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National study on the frequency, types, causes, and consequences of voluntarily reported emergency department medication errors.

June 29, 2011
Pham JC, Story JL, Hicks RW, et al. National study on the frequency, types, causes, and consequences of voluntarily reported emergency department medication errors. J Emerg Med. 2011;40(5):485-92. doi:10.1016/j.jemermed.2008.02.059.
https://psnet.ahrq.gov/issue/national-study-frequency-types-causes-and-consequences-voluntarily-reported-emergency

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A 2006 Institute of Medicine report highlighted growing concerns about the state of emergency department (ED) care, particularly around overcrowding and its impact on safety. Medication errors are a known safety threat, and this study provides a cross-sectional perspective using reports from the MEDMARX database. Investigators found that physicians were responsible for 24% of errors while nurses were responsible for 54%. The administration phase was the most error-prone, and the most common error type was improper dose/quantity. Interestingly, computerized provider order entry was noted to cause 2.5% of the errors reported. The authors advocate for future interventions to improve medication safety in the ED. A past AHRQ WebM&M commentary discussed a near miss medication error in the ED that illustrates the many safety issues that contribute to this high-risk care setting.