabbing me in the back. I was forewarned that the wet tap would result in a very bad headache. It did and I endured it for as long as I could before requesting a blood patch to repair the wet tap. As for what I did about it, I suppose I could write the administration of the hospital, but these things happen occasionally, so we didn't. It was very discouraging to have so much pain, though, at a time when I wanted to enjoy my baby. My advice would be to educate yourself on natural childbirth and the risks of epidurals.

My husband was admitted to the hospital on 2/14/2009. He was in severe pain and his white cell count was extremely high. After running tests they found that he had diverticulitis and there was a small rupture in his intestines. He was put on a NPO diet. At the time, neither one of us understood what that meant. The next day they brought him lunch - jello, chicken broth and crackers. Less than an hour after he ate, he went into shock. He had to be rushed to another hospital. They also put him on NPO. I asked them what that meant and they told me that means nothing by mouth. He was not supposed to have ANY food or liquids by mouth. The first hospital could have killed him. About six months after that I went to visit a friend who was in that 1st hospital. There was a note on her door stating that she was also NPO. While I was there they brought her lunch in. I made them take it away and immediately told the nurse about it. I also talked to the administrators and told them that this was the second patient that I had seen this happen with and told them they need to do something about this problem. I don't know if they did take care of it or not but I do know that it is very important to understand what these hospital

terms mean. I could have lost my husband just because I didn't know what kind of diet he was supposed to be on.

One of the worst hospital experiences I can recall was the one in which my late husband was a patient in the local hospital after being stricken with lung cancer. Although we knew his chances at surviving were slim to none the staff did little if anything to spare our feelings. They did not consult either of us and just gave my spouse no respect whatsoever. On the day of his discharge they had his nerves tore up and did nothing to help us prepare for what to do at home-so we did it together on our own and were happier. I did relay my thoughts to them on how careless they are where people's feelings are concerned and how lacking they are in general for caring for their patients.

When I was 17, I had knee surgery. I was nervous, as I had never had surgery before. I was not going under general anesthetic, like most patients would for this type of surgery. Rather, I was given an epidural and carefully monitored due to my low blood pressure. About twenty minutes after my surgery was supposed to start, a nurse came in to wheel me down to the operating room. She called me by the wrong name, but I didn't think anything of it. I figured she had a lot of other patients and it was an honest mistake. A few minutes later, she called me the wrong name again, and told me they were about to put me under for the surgery. That is when I spoke up. I knew that I was NOT supposed to be given general anesthesia due to my blood pressure, so I told her that was a mistake. She finally looked more carefully at my chart, asked how old I was, and asked my name. It turned out, I was NOT the patient the nurse was supposed to bring to anesthesia. Had I not spoken up, I would have received a hysterectomy at the age of 17. I can honestly say that if anything doesn't feel right, ask questions. Know what procedure you are supposed to have, and know about every detail of what is supposed to happen. Hospitals make mistakes all the time, but you can prevent a mistake by asking questions, being your own advocate, and being aware of what is planned for your medical care.

When my mother was admitted to the hospital after a serious stroke, my sister and I had had hospital experiences before. We were both well aware that we needed to be vigilant patient advocates. It was still difficult to pay the kind of constant attention necessary to prevent mistakes. Even with cooperative nurses and doctors, we stopped an incorrect DNR order that could have been tragic, prevented a possible drug interaction with the blood thinner warfarin, and prevented a nurse’s aide from giving her another painful injection when she’d already had a “pic” installed, among other incidents. All this, even then they knew we were watching carefully. You have to take responsibility and coordinate the care yourself. You have to know about palliative care and ask for it if you need it. You have to make friends with the nurses. It also takes the ability to fight the hospital’s old paternalistic “everything’s going to be just fine” culture, patience, quick reflexes sometimes, good recordkeeping, and a willingness to keep asking simple questions until you get good answers.

About a year ago my mother-in-law was hospitalized. After three visits to the emergency room the doctors just kept on giving the same old story that she had a stomach virus, this of course was after the 4 hour wait that customarily comes with emergency rooms. She was in severe pain and extremely nauseated and knew that it was more than just a virus. After being given this same old line for the third time my brother-in-law and I went to the hospital administrator and after must convincing she was

finally admitted for more test. After several rounds of test it came back that she had a very severe infection around her spinal cord that the doctors had missed on all three trips to the emergency room. The Doctor told us it was very fortunate that she got admitted when she did as letting it go for much longer would most likely have caused paralysis and maybe death.

I asked hospital staff exactly what kinds of pills I was receiving daily and why I was taking them. I made sure to ask a lot of questions to make sure I wasn't being misled in any way, and I was completely honest about my medical history and current feelings to ensure I was receiving the best possible care. Any lies you tell could backfire if you are not clear about a condition you have or meds you are currently taking. Whenever I received food, I made sure to eat all of it, or as much of it as I could, because the meal was especially prepared for me and it was important I stay healthy during my stay. I also made sure to communicate properly for payment purposes, because I didn't want to be billed for anything I didn't know about, and I asked questions about if doing certain things would be put on my bill.

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have a story for you:In June 2011 i was having chest pain,dialed 911,ambulance took me to the ER.Lots of tests were performed-including the usual blood tests to check enzymes in the blood.For a while a doctor give me a good look over and questions and I even told him that the pain was easing up.A hour later a nurse came in there and told me to take a handful of pills,she said that blood tests show I was having a heart attack.My first thought was no way,because Im not in extreme pain,I am focused,I feel fine.Soon after that a orderly took me downstairs for a procedure,I demanded to see the ER doctor first,he finally arrived and told me that I am having a heart attack and they need to do a "cardiac catheterization" to see how bad and what condition my heart was in.Soon after that,I woke up,the nurse said that the blood tests was accidentally mixed up and that I wasn't having a heart attack,I was relieved but I told her-you mean that procedure was done for nothing,she said well its good news after all-that it wasn't have a heart attack. As for what I did about the mistake,there wasn't much I could do,turns out with the procedure,they discovered that I have a oversize aorta valve and that's where the pain in my chest is occurring. So the way things turned out,it was a good thing the procedure was performed.

Healing Through Family Unity My story of family advocacy and trust resulting in healing and appropriate treatment for my mother is a great source of pride and comfort regarding the faith our family placed in my brother. In the year 2000, my mother was very ill and her chief complaint was a severe and unrelenting stomachache. She had lots of ailments and was in her eighties, but we knew this was unusual. She could not eat, yelled out in pain and curled up in a ball when spasmodic pain hit her in the midsection of her body. There were nine of us siblings and my oldest brother was an internist, specialist in rare and infectious diseases and a microbiologist. He came from Wisconsin to see our mother and consulted with the treating physicians at the hospital. He told them of a triple antibiotic cocktail that he created to treat patients with similar complaints in his practice. The decided to try the cocktail as he prescribed and it did work very well. The faith that our family, the doctors and most of all, my brother had in his specially tailored remedy was healing for my mother and we were all thankful for this advocacy blessing. The input, knowledge, experience and talents of family who also happen to be healers can turn out to be the best source of advocacy when families tap into their own blessed healers.

When my grandfather was in the hospital he was very out of it and lethargic. He couldn't stay conscious, even when given breathing treatments. I happened to glance at the medications he was getting and realized there was a lot less than usual. When asked it was discovered he was getting another patient's meds and he was getting theirs. My family & I always stay in the hospital with a family member, particularly if they aren't completely with it to avoid mistakes being made and to ensure proper treatment is being given.

My Husband was in the Hospital in 2011. He had a stent put in his heart. It was a very difficult evening, and very very stressful. They put all his belongings into a bag, which I carried from the ER to the surgery waiting room. When he was sent to recovery I was told to leave his things there. It was very late, and knowing he would be in recovery overnight, I went home. When I went to the hospital in the morning he was in another room. He was in great spirits, but all of his things were gone! I went to the desk, and asked what happined. They had no idea!! His clothes, sneakers, cell phone and other personal things. I ended up going back to the ER, the surgery waiting room, and the recoveryroom. No one would help me or offer to help. I gave up after about an hour, and went back to his room. We were very upset. Then I saw an orderly that had been very nice to us when my Husband was brought into the ER. He waved and came in the room to see him. I told him what had happined and he said he would look around. He came back 20 minutes later with the bag! He said someone in housekeeping had put it aside. I was very greatful. He was very sorry, and said that this happines a lot. I had an idea! I went to the ER, and I told them what had happined, and then I told them that when someone comes in to the ER they should give them the bag and a marker to write the persons name on the bag and the area they would be going to or the room # if it was known. They thought it was a wonderful idea, and wondered why noone ever thought of it before. A few months later my Husband had to return to the ER (nothing serious) the first thing they did was give us a bag for his things, and a marker to write his name and area he would be going to. I smiled, knowing that they were using my idea. Simple, but so useful. Mistakes happen all the time, but when you are under stress and are upset you don't need more to upset you.

My personal experience with hospital mistakes isn’t the most serious, though could have been. I have crohn’s disease and am lactose intolerant. I had just undergone a bowel resection surgery. The first few foods given to me were to be bland and soft. For 3 days straight I was given milk based products with every meal. Being as I was just out of a digestive surgery, a mistake like eating iced cream could have cost me my life! At first I thought it was a simple mistake and called to have it corrected. The second time I asked to speak directly to the Nutritionist. She agreed there was something wrong with my food containing milk products. The third time it happened, the Nutritionist herself went and made me a tray of the foods available in the kitchen without milk. She also ordered a retraining of the cart preparation people, and offered me a few dollars credit at the gift shop. My final day at the hospital was to include a meal of solids and if I did well, I could return home. This being 7 days after the last milk-based incident, I felt I was in the clear. The lunch was grilled cheese and tomato soup made with milk, and a 2% carton! I couldn’t believe it! I demanded an apology from everyone who had contact with my tray, informed my doctor of what had happened, and he even gave everyone a “firm talking to”. In reality, I don’t think anything would have improved had I stayed another day.

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8 years ago I was hospitalized for 2.5 weeks. I came in with a growth on the left side of my throat, and was told to get X-rays and MRIs. Right away, I was told it was nothing terminal and that I should check

into the hospital sometime soon. The next day I went to the ER and ended up staying at the hospital in my small town of about 7,000. The growth was not going away, but the doctors did find out that it was an infected lymph node. Eventually, I was shipped to another town 60 miles away, which couldn't do anything either, and finally landing in Chicago Illinois. I was transported between all of these hospitals, yet the process took around 2.5 weeks. I had most doctors stumped and finally was given a pill that cured everything. Still, I was never formally diagnosed. Four years later, I went into the doctor for symptoms of mononucleosis and bacterial infection. I was shipped back to my hometown. This time my family and I took more control of the situation. We actively asked doctors about the process and what they were doing to make it better, rather than just listening to them say they were doing their best. Asking how and why gave us insight into my problem. In this instance, my mother actually ended up calling a different hospital which gave me surgery and fixed the problem in no time. The knowledge that asking questions and being direct (even though the person has a medical degree) can be extremely beneficial and led me to being treated at a faster rate. On top of it all, I gained knowledge of the medical system and the issues that its bureaucracy can solve without taking a step forward. The difference between my two visits came from addressing the problems within the bureaucracy (e.g. asking questions) as well as challenging the bureaucracy within the hospital system (i.e. calling a different doctor to help us).

The day I was in the hospital for a routine arthroscopic knee surgery, the nurse appointed to me had quite a bit of trouble setting up my IV. My veins do not roll and actually protrude rather well from my skin. In short, nurses generally tell me my arms are ideal when I give blood. Sadly, I was poked and prodded a total of 6 times before the nurse had her superior come in to do it. Fast forward several hours and, I am waking up in excruciating pain. The incompetent nurse from before withholds giving me morphine as she says that the anesthesia must wear off first. My knee feels as if I was on the operating table with a scalpel continually carving into my flesh. Finally, another nurse comes and administers my medication. The incompetent nurse attempted to say that I was in pain due to a bad reaction from the anesthesia. I found this rather odd considering I have undergone multiple surgeries in my lifetime and have not once had a problem in another hospital. All in all, I filed several complaints and did not pursue negligence charges after several more incidences of extreme incompetence.

My dad had been complaining of symptoms of weakness, being light headed and a feeling of a flushed, "hot" face for a few days some time ago. He decided to go to the hospital emergency room. While he was there, they did the normal tests for his heart--ECG and tested his troponin levels. His troponin levels were elevated. Troponin is an enzyme released only when the heart has undergone trauma and is usually an indicator of a heart attack. The ER doctor in charge of his case decided he should see a heart specialist the next day. The next day, he did see a specialist, but the specialist looked at his chart and decided that he was not in danger and just gave him a stress test. My dad is 65 years old--he can't run on a treadmill even for 5 mins. The specialist then decided that was sufficient and wrote him a good bill of health. The problem is, a stress test is not accurate (valid) for the 5 mins or less my dad ran. He did not even consider the elevated troponin level which is a definite indicator of heart trauma. But he still sent my dad home, saying there is no problem with his heart. The ER doctor who saw him previously called our home. She told us that the stress test was inaccurate and should be void. The specialist should have given him a heart catheter. If it were not for her, we would never know there was something amiss. She referred us to a different heart specialist whom she trusted and he had blockage in his

arteries. He has gotten a stent to relieve the blockage and is on preventative medicine for his heart. My advice is always ask what the tests are for and why are they relevant.

The baby was born four and a half weeks early. Knowing this the delivery team over bagged his lungs and blew a hold in his left lung. The baby also had multiple life threatening issues. The parents and physicians were able to work together and the baby survived. Added to the trauma unnecessarily was the horrendous care received by the neonatal nurses. One day they told the mother that she couldn't see her baby that day. When asked why, they had no explanation. There did not appear to be anything going on in the NICU. The nurse just seemed to enjoy her power to keep the mother from her baby. Another day, the same nurse gave the mother a bottle of formula to give the baby. It had been heated in a microwave so hot that it was difficult to hold. The nurse told the mother that if she couldn't get the baby to take it, that the nurse would put it down the baby's throat with a feeding tube. The mother would stand up to the nurses, and the father, who was a hospital resident would apologize and not talk to the nurse's supervisors or hospital administrators, because his job was more important to him than his infant. (I have already submitted this once and it didn't seem to take. So I'm resubmitting the text and apologize if it's a duplicate.)

My daughter was born in a military hospital five years ago. There were no unresolved complications during pregnancy. At 37 weeks, my water “broke” – or tore, actually. However, by the time they checked me (which was probably five hours later), I was no longer leaking amniotic fluid, and so they sent me home. (I later learned that this was dangerous.) When I returned to the hospital three days later, I was clearly in labor (and also throwing up and having terrible diarrhea). The doctor refused to admit me, and told me to go home. I did not go home, as I knew that I was in labor, and labored in the waiting room until a nurse finally saw me and admitted me herself. During the time I was pushing, I was told that there was meconium in the amniotic sac and so they would have to check my daughter before letting me see her. Various times while I was pushing, the fetal heart rate lowered, but would then come back up. In the end, I pushed for over three hours (which is never done anymore). When my daughter was born, she was not breathing and her heart was not beating. It took them five minutes to resuscitate her. She spent a day in the NICU, but she improved very quickly and was allowed to stay with me after that. She is a very healthy girl, and so my story ends happily. I was a new mother. I did not have a doula or any advocate with me. My husband did not know that I should not have pushed that long, and so we never knew to insist that something else be done (c-section, for example). I was treated badly through every step of my delivery; even a military hospital should be up to standards and be respectful of their patients. With the birth of my second child, I told the doctor about my first birth (new doctor, different hospital). I told him that under no circumstances did I want that to happen again, and he assured me that it would not. I ended up having a c-section with my second child, and he was very healthy. Every woman should have an advocate in the room with her. The parents are under too much stress/pain/emotion to advocate for themselves.

Preventive Care When Family Is Not There A situation that myself and my four sisters and daughter experienced in the care of my mother while she was in the hospital was the basis of a special care protocol that we developed. My mother was in her seventies and had started showing signs of medically induced dementia. The family, as her supportive caregivers, knew she could be argumentative and easily excitable when not in her home surroundings. Sure enough, within the first 48 hours of her hospital

stay, she did have an altercation with a nurse regarding the administration of her medicines. She told us that the nurse dropped her pills on the floor and picked them up with her bare hands and refused to give her a new and unopened set of medications and refused to wash her hands and put on gloves. We told my mother that we would handle the problem. We talked to the head nurse and she agreed to inform all three shifts to strictly adhere to the following protocol for our mother: 1.) enter her room and wash hands in front of the patient, 2.) put on clean gloves from the dispenser in front of the patient and 3.) bring all medications still in their containers and open them at bedside upon administration. This protocol calmed our mother, prevented spread of infection since she was hospitalized with possible unknown infection, calmed our fears about cross-contamination and hygiene issues, and was a reasonable request of the nursing staff. Best of all, the intermittent episodes of argumentative and accusatory behavior were stopped. This was an advocacy action that my sisters and I took that was a true win-win for nursing administration, the patient and our family. Positive communication goes a long way to resolve conflict and promote harmony.

In 2006, my ex-husband passed out for stooling blood continuously for three days. We rushed to the emergency room. An X-ray was done and he was retained at the intensive care for colonoscopy. The results showed nothing. To my surprise, the doctor assigned did not care for him as he should when he sent him home without digging deeper to find out why he was stooling blood when the results from the tests could not prove it. The illness reoccurred after few days. We rushed back to the hospital. Then, I asked for a different doctor who decided to go further by ordering a Cat-Scan that revealed he had a strange tumor of 3.18 in his belly. According to the doctor, the tumor had cut his intestine which caused him to bleed whenever we wanted to ease himself. The new doctor put him on emergency surgery and within six hours, he was operated upon and the tumor removed.

I went into our local hospital for COPD complications one time and had to have injections of Lasix and pain killers. during one of the injections the nurse had placed several vials of the medications on the night table right next to each other and without looking drew up the first syringe and did the injection and then without looking grabbed a second vial and drew up the second syringe and injected me. She then left to do her other paitints. But in very short time I knew there was something wrong as I could not stay awake. I quickly called the nurse back and tried to tell her something was wrong but she could not understand me. She said I'll let you rest and come back later. This was in the early afternoon, the NEXT day I awoke and asked what happened. The new nurse said that the nurse the day before had injected me with 2 doses of pain meds and not one of each medication like she was supposed to. The nurse was very apologetic and said I was lucky and had to be watched all night to make sure I did not quite breathing due to the overdose. They gave me something but I don't know what to help me thru the night. The nurse was relieved and never did return to attend me again. The hospital said that they would be changing their policy and that all Pain medication given by injection would be drawn up in a labeled syringe in the drug room before it was brought to the patients room. That way it could not be mistaken for anything else or drawn up more that once. In other words they would bring into the room a vial of lasix and an empty syringe for it and a labeled syringe that had the pain medication already drawn up at the same time. This is just one of many mistakes that have occurred to me over the years but it was very scary to me.

About fifteen years ago my mother was diagnosed with an advanced stage of breast cancer. She went through many radiation and chemotherapy treatments. I would like to point out that these specialized treatment facilities were incredible, as were the nurses and staff. Fortunately, the treatments were working and reduced the size of the tumor to the point that her doctor now felt they could perform a mastectomy on my mother's right breast in order to remove the remaining tumor. My mother had a hard, but successful surgery which required several days of recovery in a general type of hospital. We immediately recognized that the nursing staff here was not nearly as caring or attentive as at the specialty care facilities. It was extremely important after the surgery that my mother not have her blood pressure or other vitals taken from her right arm as, because of the surgery, it could cause much damage. We were so frustrated, as we repeatedly had to tell each nurse this even though it was written on the doctor's chart. My family could only think of other patients that were not fortunate enough to have family with them around the clock to make sure that proper care is taken. We finally took it upon ourselves to write on a big sheet of paper, "Do Not Use Right Arm!" and placed it on the medical equipment directly above her. Amazingly, this was not enough, so we even resorted to writing a message on her right arm to prevent the situation. We were just in disbelief that the nurses wouldn't have done something of this sort when they were about to make the mistake the first time. The lesson here is simple: Do not take anything for granted when you or a close one's health is on the line in the hospital! Several years later I had to go in for major shoulder surgery and I made sure the surgeon knew which arm to work on. He even had the nurse mark a big "X" on my arm to make certain.

I went to the ER about two years ago complaining of tachycardia (rapid heart rate). The doctor wanted to give me a drug called Vistaril to help me calm down, as he thought my heart rate was fine (a resting heart rate of 120 bpm is NOT fine!) I asked the nurse, "What is Vistaril? What's the generic name?" "Hydroxyzine," she said. Hydroxyzine is an antihistamine. Most patients will be sedated by antihistamines, but at the time I was actually becoming agitated when I took antihistamine drugs. I explained this and the nurse left with the syringe. The doctor returned and tried to persuade me to let the nurse administer the drug. I kept refusing and explained over and over that I had some pharmaceutical background, that I knew for certain that antihistamines had an opposite effect on me. He became irritated and discharged me without offering any other treatment. The next day I had proper blood work done by my regular clinic. That afternoon I found out I was having a thyroid storm; my TSH levels were eight times higher than normal. I was put on a beta-blocker and given methimazole to regular my thyroid. Knowledge is indeed power. Everyone should have at least a basic understanding of human anatomy and physiology, as well as drugs. I am very glad I do, because it may have saved my life. Since that day I have told many people my story and several have elected to learn more about their own medicines, be they prescribed or over-the-counter. They have learned a lot and it did help one of my friends prevent what could have been a fatal reaction.

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n 1985, a woman came into the hospital in labor. Her and the child's vitals were fine and she was taken to the maternity ward. The doctor was an incompetent little man that glossed over the finer details of her chart before going into her room. The woman was barely effaced, but thad previously notified the staff she wanted a cesarian. The doctor briefly spoke with her and her husband before he ordered pitocin - a medication that induces natural labor. The midwife arrived an hour or so later and ordered for the agonizing mother to be given her epidural for the c-section. As the midwife walked out, as the doctor walked in to check how far effaced she was. She was in a considerable amount of pain before anyone checked on her to find out why the epidural was not working yet. Finally, the screams of pain

were not longer muttled. The midwife then began to scream at the error the doctor made without advicing others, or merely looking at the second page of her chart. A patient should not have to know terminology in order to prevent a similar situation. As a patient, asking questions before being administered anything could have prevented this situation.