

Report: Deadly errors made in intensive care

More than 38,000 mistakes reported in U.S. between 2000 and 2004



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WASHINGTON - A patient given three separate prescriptions for blood thinners. Patients who do not get needed insulin. Someone given seven times the proper dose of a heart drug.

These mistakes are typical of more than 38,000 errors reported from U.S. intensive care units between 2000 and 2004, and documented in a report from the U.S. Pharmacopeia on Wednesday.

"There were actually more than 950 different medications recorded in these error reports," John Santell, a pharmacist who said in a telephone interview

"This tells us that there are so many different medications being used to treat a wide variety of illnesses, making it a big challenge for any doctor, nurse or pharmacist to be knowledgeable about these drugs," he added.

Santell is director of Educational Program Initiatives for the Center for the Advancement of Patient Safety at U.S. Pharmacopeia -- a non-profit group that sets standards for drugs and pharmacy procedures.

The report helps support the logic behind a World Health Organization initiative to reduce such errors, which the U.S. Institute of Medicine estimates kill as many as 98,000 people every year in the United States alone.

The U.S. Food and Drug Administration estimates as many as 1.3 million Americans are injured by medication errors every year. The Health and Human Services Department has been working on a nationwide electronic prescribing, records and inventory control system to help reduce those errors.

Santell says the USP study relied on voluntary, anonymous reports from 503 hospitals of differing sizes from across the United States. It is not necessarily representative of the average U.S. intensive care unit, he said.

They reported 38,371 errors in ICUs between 2000 and 2004. These resulted in 14 deaths and included 68 "very serious errors."

Heroic interventions

"That means that the patient either ended up with permanent harm or the error caused the patient to receive some sort of heroic intervention necessary to save life, such as CPR (cardiopulmonary resuscitation) or surgery," Santell said.

About 24 percent of the mistakes originated with the original prescription, and another 24 percent occurred in transcribing that prescription, including messy handwriting and unclear abbreviations, according to the report.

Santell said the single most common error involved insulin -- forgetting needed insulin, giving too much, too little or the wrong kind.

New technology, such as installing computers for keeping track of prescriptions, added another opportunity for errors, Santell said.

A second big area for mistakes was in running complicated intravenous infusion or IV machines, said Santell. "There were mix-ups in IV tubing, in pump setup," he said. "Each drug has its own dose and rate. Then a person is on three, four, even five different IVs, all with different rates."

Santell gave details of specific cases, including a patient given a blood-thinner in the emergency room -- a common procedure for heart attack or stroke patients.

"The patient then was transferred to the coronary care unit where a physician, unaware that the patient was on this IV, ordered a second blood-thinner, which is not supposed to be given with the first drug," the report said.

"Later, an on-call physician, unaware that the patient was receiving the second blood-thinner, ordered another dose of the first blood-thinning IV," it added.

"The patient received both blood-thinning drugs for 15 hours, which resulted in massive bleeding. The patient then had to be given a blood transfusion, as well as placed on a ventilator."

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