Preventable Errors Killed 32 Patients in Oregon Hospitals Last Year

Written On August 25, 2010 By Bob Kraft

This article from OregonLive.com is specific to Oregon, but I have no doubt that it would apply to the entire country, probably in proportion to the number of hospital beds in each state.

Hospitals are trying to improve their safety records, partly because of the work of medical malpractice trial lawyers, partly because of high insurance premiums, and of course partly because they do care about their patients. Still, as more than one doctor has told me privately “a hospital is a dangerous place for a patient.” My personal doctors always recommend outpatient services when possible and hospitalization only when absolutely necessary because too many bad things can happen to a patient while in a hospital. Here are excerpts from this informative article:

At least 32 patients died as a result of preventable errors in Oregon hospitals last year, according to a report released Thursday by the Oregon Patient Safety Commission. The commission, created by the Legislature in 2003, represents a collaborative effort between the state and the health care industry to reduce serious medical errors. Fifty-six of Oregon’s 58 hospitals are participating in the voluntary program.

Hospitals reported 136 incidents in 2009. In 22 percent of cases, patients suffered minimal or no detectable harm. But half of the incidents resulted in serious injury or death. In nine cases, a surgical team operated on the wrong body part or the wrong patient. Surgeons accidentally left objects in patients 21 times – despite the commission setting a target of eliminating this type of error.

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Oregon hospitals made progress in three other patient safety targets set by the 17-member commission: establishing electronic medical records, adopting evidence-based safety practices, and promoting a workplace culture of safety. According to the report, 61 percent of Oregon hospitals have developed electronic medical record systems with built-in error checking and decision support, significantly more than the national average of 51 percent.

And 87 percent of Oregon hospitals met targets for giving surgical patients antibiotics on time, up from 75 percent compliance at the beginning of 2008. Oregon's performance is about equal to the national average on this measure, the report noted.

"There's lots to point to that says people are taking this serious," said Jim Dameron, administrator of the patient safety commission. "People are making a good faith effort to improve quality and make care safer for patients."

Reports of objects accidentally left in surgical patients have declined from a high of 50 in 2007, but the number has persisted at around 40 incidents a year since 2002, leading the commission to conclude that hospitals have not made meaningful progress in reducing such errors. "There is no indication that it's going down, which is frustrating," Dameron said. "Oregon is not unique there. It's a stubborn problem."

Another area of stalled progress is notifying affected patients in writing about every serious adverse event. Doing so is a requirement of participating in the patient safety program. Last year, hospitals provided written notification about half of the time, 43 out of 80 cases in which it was required, according to the commission's report.

"Most hospitals do a pretty good job of oral disclosure, but clearly they don't do the written notification," Dameron said. Diane Waldo, a registered nurse and director of quality and clinical services for the Oregon Association of Hospitals and Health Systems, said hospital leaders worry that written notifications could alienate patients.

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“They’ve made a big effort to address this and meet with patients and families,” Waldo said. “They believe a letter could be received as cold and wonder, is it helpful at all to the relationship?”

It’s possible that hospital leaders are concerned about exposing their institutions to greater legal liability.

Eight hospitals have shown that compliance is possible. They’ve notified patients of adverse events in writing for every serious harm event since reporting began in 2006, according to the commission.

The reporting system may underestimate the extent of preventable errors. For instance, hospitals reported eight health-care-associated infections to the commission last year — far less than the number identified in the state’s independent infection reporting program. Among intensive care patients alone, that program identified 75 central-line-associated blood stream infections. The patient safety commission asks hospitals to report “serious harm” infections only, which could account for part of the discrepancy. But the commission asserts that hospitals probably underreport serious infections in the patient safety program.

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