# SOUTHWESTERN NEWS

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## BLOOD-ERROR REPORTING SYSTEM TRACKS MEDICAL MISTAKES

DALLAS – November 22, 1999 – When a hospital employee's error results in a patient's death, it's news. But when an error is caught before something bad happens, it's not news.

A group of UT Southwestern Medical Center at Dallas and Columbia-Presbyterian Medical Center researchers, however, thinks that every mistake, even those caught before tragedy, provides important lessons that could prevent the next headline.

The Medical Event Reporting System for Transfusion Medicine, MERS-TM, is a UT Southwestern- and Columbia-based, National Institutes of Health-funded project that seeks to stop blood-transfusion errors before they happen.

Dr. James Battles, professor of biomedical communications, oversees the project at UT Southwestern in the Office of Medical Education.

Battles said there are 46,000 deaths due to auto accidents a year. But it is estimated 180,000 people die each year due to medical error, some of which are blood transfusion errors.

"We want to identify how to prevent these deaths," Battles said. "We want to find and reduce patient risk."

With a $4 million grant over the next four years, the research team is working with several affiliated organizations -- including Parkland Health & Hospital System, Carter Bloodcare and the American Red Cross -- to track transfusion error through a no-fault, standardized reporting system. After testing the model in a small prototype, the group recently began testing it nationally through organizations such as the Red Cross. The project has caught the attention of Congress and the Surgeon General.

"There has not been a study of this scope in medicine," Battles said. "The whole purpose is to save as many lives as possible."

Doctors, nurses and other health-care personnel involved in transfusion errors or near misses report the problems within their local organizations, which then transfer their data to the MERS-TM team.

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"Fatal accidents get our attention because they are a rare event," Battles said. "But for every accident, there are many, many near misses."

By tracking and comparing the near misses, the team hopes to learn how the errors and near errors are happening. For example, by analyzing near misses at one clinic, researchers learned some patients were using false identification to receive medical attention.

Most hospitals already track such errors, but Battles said hospital personnel often do not report near misses in order to avoid punishment. In the new reporting model, those who file reports are not punished.

"The problem is that not reporting the event doesn't reduce the risk," Battles said. "The more information we have, the more likely it is we can prevent the event."

Another goal of the program is to standardize transfusion-reporting systems nationwide. Currently, every organization has its own reporting system.

"That makes it very difficult to trend and track the events," said Quay Mercer, research study coordinator at UT Southwestern. "The completed reports are filed, and the information is not used. We want to create a nationwide databank where information can be stored and easily analyzed."

Such nationwide systems have long been in place in other potentially risk-prone fields like aviation.

Ultimately, UT Southwestern researchers said, they hope the MERS-TM project will encompass all transfusion services and blood centers and eliminate common errors.

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