Richmond Times-Dispatch

Medical errors described as a continuing problem

TONY KING

Sorrel King, formerly of Richmond, is developing a **patient** journal that will also be available as an iPhone application.

Related Info

For more information

The Josie King Foundation: http://www.josieking.org
Virginians Improving Patient Care and Safety:
http://www.vipcs.org
Virginia Business Coalition on Health: http://www.myvbch.org

TAMMIE'S BLOG: Your Health

By Tammie Smith
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Hospital staff have a name for those patients and family members who write down every detail of what's being done to a **patient** during a hospital stay.

They call them scribblers.

Scribblers make hospital staff uncomfortable, said health-care **safety** advocate Sorrel King, one of the speakers yesterday at a **patient-safety conference** in Richmond attended by hundreds of health-care workers.

King, who lost a daughter in 2001 to a medical error at one of the country's top hospitals, thinks scribblers have the right idea.

"It's so important to know the names of the doctors and nurses who are caring for us every day," said King, formerly of Richmond, holding up a copy of the **patient**-care journal she has developed so scribblers have an alternative to memo pads.

"You all -- doctors and nurses--talk about daily goals every day," she told the audience in the Richmond Marriott ballroom. "Tell us. What are our daily goals? To eat a healthy meal? To get the potassium level down? To walk around that unit? Medications. What are the side effects?"

In a few weeks, the **patient** journal will be available as an application for iPhones, she said.

Ten years after a landmark report on medical errors from the Institute of Medicine suggested that close to 100,000 people in the United States die every year because of medical errors, speakers yesterday said many hospitals still are not up to speed.

Virginians Improving **Patient** Care and **Safety**, a coalition of health-care organizations created as a result of that 2000 report, was co-presenter of yesterday's **conference** with the Virginia Business Coalition on Health.

"Have we made progress in **patient safety**?" asked Leah Binder, chief executive officer for The Leapfrog Group, a national **patient-safety** group. Yes and no, she said.

Binder said 1,200 hospitals participated in a 2009 **safety** practices survey, with mixed results.

For instance, hospitals were asked if they had a hand hygiene program that focused on reducing risk from health-care-associated infections.

Nationally, 59 percent of hospitals did. In Virginia, 44 percent did, Binder said.

"This should be 100 percent," Binder said. "This is not hard."

She said only 10 percent of surveyed hospitals were using computerized systems for ordering medications and tests, up from 5 percent in 2001.

Such computerized systems significantly reduce risk of medication errors, like the one that killed King's 18-month-old daughter. Josie King died when a nurse gave her a medication dosage that a doctor had verbally canceled that morning, Sorrel King said.

"I believe we are getting safer," King said. "We are getting better. The culture is changing. . . . Medical and nursing students, they are talking about this stuff."

Contact Tammie Smith at (804) 649-6572 or TLsmith@timesdispatch.com .

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Flag Comment Posted by NB on May 28, 2010 at 2:33 pm

It’s terribly sad that the writer of this article chose to treat Jose King’s death as little more than an afterthought and did not identify the hospital or the tragic details of her death. Jose King died at Johns Hopkins in January 2001 following terrible medical errors by the medical staff and their refusal to listen to Ms. Kings repeated pleas that something was terribly wrong with her daughter. Jose was given no liquids for an extended period of time and was given strong narcotics by the nursing staff after the doctor had ordered

that narcotics be discontinued. The result was that Jose died from acute dehydration and methadone poisoning. It was a terrible and completely avoidable tragedy. Ultimately, the only person responsible for your healthcare (and your child's) is YOU. Never be afraid to ask healthcare workers tough question and demand answers.

Flag Comment Posted by concerned on May 28, 2010 at 11:13 am

Jeremiah,
I too am going through the exact same thing in caring for my elderly parent. Too many doctors and nurses involved who are not talking to each other and give conflicting advice and false information. I have to insert myself in the middle because they will leave me out of discussions. They give me erroneous information all the time. The left hand does not talk to the right hand. I am the decision-maker and Principal Responsible Party, but decisions are made all the time without my knowing or input. Then they tell me one thing and another to each other, if at all. Even though our hospital of preference is one, they send my parent to another, which is filled with errors and incompetence.

Oh, and a visit to the doctor (gp) simply means an extra unneeded step in the process to direct back to the hospital for another "test" they should have done the first time. From now on, I am going to be sending my parent to the emergency room at St. Francis, and pay the extra, which is well worth it in terms of less aggravation, less time, and fewer errors.

Imho, this all has to do with getting Medicare/Medicaid funding. That is all the medical profession cares about today. Funding.

Flag Comment Posted by JeremiahJohnson on May 28, 2010 at 10:59 am

This is one article that everyone in Richmond should read. I'm going thru a situation now that's involved multiple docs and hospitals in the area and what I've experienced scares me! Carelessness and misinformation run rampant and docs/nurses/adminstrative staffs are surly and could care less about their performance; they act as though patients are just obstacles!

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