PSNet
PATIENT SAFETY NETWORK

Learning from diagnostic errors to improve patient safety when GPs work in or alongside emergency departments: incorporating realist methodology into patient safety incident report analysis.

January 12, 2022
Cooper A, Carson-Stevens A, Cooke M, et al. Learning from diagnostic errors to improve patient safety when GPs work in or alongside emergency departments: incorporating realist methodology into patient safety incident report analysis. BMC Emerg Med. 2021;21(1):139. doi:10.1186/s12873-021-00537-w.
https://psnet.ahrq.gov/issue/learning-diagnostic-errors-improve-patient-safety-when-gps-work-or-alongside-emergency

Overcrowding in the emergency department (ED) can result in increased frequency of medication errors, in-hospital cardiac arrest, and other patient safety concerns. This study examined diagnostic errors after introducing a new healthcare service model in which emergency departments are co-located with general practitioner (GP) services. Potential priority areas for improvement include appropriate triage, diagnostic test interpretation, and communication between GP and ED services.