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State starts project to track serious hospital mistakes

Public health - Participation is voluntary and the confidential information will be used to reduce errors

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The Oregon Patient Safety Commission on Tuesday launched its effort to get hospitals to report - and reduce -- serious medical errors.

The Oregon approach, unique in the nation, is a mix of voluntary and mandatory features. Hospitals can choose to participate, or not, but refusal to join will be reported on the commission's Web site.

The 17-member commission unanimously adopted rules and guidelines for that process Tuesday in a three-hour meeting in Portland.

"Milestone," said commission Chairman Dr. Glenn Rodriguez, who is chief medical officer in Portland for Providence Health System, after the unanimous vote. He called the new rules "a starting point. We will find ambiguities, but we'll have to work with this."

The Oregon commission relies on voluntary reporting because its members believe that doctors, nurses and hospitals B1 are more likely to disclose errors and share data if they can do so confidentially and without fear of penalty. They say it's more important to look at root causes and prevent an error from recurring than to affix blame.

Jim Dameron, the commission's administrator, said he hopes half of the state's 59 hospitals will be reporting by June, and most or all of them by the end of the year. Medical mistakes in U.S. hospitals kill 44,000 to 98,000 patients a year, a 1999 study by the Institute of Medicine found.

The report, "To Err Is Human," concluded that most serious medical errors result from communication breakdowns amid the growing complexity of today's health care systems. The root cause is often a system problem, such as on-the-job stress, sleep deprivation or overuse of abbreviations in medical paperwork.

The Legislature created the Patient Safety Commission in 2003 and charged it with "reducing the risk of serious adverse events occurring in Oregon's health care system and . . . encouraging a culture of patient safety in Oregon." The governor appointed the commission members, who include consumers, doctors as well as representatives of hospitals, nursing homes and pharmacies.

It has taken more than two years to assemble the commission and gear up for its reporting system. The hardest task was defining "serious adverse event" -- the panel's term for harmful mistakes.

Reportable mistakes range from drug errors to botched surgery. But defining "serious adverse events" in medicine is not always easy. For example, under the rules, participating hospitals must report a prescription for the wrong dose of a drug -- but not "reasonable differences in clinical judgment on drug selection and dose."

Half of all states require reporting of hospital errors, but the rules and definitions vary widely. Wisconsin records fewer than 100 reports a year, Dameron said; Pennsylvania logs about 150,000.

Information that Oregon hospitals report to the commission is confidential, subject to neither legal discovery in a lawsuit nor the state public records law. By law, such notification cannot be used as an admission of liability in court, but it does not prevent a patient from filing a malpractice suit.

The commission will not create hospital "scorecards," but it will post statewide data and list participating hospitals on its Web site: www.oregon.gov/DHS/ph/pscommission. Oregon's new reporting rules eventually will apply not only to hospitals, but also to nursing homes, pharmacies and outpatient surgery centers. The commission gets no state tax dollars and pays for its work through donations and fees paid by participating hospitals.

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