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Medical errors cause at least 18 deaths, report says

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BEND, Ore. (AP) — Medical errors caused at least 18 deaths at Oregon hospitals last year, according to a draft state report.

The Oregon Patient Safety Commission, created by the 2003 Legislature, began asking hospitals to voluntarily report so-called "adverse events" last spring.

From May through December, 27 hospitals reported 53 adverse events — with about 60 percent causing serious harm to patients or death.

Hospitals are not penalized for reporting medical errors and names of the hospitals that report events are not made public.

The events included surgical errors, such as leaving sponges and guidewires inside patients, and operating on the wrong site or performing the wrong surgery. They also included patient falls, infections, equipment problems and medication errors.

The goal is to reduce the risk of medical errors or problems and to encourage discussion about them, said Jim Dameron, the safety commission's executive director.

"Of our first 53 cases, 10 of those reports were around retained objects, leaving in a sponge, leaving in a guidewire," during surgery, Dameron said. "The literature shows it's not the number one problem out there for errors. But it sure rose to the top of our list. We want to talk to hospitals about how you organize surgeries."

Dameron said the draft report released at the commission's monthly meeting provides an initial summary of results, but has little analysis of what the results mean. He hopes to have a final version completed by early February.

From his initial review, Dameron said, it's difficult to know if the reporting system is returning accurate information.

"I think based on what I've seen from other states, it's fewer reports than I would ultimately like," he said. "I don't know what the right number is."

Gwen Dayton, executive vice president and general counsel for the Oregon Association of Hospitals and Health Systems, said she thinks the fact that a majority of hospitals in the state have signed on is a positive sign for the commission. But, she said, the commission could use improvement in some areas.

"I think there are things we can do to make it work better. Additional clarity in what is a reportable event would be helpful," she said. "We don't want underreporting because of lack of clarity."

Dameron said hospitals have not received copies of the draft version but will receive the final report.

So far, 53 out of 57 hospitals in the state have voluntarily signed up to participate in the reporting program.

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