Hundreds of hospital fatalities 'avoidable'

By Rebecca Smith, Medical Editor
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One third of deaths in hospital investigated by a patient safety watchdog could have been avoided, claims a report released today.

The National Patient Safety Agency looked into 1,804 fatal hospital incidents reported to it in 2005. It found that 576 were "potentially avoidable" if there had been better communication between staff, faster recognition of the patient's deteriorating state, improved training and more accurate interpretation of test results.

Some 425 of the deaths investigated by the NPSA in 2005 were in acute or general hospitals. Of these, 71 were reported to be related to diagnostic errors, in 64 cases the patient's deteriorating condition was not recognised or not acted upon, and 43 involved a problem with resuscitation after cardiac arrest.

The remainder were connected to medication errors, suicide or still-birth.

In 14 of the patients who deteriorated, no checks had been made on them for a prolonged time and changes in their vital signs such as blood pressure, heart rate or temperature were not detected.

In a further 30 cases, the checks had been made but staff either did not recognise the patient's worsening condition or they did not act. In 17 other cases help was sought but there was a delay.

Professor Richard Thomson, the NPSA's director of epidemiology and research, said: "These are not new concerns but more effort is needed to recognise and act upon them.

"This work helps us to further raise the profile of these issues and support a programme of activities involving a range of national organisations and individual experts. Every preventable death is a tragedy, not only for the family but for the staff involved."

The report says all staff should be trained in dealing with cardiac arrest. Among the 43 deaths involving resuscitation, the study found that many of the incidents suggested that "medical and nursing staff did not have the depth of knowledge and skills required".

It said: "In most cases the delay in starting the resuscitation was reported to be because staff did not recognise the acute situation, failed to call the resuscitation team or did not make an attempt themselves to resuscitate the patient."

Fourteen reported incidents related to the use of equipment. One such report said: "During a cardiac arrest, defibrillator found not to have the correct leads and paddle

to fit the defibrillator. This caused a delay of approx five minutes during the arrest."

During 2006, the Medicines and Healthcare products Regulatory Agency (MHRA) received 141 reports of adverse incidents involving defibrillators. Many were related to problems with electrodes or batteries.

In the first six months of 2007, the MHRA received 86 reports and receives an average of 14 incident reports a month on these devices, some of which are duplicate reports from manufacturers.

The NPSA report said: "Several of these incidents occurred in resuscitation situations, when user error may have contributed to the incident, for example, incorrect connection of suctioning tubes."

The report stresses that there may be many similar cases which have not been reported to the NPSA.

Researchers said that about 13 million people are admitted to hospitals in England and Wales each year.

The findings come as the National Institute for health and Clinical Excellence releases guidance to clinicians on how to manage patients in hospital who deteriorate rapidly.

It emphasises making a complete medical assessment of the patient, regular monitoring and improving communication between staff.