

# LINNEAUS EURO-PC

## WP 2 Developing a Taxonomy of Errors for Primary Care

Kerstin Klemp

LINNEAUS EURO-PC



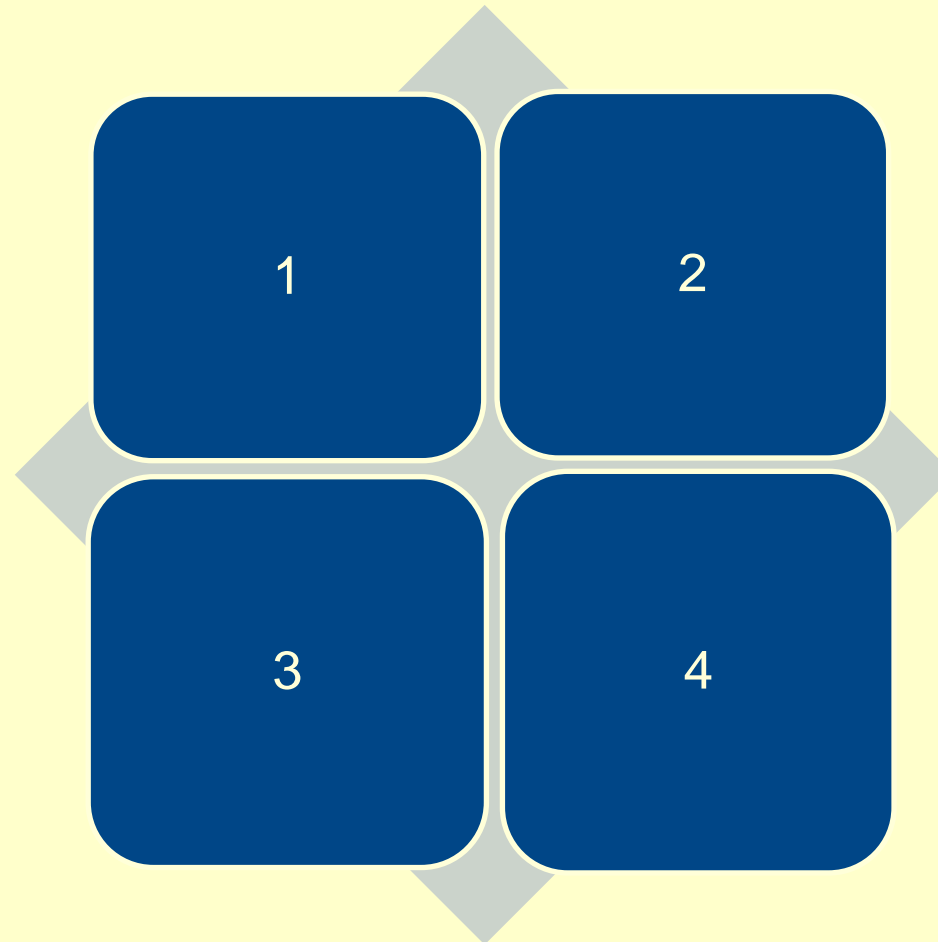
Learning from International Networks about Errors and Understanding Safety in Primary Care

Institut für  
**Allgemein-  
medizin**

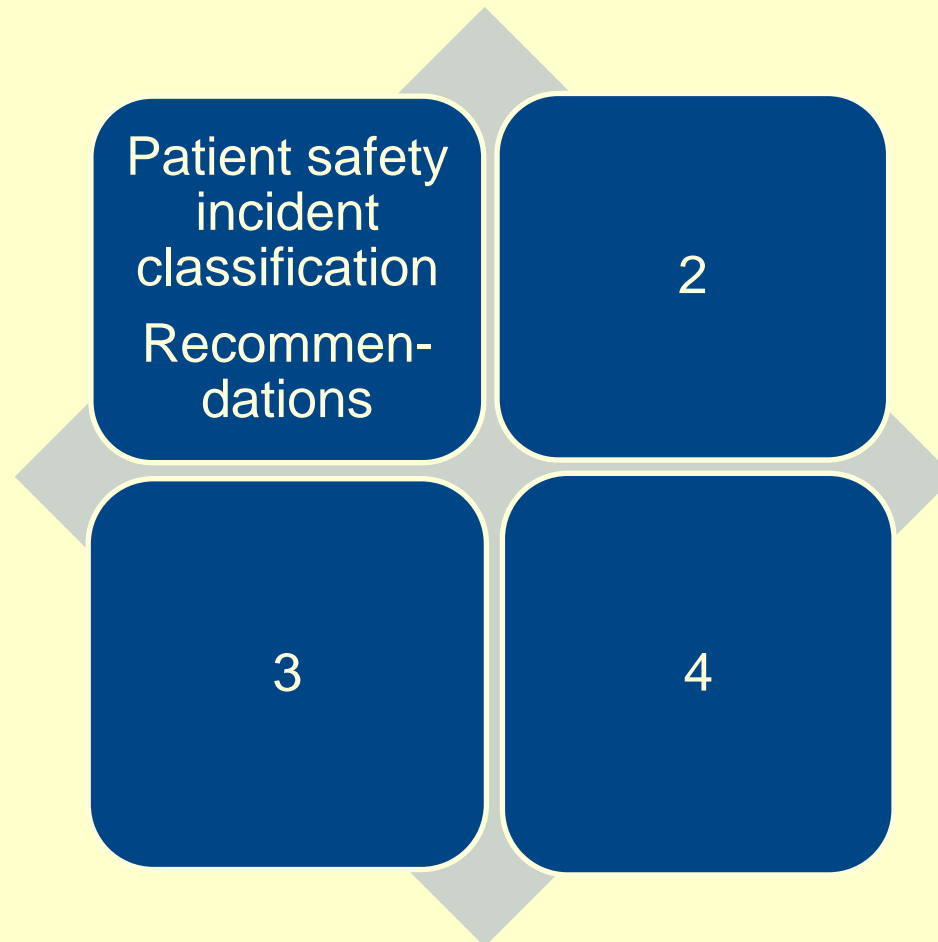


Johann Wolfgang Goethe-Universität, Frankfurt am Main

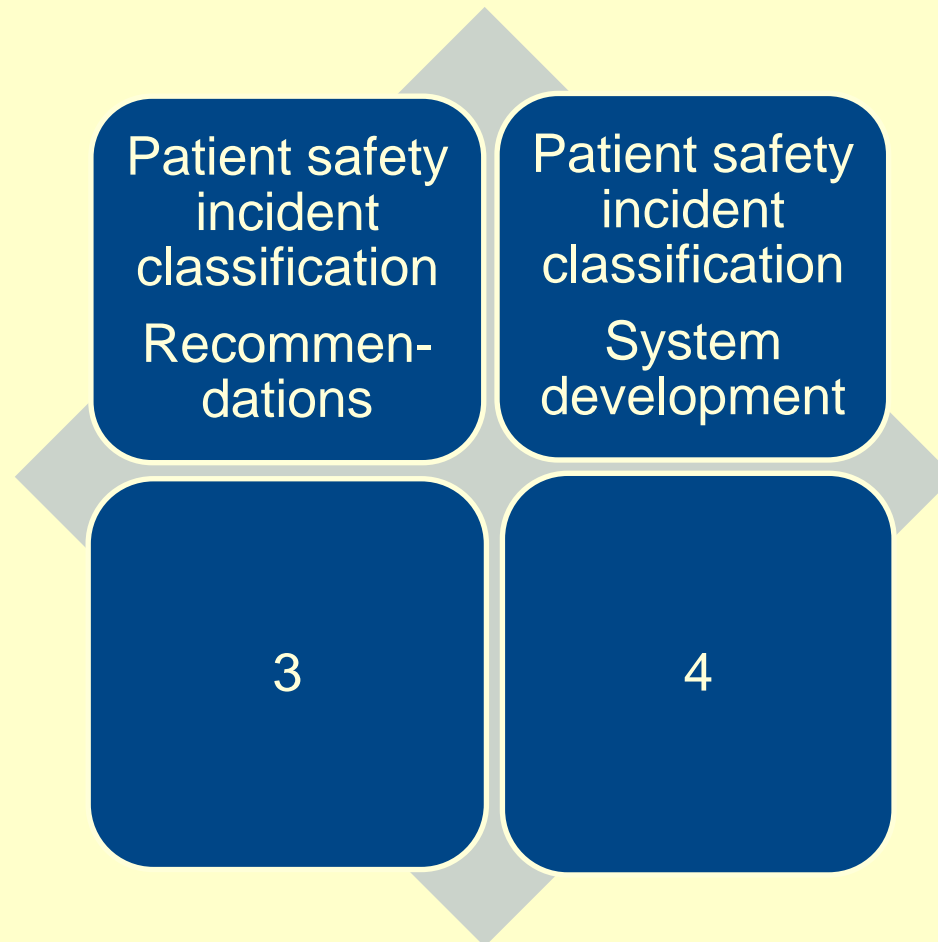
# Four objectives in Frankfurt



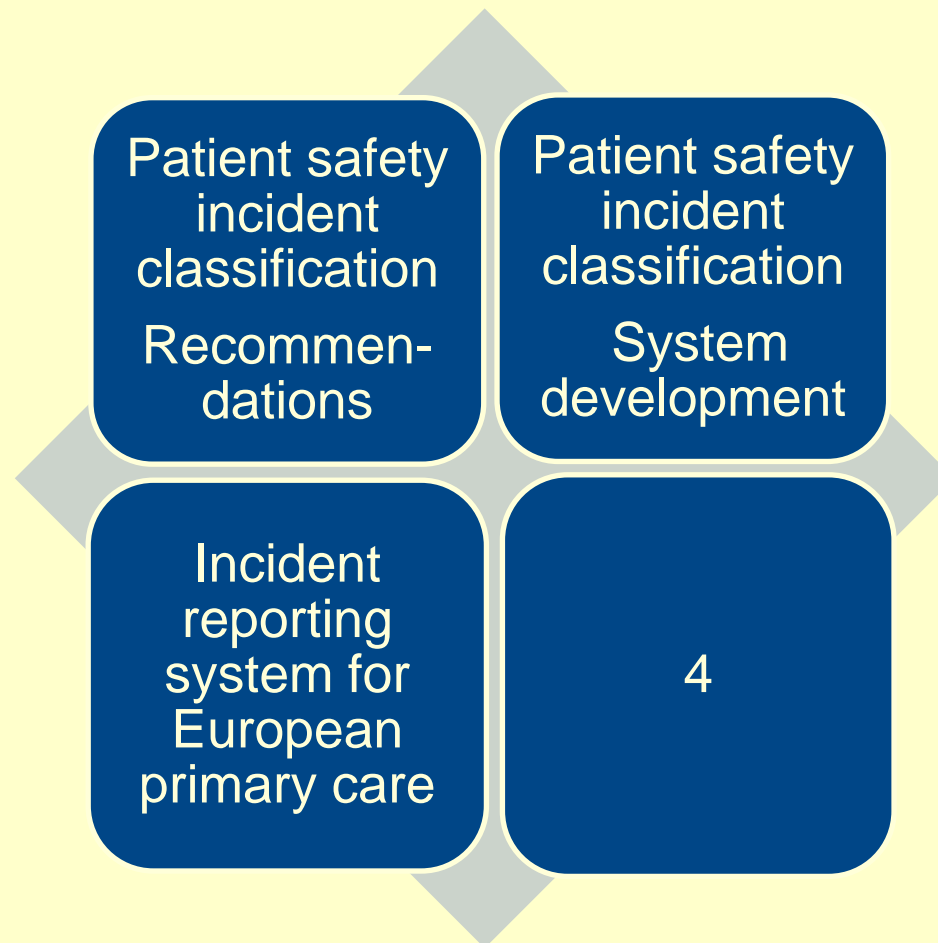
# Four objectives in Frankfurt



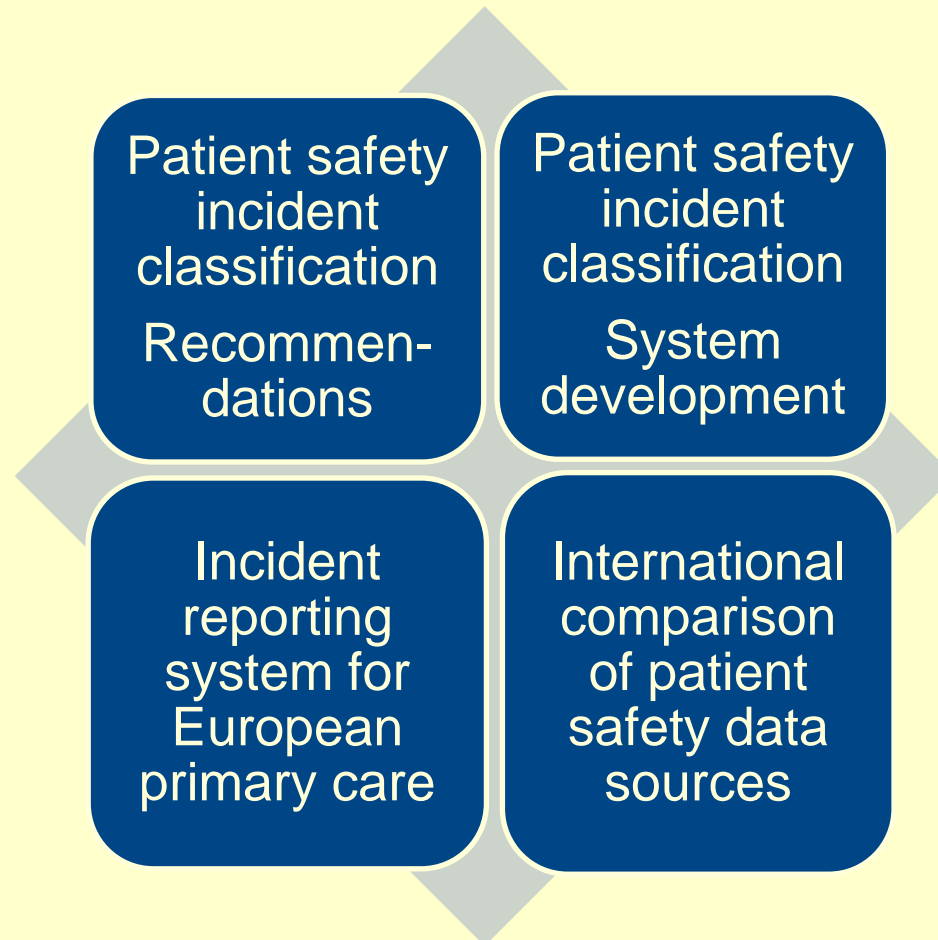
# Four objectives in Frankfurt



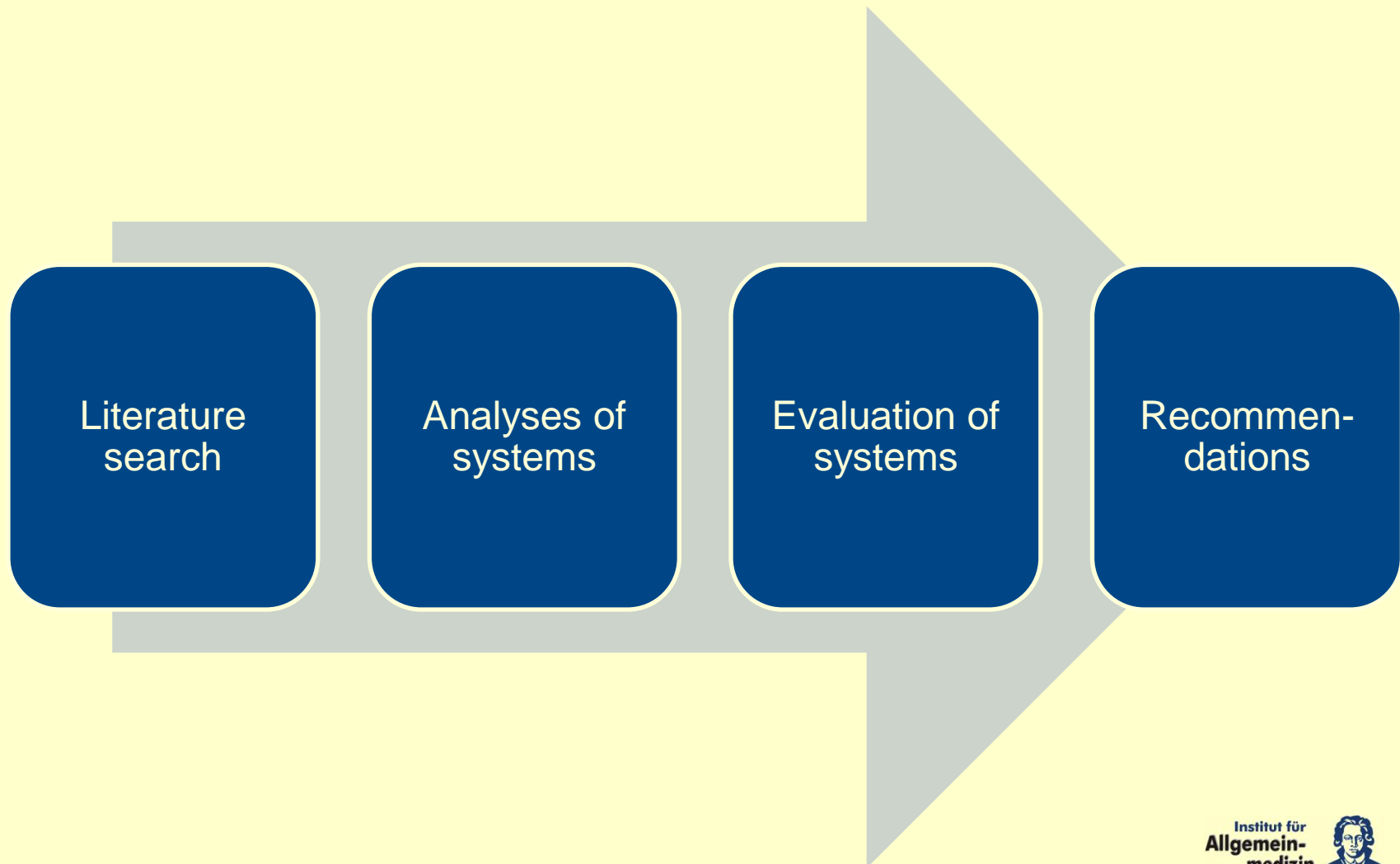
# Four objectives in Frankfurt



# Four objectives in Frankfurt






# O1: Classification system - Recommendations



# O1: Classification system - Recommendations

- Purpose
- Structure
- Content

**LINNEAUS EURO-PC**   

Summary of the discussion with regard to the content and structure of the Linneaus patient safety incident classification

This paper aims first to present the preliminary recommendations for a future patient safety incident classification and second to illustrate the consensual process the group passed through to identify important features of the classification system.

**1. Preliminary recommendations with respect to the structure and content of classification system for patient safety incidents in primary care**

In a consensual process the expert advisory group for the development of a patient safety incident classification system in the LINNEAUS EURO-PC project has defined the object of the classificatory process. A patient safety incident is any unintended event or hazardous condition in the process of care, rather than due to the patient's underlying disease, that led or could have led to unintended consequences for the patient.

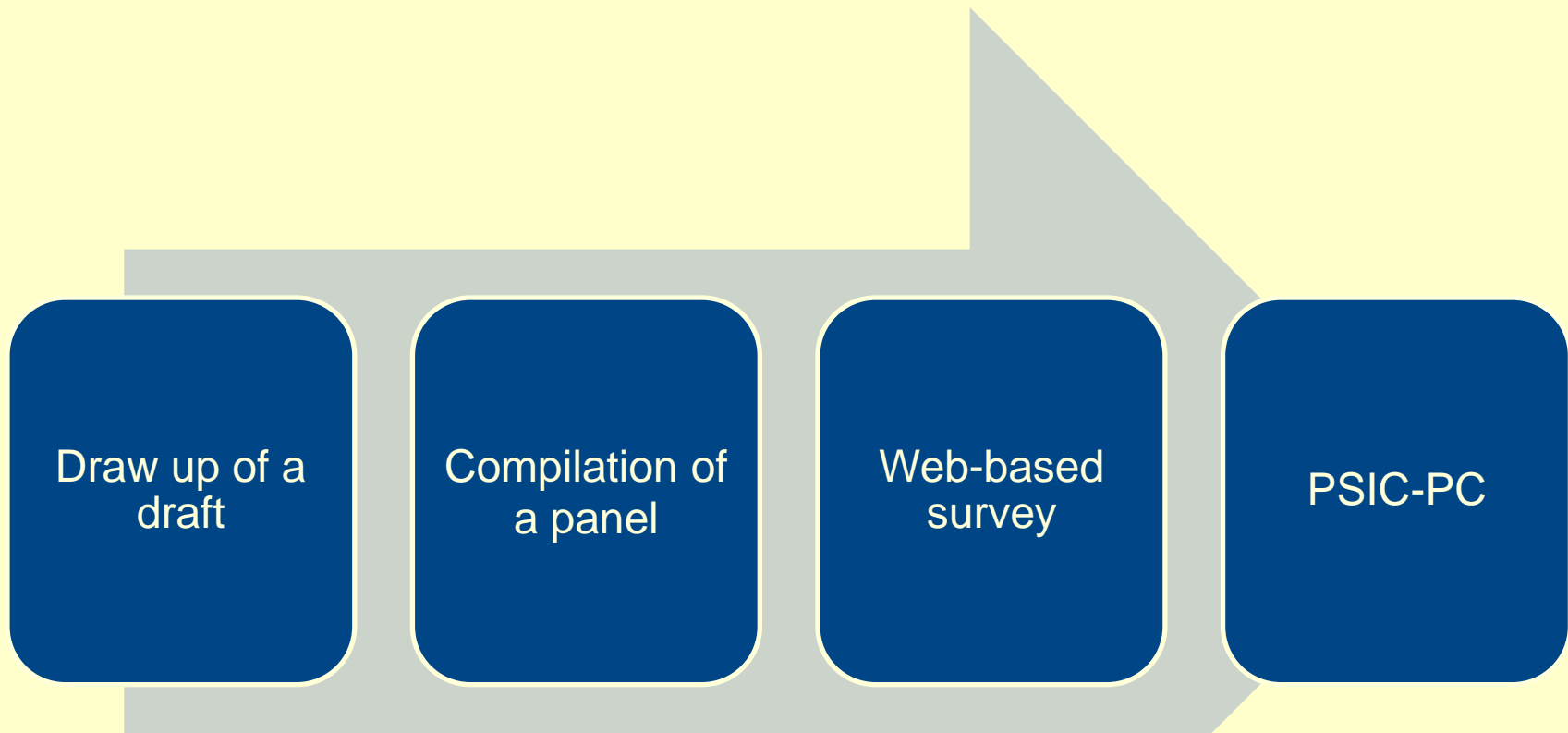
The term 'error' should be avoided, because it implies that someone has made the error and neglects the underlying weaknesses in the system.

The expert advisory group recommends the classification system to

- focus on 'patient safety incidents' rather than on 'errors' to avoid the presumption that a single person is mainly responsible for the occurrence of the event,
- serve purposes such as monitoring organisational change and learning, conducting reviews and audits, carrying out epidemiological studies, and analysing litigation data.
- be usable within the different European health care systems.
- be feasible for application on different levels of granularity.
- have a modular structure in order to provide the opportunity for adaptation.
- be applicable to and support the analysis of all patient safety data that are generated in primary care: staff reports, patient reports, malpractice claims, case notes reviews etc..
- contain categories to indicate a lack of information, or unclassifiable data.
- be based on a model/theory/framework of human behaviour as well as on empirical data/evidence.
- include comprehensive modules for analysing incidents in such a way that they cross refer to well developed and tested systems.
- allow for the classification of contributing factors to a patient safety incident but also to label factors as causal if possible.
- involve modules for the type of incident, the contributing/causal factors to the incident, the outcome of the incident, *details of the patient safety incident, and incident prevention strategies for future events.* (Debatable is the appropriateness of the last two proposed modules written in *italics* to be part of a classification system. This question will be settled during a Delphi survey)
- provide a definition for each of the classes in the system.
- include a hierarchy with a limited number of levels.



## O2: Classification system- Development



# O2: Classification system- Development

- Definition of a patient safety incident
- 5 moduls ( incident type, incident characteristics, contributing factors, outcome, action taken)
- Definitions for classes and subclasses

LINNEAUS EURO-PC

LINNEAUS EURO-PC

LINNEAUS EURO-PC

Institut für Allgemeinmedizin

**Patient Safety Incident Classification for Primary Care (PSIC-PC) Version 3.0**

A classification system is a tool for the organization of facts within a framework and is aimed at reducing the complexity of diffuse information. The Patient Safety Incident Classification will be developed for the collection and analysis of patient safety data derived from various sources but originating in primary care. The object of this classificatory process is the patient safety incident, defined as follows:

"A patient safety incident in primary care is any unintended event or hazardous condition resulting from the process of care, rather than due to the patient's underlying disease, that led or could have led to unintended health consequences for the patient."

To classify patient safety data it is recommended that every applicable class be selected. The user should avoid speculating about what happened and it is strongly recommended that he or she rely on facts from the original data source.

The classification system presented here is based on recommendations that have been made regarding the context and structure of a classification system for patient safety incidents in primary care, as well as on already existing classification systems. The following systems played a particularly important role in its development:

- International Taxonomy of Medical Errors in Primary Care
- Patient Safety Event Taxonomy
- Eindhoven Classification Model
- Applied Strategies for Improving Patient Safety
- Diagnostic Error Evaluation and Research Taxonomy
- NCC MERP Taxonomy of Medication Errors
- International Classification for Patient Safety

Our classification system is still work in progress. Some classes and subclasses still lack definitions and / or need to be populated with further attributes. The missing information is indicated by three dots "... " on the relevant level of the classification system. Last changes are indicated by red letters.

**The classification structure is:**  
(Definitions for all levels are written in *italics*.)

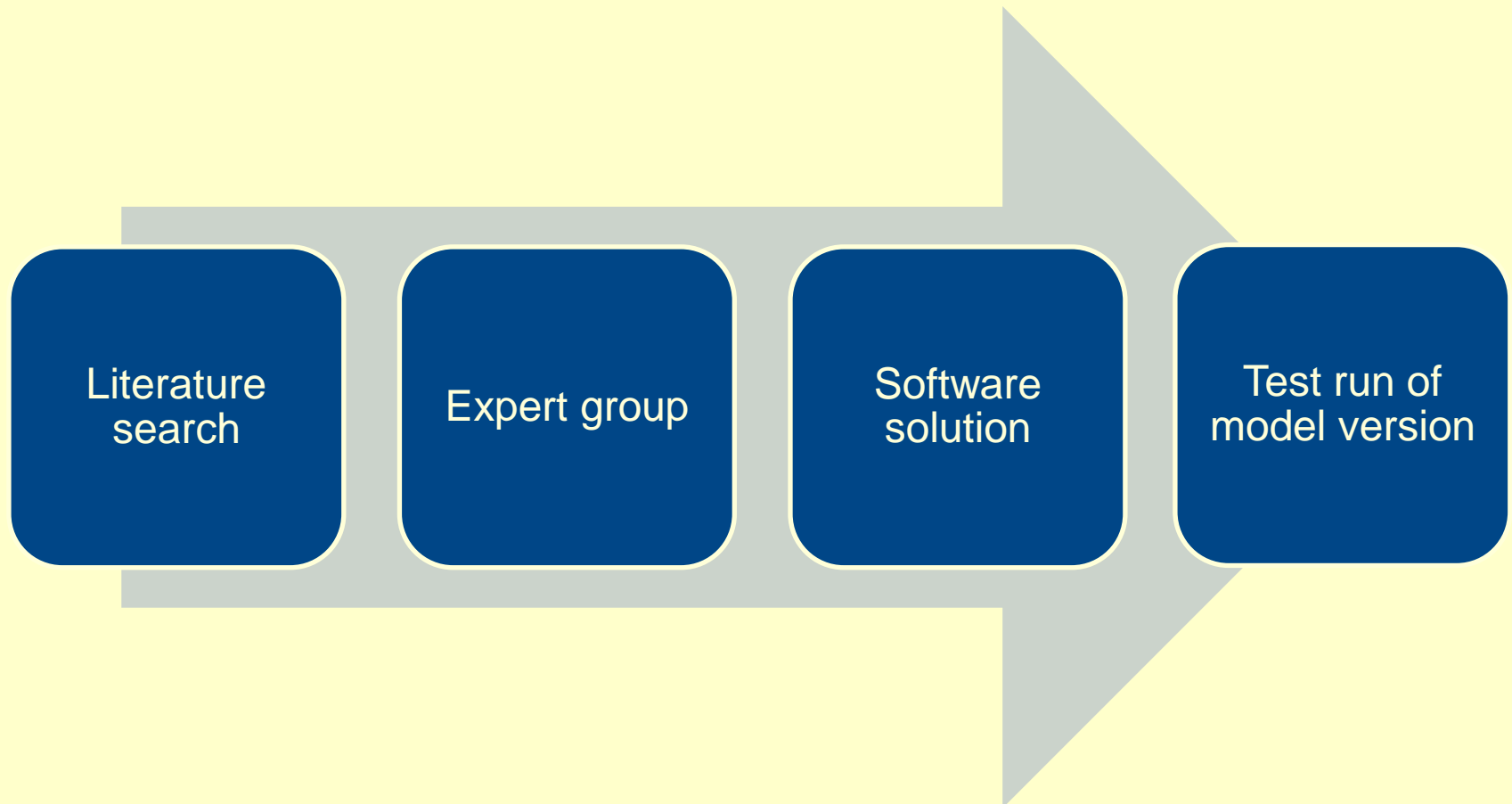
**A. Dimension (level 1)**  
*A discrete module to describe a well-defined aspect of the incident. It is populated with classes and subclasses to specify the aspect in question and can be used separately as well as in combination with other dimensions according to the purpose.*

○ **Class (level 2)**  
*A general category to collect objects with similar attributes.*

- **Subclass (level 3)**  
*A more specific category to collect objects that differentiates according to the value of an attribute and specifies objects summarized on the superior level.*
  - **Subclass (level 4)**  
*A very specific category to differentiate objects summarized on the superior level.*

1

## O3: Incident reporting system

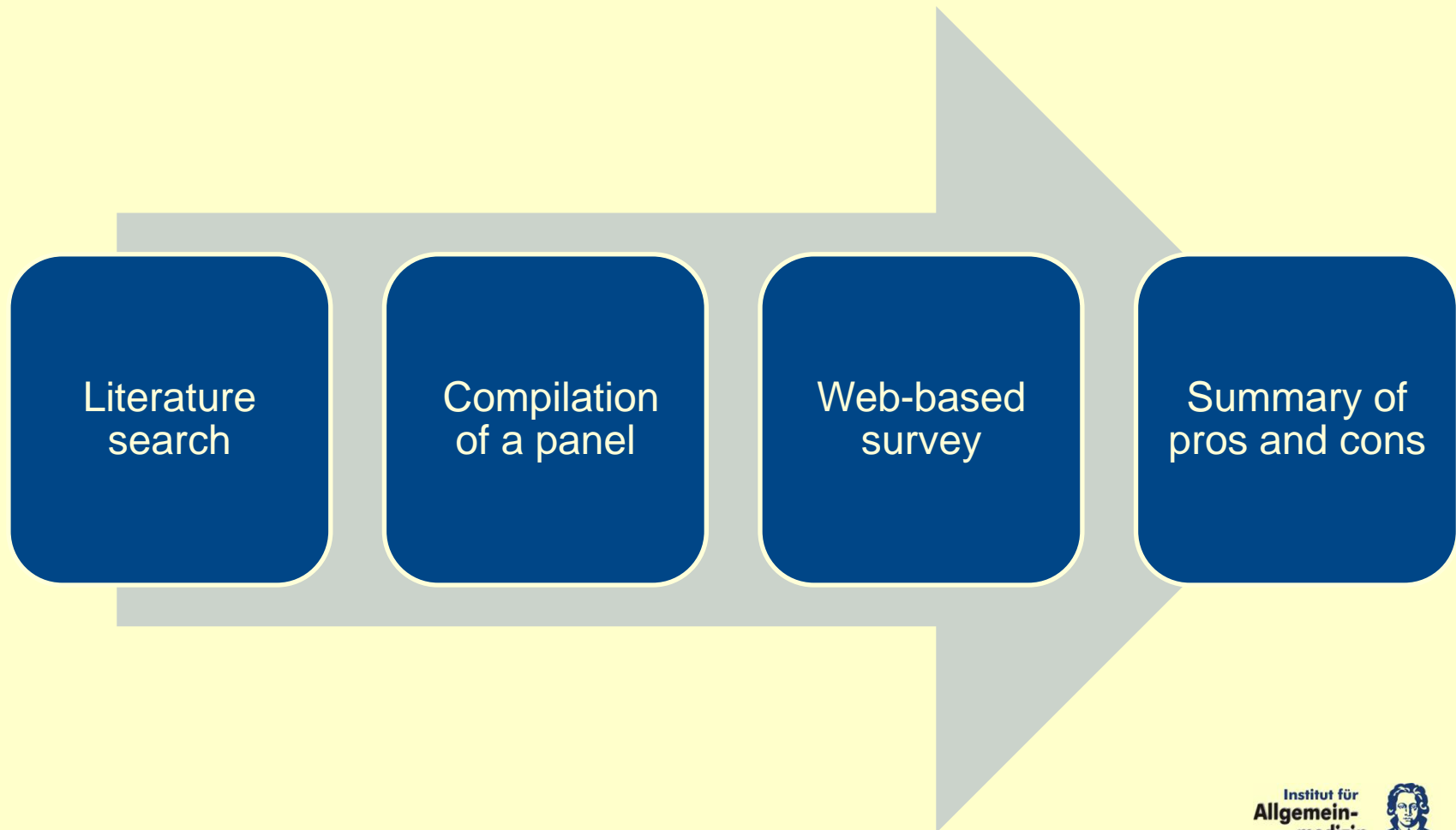


# O3: Incident reporting system

- <http://www.lirals.com>

The screenshot shows the homepage of the Linneaus Incident Reporting and Learning System. The page has a dark blue header with the title 'Linneaus Incident Reporting and Learning System' and a navigation bar with 'Home' and 'Reporting'. A left sidebar contains a menu with 'Home', 'Reporting', 'FAQ', 'Contact', 'Imprint', 'Disclaimer', and 'Feedback to Linneaus'. The main content area is titled 'Error Reporting' and features a quote: "You can't make an omelette, without breaking eggs." Below this is a 'Preamble' section explaining the system's purpose: to collect information about critical incidents to improve patient safety. It states that system changes based on incident information lead to a pro-active increase in patient safety. A 'Feedback to Linneaus' button is visible in the sidebar. The footer contains copyright information for 2012 Johann Wolfgang Goethe-Universität, Institut für Allgemeinmedizin.

## O4: Comparison of patient safety data sources



Thank you!