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Hospital plan aims to reduce medical error

BY DAWN WALTON, CALGARY

Canadian hospitals are embracing "a prescription" for reducing the number of medical mistakes that routinely kill and injure thousands of patients across the country each year.

The six-point plan, which involves things as simple as frequent hand-washing or double-checking medication, was formally announced yesterday as Canada's response to a bombshell study that found one in 13 patients was harmed while in hospital.

"This is going to make a difference," said Peter Norton, head of the department of family medicine at the University of Calgary, who co-wrote the groundbreaking report. "It's time to improve the safety of our system."

The study, which was published last year in the Canadian Medical Association Journal, found that between 9,250 and 23,750 patients died in Canadian hospitals in 2000 as a result of a mistake made by a health-care worker.

The report also found that 7.5 per cent of Canada's 2.5 million hospital patients experienced at least one "adverse event" or error that led to disability or death or that lengthened their hospital stay in 2000.

The Canadian study described a variety of medical woes including patients who had contracted infections while in hospital, received the wrong medication or dose or had foreign objects left in them after surgery.

Ross Baker, a health-policy management professor at the University of Toronto who co-wrote the study, said Canada's problems are similar to those found in the United States.

Last December, the U.S. implemented a strategy to curb such incidents, which is now the basis for Canada's plan and is dubbed "safer health care now," said Phil Hassen, who heads the federally funded Canadian Patient Safety Institute.

Canada's strategy includes:

- Deploying a critical response team at the first sign a patient is getting worse.
- Preventing avoidable heart-attack deaths by providing consistent care based on up-to-date research.
- Checking and double-checking medication with the patient, on the chart and in an electronic database. Most mistakes happen when patients are transferred between home and hospital. The federal government announced yesterday that it would hold consultations to develop a mandatory system for reporting adverse drug reactions.
- Preventing the spread of infections. Already some health-care workers carry bottles of hand sanitizer to promote proper hygiene.
- Preventing postsurgical complications by making sure patients have the right medications when they leave the hospital. For example, about 90 per cent of heart-attack patients should be prescribed beta blockers after they leave hospital, yet a recent study showed just half had been, Dr. Baker said.
- Preventing pneumonia by doing things such as elevating the heads of patients on ventilators.

"Implementation of these strategies can improve care and save lives," Dr. Baker said.

So far, more than half the hospitals, and health-care regions that run them, have signed on to the Canada-wide program. It will be studied through December, 2006, to evaluate its success in reducing the number of medical mistakes.