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A review of adverse event reports from emergency departments in the Veterans Health Administration.

March 18, 2020
Gill S, Mills PD, Watts BV, et al. A Review of Adverse Event Reports From Emergency Departments in the Veterans Health Administration. J Patient Saf. 2021;17(8):e898-e903. doi:10.1097/pts.0000000000000636.
https://psnet.ahrq.gov/issue/review-adverse-event-reports-emergency-departments-veterans-health-administration

This retrospective cohort study used root cause analysis (RCA) to examine safety reports from emergency departments at Veterans Health Administration hospitals over a two-year period. Of the 144 cases identified, the majority involved delays in care (26%), elopements (15%), suicide attempts and deaths (10%), inappropriate discharges (10%) and errors following procedures (10%). RCA revealed that primary contributory factors leading to adverse events were knowledge/educational deficits (11%) and policies/procedures that were either inadequate (11%) or lacking standardization (10%).