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Pharmacy mistakes seldom reported

Large chains mostly unwilling to sign on to voluntary system

By peter korn

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A state program aimed at reducing medical mistakes is having trouble getting pharmacies to voluntarily report serious errors, which national studies suggest happen in as many as one in 50 prescriptions.

Jim Dameron has a problem.

And when Dameron, the soft-spoken administrator of the Oregon Patient Safety Commission, has a problem, patients in Oregon's hospitals and other health care settings generally have a problem, too.

The safety commission was created nearly four years ago by the state Legislature to help Oregon hospitals reduce medical mistakes – the headline cases of surgeons operating on the wrong leg, but also the more mundane and common errors, such as pharmacists producing the wrong drug because they misread the doctor's handwriting on the prescription form.

Dameron has had success – nearly all the state's hospitals have agreed to participate, even paying participation fees to fund the commission's work. Many nursing homes and more than half of the state's outpatient surgical centers also have signed on.

Dameron's problem: the state's pharmacies, which generally are refusing to participate in the patient safety program.

There are about 450 chain-store pharmacies and 300 independent pharmacies in Oregon. Dameron has been able to get only 100 pharmacies to commit to the commission's program. And about half of those 100 come from Fred Meyer, the only chain to sign on.

"Fred Meyer, to their everlasting credit, has said, 'We think this is a good idea,' " Dameron says.

"They think they're doing a good job with quality, and they think they can still learn some things."

National studies show that serious medication errors at pharmacies can occur as frequently as one in 50 prescriptions. Studies also show that most of the mistakes made in pharmacies are preventable.

But the commission's program can't get started with only 100 out of 750 pharmacies participating, Dameron says. He figures the program needs at least two or three more of the eight pharmacy chains operating in the state to participate.

"It's a hard sell," he says. "There's a lot of risk assessment going on about how dangerous it might be to report. I don't know if we're going to be able to convince them."

Some sign on 'in name only'

Jim Thompson, executive director of the Oregon State Pharmacy Association, says that eventually many of the local independent pharmacies might sign on, but that getting the chain pharmacies involved means Dameron will have to move through levels of bureaucracy that usually end up at a legal department.

"They're leery," Thompson says. "Why does a multistate corporation want to get involved in something like this in one state and expose themselves to liability? They're going to drag their feet until somebody beats them into submission."

And the safety commission doesn't have the club – statutes requiring participation – that could be used to do that.

For that matter, Dameron says, he doesn't have a lot of leverage to get hospitals, nursing homes and surgical centers that have agreed to participate to actually send in reports on all their adverse events. In fact, Dameron knows they don't.

Dameron says the state's hospitals sent in about 90 adverse-event reports last year. The reports are supposed to cover major preventable events that result in death or serious injury or come from a standardized list of lesser events that experts agree never should happen.

But Dameron says he knows the number of reports is low, based on national studies of the prevalence of hospital errors. And a few hospitals, he says, participate "in name only," having never sent in a report about an error they made.

"It appears to be serious underreporting," Dameron says. He says the reports that are made usually focus on the mistakes that are more easily identified, such as sponges left in patients after surgery. The commission hears little about infections acquired in the hospital and patients getting the wrong medication.

Others mandate reporting

When the patient safety commission was formed, many in health care circles thought Dameron wouldn't be able to get hospitals to participate at all. They had a reason to think that.

Nationally, 26 states and the District of Columbia have set up mandatory adverse-event reporting systems. Only one state – Oregon – has an exclusively voluntary system in which hospitals can participate or not.

Nevertheless, Dameron and his staff have convinced 55 out of the 57 hospitals in the state to join in the commission's effort, including Portland's six hospitals.

The commission, in return, sends reports out to hospitals based on the medical errors that have been reported to the commission.

The reports pinpoint the systemic problems that led to the reported adverse events and are intended to help other hospitals avoid making the same mistakes. The commission keeps confidential the reports that come in from the hospitals.

Diane Rydrych oversees Minnesota's adverse-event reporting system as the assistant director of the division of health policy for the Minnesota Department of Health.

She says that all states are having trouble getting hospitals to report their mistakes. But she says that Minnesota's mandatory reporting system gives her leverage that Dameron simply doesn't have.

In Minnesota, if hospitals don't cooperate, they can be sanctioned, even to the point of having their licenses revoked.

Even so, Minnesota's hospitals and surgical centers reported only 125 adverse events last year – about equal per capita to the 90 reported in Oregon.

"It's a different position for them to be in, to have a law that's voluntary," Rydrych says. "You really want to encourage compliance, but you don't have any way to require it. I'm fortunate that we are not in that position. It's nice to have the support of a law that requires participation."

Dameron says he's convinced that as hospitals get used to the idea of reporting their mistakes, more reports will come in. And he's not convinced that a mandatory system would be an improvement.

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Families rarely hear about serious errors

The Oregon Patient Safety Commission not only asks hospitals to report their medical errors to the commission; hospitals that agree to participate in the voluntary reporting program also are required by statute to report serious adverse events to patients or their families in writing.

They don't do that very often, according to commission administrator Jim Dameron.

Dameron estimates that in 2007 Oregon hospitals abided by the state's written notification policy in only about three or four cases out of 10.

He says that's what the hospitals themselves are telling him. In 2006, he says, the number of hospitals willing to notify patients or their families was as high as seven in 10.

As to why more hospitals aren't complying with the notification statute, which guarantees hospitals that their notification letters cannot be used against them in court, Dameron says, "Usually they say they learned of the event too late or the patient died and had no family."

Larry Wobbrock, a Portland medical malpractice attorney, says even four out of 10 sounds high to him.

"I've never seen any hospitals tell anybody, 'We've made a mistake' – in writing or otherwise – in 31 years," Wobbrock says.

Wobbrock says that even if the letter from the hospital can't be used in court, it still could alert patients or their families that there is something they might want to pursue with an attorney.

"They probably don't want the patients to know they've been malpracticed on," Wobbrock says. "It doesn't mean you couldn't prove the case otherwise."

Dameron says the commission's statutes leave the hospitals room to notify patients without disclosing too much.

"A letter doesn't have to say 'We did this horrible thing, please sue us,' " Dameron says. "It can say, 'We're committed to understanding what happened. We're sorry it happened, and we'll let you know.' "

Gwen Dayton, general counsel for the Oregon Association of Hospitals and Health Systems, says that the association supported putting the written disclosure notice.

"What I hear is hospitals are engaged in trying to do it," Dayton says of notifying patients and their families.

Dameron says that the voluntary nature of the commission means he has little leverage that would force hospitals to comply with the notification statute. And that places Dameron in a delicate role in dealing with the hospitals.

"There's that sweet tension of how do you hold them accountable when they can just say, 'Enough already,' " Dameron says.

– Peter Korn

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