

Out-of-hospital medication errors among young children in the United States, 2002–2012.

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Smith MD, Spiller HA, Casavant MJ, et al. Out-of-hospital medication errors among young children in the United States, 2002-2012. *Pediatrics*. 2014;134(5):867-76. doi:10.1542/peds.2014-0309.

<https://psnet.ahrq.gov/issue/out-hospital-medication-errors-among-young-children-united-states-2002-2012>

[Medication errors](#) are prevalent among [children](#), especially those younger than 6 years old. Analyzing a database of telephone calls to poison control centers in the United States, this study found that medication errors are frequent. Adverse drug events are most likely with liquid medications and often occur because of confusion with [units of measure](#) or administration of an incorrect medication. These findings support [prior studies](#) which revealed the challenges related to [liquid medication dosing](#). Of concern, compared with older children, infants (children under age 1) were twice as likely to die or require admission to the intensive care unit for medication errors. American Academy of Pediatrics [guidelines](#) on standardized units of measure may address some of these administration errors. A previous AHRQ WebM&M [commentary](#) discusses medication safety in pediatric medicine.