Classification of patient-safety incidents in primary care

Jennifer Cooper, Huw Williams, Peter Hibbert, Adrian Edwards, Asim Butt, Fiona Wood, Gareth Parry, Pam Smith, Azim Sheikh, Liam Donaldson & Andrew Carson-Stevens

Abstract Primary care lags behind secondary care in the reporting of, and learning from, incidents that put patient safety at risk. In primary care, there is no universally agreed approach to classifying the severity of harm arising from such patient-safety incidents. This lack of an agreed approach limits learning that could lead to the prevention of injury to patients. In a review of research on patient safety in primary care, we identified 21 existing approaches to the classification of harm severity. Using the World Health Organization’s (WHO’s) International Classification for Patient Safety as a reference, we undertook a framework analysis of these approaches. We then developed a new system for the classification of harm severity. To assess and classify harm, most existing approaches use measures of symptom duration (11/21), symptom severity (11/21) and/or the level of intervention required to manage the harm (14/21). However, few of these approaches account for the deleterious effects of hospitalization or the psychological stress that may be experienced by patients and/or their relatives. The new classification system we developed builds on WHO’s International Classification for Patient Safety and takes account not only of hospitalization and psychological stress but also of so-called near misses and uncertain outcomes. The constructs we have outlined have the potential to be applied internationally, across primary-care settings, to improve both the detection and prevention of incidents that cause the most severe harm to patients.

Introduction

Health organizations have a responsibility to learn from health-care-associated harm. In 2002, the World Health Assembly called for action to reduce the scale of preventable deaths and harm arising from unsafe care. Almost immediately, several health systems responded to this call. Most of these health systems had, at the core of their mission, a commitment to learn from medical errors and adverse events. Most subsequently set up systems to report and learn from so-called patient-safety incidents. One assumed that such systems would facilitate both the identification of systemic weaknesses that contribute to errors in health care and the learning necessary to prevent such errors recurring. However, in contrast to some other high-risk industries, where learning from accidents, mistakes and system failures appears to have led to major improvements in safety, little evidence exists that such systems have led to general reductions in the incidence or severity of patient-safety incidents.

If they have nationwide coverage systems for recording patient-safety incidents may receive very large numbers of reports each month. Within the United Kingdom of Great Britain and Northern Ireland, for example, there are about 100,000 reports of patient-safety incidents from England and Wales every month. Although the data collected on each incident have some value, it is not feasible to investigate so many incidents on an individual basis. A standardized, valid method of identifying the most important incidents is needed. There is international consensus that incidents leading to death or other severe consequences should be at the top of the list for analysis. However, the identification and valid prioritization of the more severe incidents is dependent on an accurate and consistent system for the classification of patient-safety incidents according to the severity of the harm that has occurred.

In the field of patient safety, much educational material comes from the narrative accounts of clinical staff reporting patient-safety incidents, and such accounts are a key component of many reporting systems. In 2009, the World Health Organization (WHO) developed the International Classification for Patient Safety. This classification, hereafter called WHO’s International Classification, was based on several earlier conceptual approaches to patient safety and potentially enables the international and inter-specialty comparison of incidents. The classification system defines five degrees of harm severity, from no harm to death (Box 1). However, it remains a work-in-progress and although it was developed for universal use, it is mostly based on the results of hospital-based research, even though more patients are seen in primary-care facilities than in hospitals. As primary care differs from hospital care in several important ways, e.g. in patient characteristics, organizational structure, relationships between health-care professionals and patients and types and outcomes of patient-safety incidents, the risks associated with hospital-based care should not be assumed to be the same as those associated with primary care.

In 2016, the results of the then-largest analysis of patient-safety incidents during primary care were reported. These results indicated that the harm-severity element of WHO’s International Classification lacked sufficient granularity for the classification to be used in primary-care settings, especially when categorizing hospital admission, because of iatrogenic harm. By 2016, there was no universally-agreed system for the

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Submitted: 28 July 2017 – Revised version received: 22 March 2018 – Accepted: 28 March 2018 – Published online: 23 April 2018
classification of harm severity in patient-safety incidents during primary care. The use of several different frameworks for assessing the severity of harm arising from patient-safety incidents in primary care had made the valid comparison of the relevant data from different countries very difficult.10

We therefore decided to investigate how the other classification frameworks used in this field aligned with WHO’s International Classification7 and then, by building on WHO’s International Classification, we developed a new, more comprehensive system for the classification of harm severity in patient-safety incidents occurring in primary care.

Development of new system

Systematic review

We searched the research literature for studies published before May 2016 that had used a framework, system or taxonomy for the classification of harm severity in patient-safety incidents occurring in primary care. Two reviewers searched 18 databases to find research studies and systematic reviews that had covered patient-safety incidents in primary care. Disagreements over inclusion were resolved via arbitration by a third reviewer. We based the searches on, and used the same search terms and methods as, a key systematic review,10 but brought that review up-to-date by including all relevant articles and grey literature published since 1980. We found 38 relevant studies and these covered 21 distinct systems for the classification of harm severity.7,14–35

Framework analysis

We carried out a framework analysis of the content of each of the 21 classification systems, to identify the key themes and, particularly, each system’s strengths and weaknesses relative to WHO’s International Classification.7 We especially focused on the range of characteristics used to define harm. Encompassing both a-priori and emerging concepts, framework analysis facilitates the development of a themed matrix by organizing and managing data through a process of summation.16

System development

We used the results of the framework analyses in developing our new classification system, through an iterative process. Together, we have experience in coding and analysing over 60 000 reports of patient-safety incidents in primary care for several mixed-methods research studies.15,20–30

We discussed the common and novel features of each classification system and considered the practicalities of identifying such characteristics when coding incidents that had occurred during primary care. Finally, we tested the classification system iteratively, by applying it to randomly generated samples of 100 incident reports, revising the system by clarifying the definitions and then applying the revised system to further samples of reports. We discussed the revised definitions and the reasons for changes until we had a consensus.

Terminology

The results of the systematic review revealed that there were several common features within the 21 existing approaches to the classification of harm in patient-safety incidents during primary care. Most of these approaches involved harm categories that ranged from death at one extreme (16/21) to no harm, or an equivalent synonym, at the other (12/21). Eleven of the approaches used another three descriptive categories of harm, that is, either mild, moderate and severe or synonyms of these adjectives, like WHO’s International Classification.7 We decided to use the same categories in our new classification as they were relatively intuitive and globally understood (Table 1). The other 10 approaches used a grading systems based on letters or numbers, such as that used by the United States of America’s National Coordinating Council for Medication Error Reporting and Prevention.15

Ways of defining harm

The results of the systematic review revealed that most of the 21 existing approaches had been based on at least one of three broad parameters: (i) the severity of the symptoms or loss of function (11/21);7,14,17,21,25–27,30,31,33 (ii) the duration of the symptoms (11/21);7,14,16,18,20,25–27,31,35 and/or (iii) the interventions required, e.g. investigation, treatment and/or hospitalization, as a result of the incident (14/21).7,14–19,21–24,30,32,33

Three of the 21 approaches were relatively simple and did not use any of these parameters.7,6,27–29

In our new classification, we included all three broad parameters for defining physical harm because there is wide diversity in the types of incidents and descriptions of outcomes that occur in primary care. To define the severity of a patient’s symptoms and/or loss of function, we used the term “impact on physical, mental or social functioning”, which is applicable to a wide range of cultural settings and conforms with the terms used by WHO for the assessment of quality of life.30 As an outcome of a patient-safety incident, we found pain difficult to categorize as it is subjective and affected by factors such as: the patient’s environment, their mood and their understanding of cause and prognosis.7 We ask users of our new classifi-
Severity Definition Examples

No harm
Any incident that ran to completion but no harm occurred to the patient
Patient received azathioprine but missed routine haematological monitoring for several months. No harm incurred

No harm outcome due to mitigating action
Any incident that had the potential to cause harm to a patient but resulted in no harm
A receptionist issued an incorrect prescription that indicated a patient should take one tablet twice daily instead of once daily. The chemist providing the tablets, who had dispensed to the patient previously, noted the error and corrected the regimen

Mild harm
Incident in which: (i) patient was harmed, with mild and short-term impact, on physical, mental or social functioning, that was expected to resolve in a few hours; (ii) patient was harmed but required no or minimal intervention/treatment, e.g. anti-emetic, oral antibiotic or repeat of a minor procedure such as vaccination or insertion of contraceptive implant; and/or (iii) patient or their loved ones experienced transient emotional distress but no long-term consequences and incident report contains words, e.g. angry, anxious, confused, distressed, frightened, frustrated, humiliated or upset, that might describe a feeling that occurs at the time of the incident but soon passes
An on-call primary-care physician prescribed oral analgesic for a patient who could not swallow. A second physician also made a prescription error, leaving patient in pain for three hours. Relatives of a patient dying at home were unable to get drugs for a syringe driver at a weekend because their local pharmacy was out of stock. Their local hospital would not supply the drugs but they were eventually obtained from a community health-care provider. The patient was left without drugs for 3.5 hours and the relatives were very distressed

Moderate harm
Incident in which: (i) patient was harmed, causing a medium-term impact on physical, mental or social functioning that was expected to resolve in days; (ii) patient required medical intervention in the form of treatment, e.g. antibiotics or intravenous fluids; (iii) patient required short-term hospitalization for assessment and/or minor treatment in either ED or a hospital ward; and/or (iv) patient or their loved ones experienced psychological difficulty of a more longstanding nature but not requiring formal treatment, e.g. as indicated by evidence in the report of more longstanding anxiety, insomnia, or low mood
A health-care provider made a routine visit to a diabetic patient to administer insulin. The patient's blood sugar was found to be within safe limits to administer insulin and insulin was therefore given. Later on the same day, the patient was found to be hypoglycaemic. It was discovered that the patient, who had learning difficulties, had failed to tell the provider that he had received insulin 30 minutes before the provider's visit. He was admitted to a local hospital for monitoring of blood sugars overnight. A patient was prescribed amoxicillin despite being known to have penicillin allergy. Although the error was corrected and the patient given clarithromycin, the patient claimed to have lost trust in doctors and to be extremely anxious about taking the clarithromycin

Severe harm
Incident in which: (i) patient was harmed, causing a major long-term or permanent impact on physical, mental or social function or shortening of life-expectancy; (ii) patient was harmed and required major medical or surgical intervention that, most often, was delivered in a hospital setting, e.g. cardioversion, any major surgery; (iii) patient was harmed and required prolonged hospitalization or admission to CCU, HDU and/or ICU; and/or (iv) patient or their loved ones experienced enduring psychological difficulty that required specialist treatment, e.g. as indicated in the report by evidence of chronic anxiety or depression or psychosis
An epileptic child who had been prescribed phenobarbital was admitted with symptoms of drowsiness and had decreased tone for three days. He was ventilated and immediately transferred to the ITU because he had a low GCS score. His blood concentration of phenobarbital was found to be abnormally high. When the patient's own supply of phenobarbital was checked, the original manufacturer's label gave the strength as 25 mg/mL but the erroneous community pharmacy's label indicated 25 mg/5 mL. The child had been receiving five times the prescribed dose

Death
Incident in which, on the balance of probabilities, death of the patient was caused or brought forward in the short term by the incident
A patient contacted an out-of-hours service by telephone, reporting feeling unwell, vomiting and a rash on his stomach. A physician, who returned the patient's call, diagnosed a viral illness and asked the patient to make arrangements for a relative to collect a prescription for an anti-emetic. Within 90 minutes, however, the patient had deteriorated and been brought to the ED of his hospital. The patient was diagnosed with meningococcal septicaemia and died

Insufficient detail
Incident for which the report carries insufficient information to evaluate the severity of harm. The report may describe an error or outcome that was not the result of primary health care, e.g. a fall in the waiting room. Alternatively, it may fail to describe any outcome or it may describe a patient-safety incident but give insufficient information to classify the severity of harm of the outcome, e.g. it may record a delay in getting an appointment but not describe the consequences of the delay for the patient
A patient provided samples for histology and cytology, but the provider collecting the samples in specimen pots forgot to label the pots

Table 1. Primary Care Harm Severity Classification System, 2018

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ED: emergency department; CCU: coronary care unit; GCS: Glasgow coma scale; HDU: high dependency unit; ICU: intensive care unit; ITU: intensive therapy unit.
In general, health-care professionals intuitively recognize emotional harm to patients and seek to avoid such harm. However, those who report patient-safety incidents may neglect psychological outcomes in their reports and failures to report such outcomes may limit our understanding of the true nature of health-care-associated harm. Our new classification system encompasses mild, moderate and severe psychological harm as well as physical harm outcomes. We considered ”emotional harm” to be the most appropriate terminology for mild, and generally transient, harm but used “psychological harm” to describe moderate or severe and, usually, more enduring harm.

Many incident reports describe how the affected patients and/or their families were distressed by an incident. From the evidence that was routinely reported, we decided that a group of people who had struggled to obtain medications had experienced an emotional” harm. Although we thought that this event must have been extremely upsetting and is unlikely to be forgotten over the long term by the family involved, a key principle in our approach is that nothing that is not explicitly stated in an incident report should be inferred. In the future, we anticipate that our new classification system will be used by frontline healthcare professionals and risk managers who, when struggling to evaluate the level of psychological harm, will often be able to obtain clarification after a detailed investigation of an incident.

**Near misses**

WHO’s International Classification does not allow incidents where there was no risk of harm to be distinguished from so-called close-call or near-miss incidents, that is, incidents where there was no harm only because harm was prevented by a timely safety intervention. However, our systematic review revealed several approaches that permit such distinction. For example, one of these approaches differentiated between “no harm, impact prevented” and “no harm, impact not prevented”.

The taxonomies developed by the United States National Coordinating Council for Medication Error Reporting and Prevention and Linnaeus-PC Collaboration each have four separate no-harm categories that indicate whether the potentially harmful outcome reached the patient and whether an intervention took place to prevent a harmful outcome occurring. As reports of near-miss incidents should help health-care providers to learn how to prevent or, at least, reduce harm, we made a separate category to capture such incidents a key component of our new classification system.

**Finalizing the new system**

We named our new system the Primary Care Harm Severity Classification System. Table 1 provides examples, from reports collected by the United Kingdom’s National Reporting and Learning System, of patient-safety incidents that would be assigned to each of the new system’s categories of harm severity. To ensure confidentiality, we anonymized all of the reports that we used and removed date and/or location data. We used the insights gained from the process of applying the new classification system to real examples of patient-safety incidents to inform the concepts and definitions used in the new system (Box 2), which offer guidance to future users of the system.

**Policy, practice and research implications**

Definitions of harm severity vary greatly between existing classification systems for patient-safety incidents in primary care. In general, the adverse effects of
hospitalization and psychological harm have previously been neglected. Health-care organizations need a consistent and reliable way of knowing which aspects of their care result in the most harm to patients. To help health-care teams of their care result in the most harm consistently and effectively, they need a framework for classifying the severity of harm that is comprehensive, intuitive, and easy to use. This framework should allow for the generation of useful reports of patient-safety incidents, which can be used to develop robust mechanisms for generating effective interventions.

In this paper, we have mapped out the key constructs for inclusion in an appropriate framework for classifying the severity of harm associated with patient-safety incidents in primary care. Given the broad range of events described in incident reports, the wide scope of the definitions we use is intentional. Although a more prescriptive classification system may achieve greater consistency between users, it risks being too complex to use in practice and too reductionist to support useful interpretation and learning. In the future, we plan to undertake a validation study in which a diverse, multidisciplinary panel of primary-care professionals, researchers, and patient advocates will be asked to use the new classification system, initially to code examples of reports of patient-safety incidents recorded in the United Kingdom’s National Reporting and Learning System. From our experience of applying classification systems in multiple contexts, we recognize that the users of such systems must be able to select codes with intuitive definitions that the users understand and find relevant to their work. Stakeholders may wish to adapt the classification system to support maximal learning in their local settings. However, in the interests of national and international learning and maximizing opportunities to learn from rare events, the key constructs we outline must be consistently applied. Each organization applying the new classification system must ensure comprehensive training is provided for key stakeholders. If users can be kept informed of the value of their coding, they may provide increasingly meaningful incident reports in the future.

**Next steps**

The effective application of any system for classifying the severity of harm associated with patient-safety incidents depends on judgments made by the individuals coding the incidents. Such judgements will vary depending on each coder’s clinical role, level of clinical knowledge and past experiences. In this paper, we have mapped out the key constructs for inclusion in an appropriate framework for classifying the severity of harm associated with patient-safety incidents in primary care. Given the broad range of events described in incident reports, the wide scope of the definitions we use is intentional. Although a more prescriptive classification system may achieve greater consistency between users, it risks being too complex to use in practice and too reductionist to support useful interpretation and learning. In the future, we plan to undertake a validation study in which a diverse, multidisciplinary panel of primary-care professionals, researchers, and patient advocates will be asked to use the new classification system, initially to code examples of reports of patient-safety incidents recorded in the United Kingdom’s National Reporting and Learning System. From our experience of applying classification systems in multiple contexts, we recognize that the users of such systems must be able to select codes with intuitive definitions that the users understand and find relevant to their work. Stakeholders may wish to adapt the classification system to support maximal learning in their local settings. However, in the interests of national and international learning and maximizing opportunities to learn from rare events, the key constructs we outline must be consistently applied. Each organization applying the new classification system must ensure comprehensive training is provided for key stakeholders. If users can be kept informed of the value of their coding, they may provide increasingly meaningful incident reports in the future.

**Conclusions**

Previous attempts to identify and learn from the most important sources of harm to patients in primary care have been restricted by the lack of a universal standard system for classifying the severity of such harm and the general neglect of psychological harm in this context. Health-care leaders must develop robust mechanisms for generating useful reports of patient-safety incidents and acting on those reports to improve
patient safety. We have empirically developed a new classification system that has the potential to be applied internationally, across primary-care settings, to improve the detection and prevention of incidents that cause the most severe harm to patients.

Acknowledgements
We thank H Prosser Evans, A Cooper, F Smith, R Samiurwo, A Omar, R Watson, P Paul and A Chuter. GP has a dual appointment with Harvard Medical School, Boston, USA. AC-S has a dual appointment, as honorary professor, with the Australian Institute of Health Innovation, Macquarie University, Sydney, Australia.

Funding: This study was funded by the United Kingdom's National Institute for Health Research Health Services and Delivery Research Program (project number 12/64/118).

Competing interests: PH has been paid, as a consultant on incident reporting, by Power Health Solutions, St Vincent’s Health Australia and the Australian Commission on Safety and Quality in Health Care. AS and AC-S are advisers on patient safety to the World Health Organization. LD is the World Health Organization’s patient-safety envoy.

Classification des incidents liés à la sécurité des patients dans le cas des soins primaires

Les soins primaires ont du retard sur les soins secondaires en ce qui concerne l'élaboration de rapports sur les incidents qui menacent la sécurité des patients et les enseignements qui en découlent. Dans le cas des soins primaires, il n'existe pas de méthode universellement acceptée pour classifier la gravité des dommages résultant d'incidents liés à la sécurité des patients. L'absence d'une telle méthode limite les enseignements qui pourraient favoriser la prévention des traumatismes chez les patients. Dans le cadre d'une analyse documentaire sur la sécurité des patients en matière de soins primaires, nous avons repéré l'existence de 21 méthodes de classification de la gravité des dommages.

In prenant comme référence la Classification internationale pour la santé (CIS), nous avons entrepris une analyse du cadre de ces méthodes. Nous avons ensuite conçu un nouveau système de classification de la gravité des dommages. Pour évaluer et classifier les dommages, la plupart des méthodes existantes utilisent des mesures portant sur la durée des symptômes (11/21), la gravité des symptômes (11/21) et/ou le niveau d'intervention requis pour prendre en charge les dommages (14/21). Néanmoins, rares sont celles qui tiennent compte des effets délétères de l’hospitalisation ou du stress psychologique qui peuvent ressembler à des dommages graves.

Résumé

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ملخص

تقييم الأحداث المتعلقة بسلامة المرضى في مجال الرعاية الأساسية

يراجع الدراسة العالمية عن عناية المرضى في تقديم الخدمات بموجهة ل楽し المرضى أو مستوي التجربة المرضي المحتمل للمرضى. لا يوجد أساليب متاحة متفقة على نظام تقييم إجمالي يركز على أثره على الصحة العامة. هناك بناء على نقص الموارد المهنية تم اقتراح تطبيق الأساليب المبنية على المراجعة الفردية لتحديات الصحة العامة، والاستخدام في خطة الرعاية الأساسية، وتعزيز التوجيهات الدراسية. ونتوجه إلى نظام جديد تم تطويره بناءً على الموارد المهنية المستخدمة في صناعة الرعاية. وتشمل هذه الأساليب وظائف متنوعة في قضايا الصحة العامة. وتشمل أيضًا الدراسات العليا التي تقود إلى خطة الصحة العامة وتشمل أيضًا الدراسات العليا المخصصة للرعاية الأساسية. وتشمل هذه الأساليب وظائف متنوعة في قضايا الصحة العامة. وتشمل أيضًا الدراسات العليا التي تقود إلى خطة الصحة العامة وتشمل أيضًا الدراسات العليا المخصصة للرعاية الأساسية. وتشمل أيضًا الدراسات العليا التي تقود إلى خطة الصحة العامة وتشمل أيضًا الدراسات العليا المخصصة للرعاية الأساسية. وتشمل أيضًا الدراسات العليا التي تقود إلى خطة الصحة العامة وتشمل أيضًا الدراسات العليا المخصصة للرعاية الأساسية. وتشمل أيضًا الدراسات العليا التي تقود إلى خطة الصحة العامة وتشمل أيضًا الدراسات العليا المخصصة للرعاية الأساسية. وتشمل أيضًا الدراسات العليا التي تقود إلى خطة الصحة العامة وتشمل أيضًا الدراسات العليا المخصصة للرعاية الأساسية. وتشمل أيضًا الدراسات العليا التي تقود إلى خطة الصحة العامة وتشمل أيضًا الدراسات العليا المخصصة للرعاية الأساسية. وتشمل أيضًا الدراسات العليا التي تقود إلى خطة الصحة العامة وتشمل أيضًا الدراسات العليا المخصصة للرعاية الأساسية. وتشمل أيضًا الدراسات العليا التي تقود إلى خطة الصحة العامة وتشمل أيضًا الدراسات العليا المخصصة للرعاية الأس...
les patients et/ou leurs proches. Le nouveau système de classification que nous avons élaboré repose sur la Classification internationale pour la sécurité des patients de l’OMS et tient compte non seulement de l’hospitalisation et du stress psychologique, mais aussi de ce qu’il est convenu d’appeler les accidents évités de justesse et des résultats incertains. Les concepts que nous avons définis peuvent être appliqués dans les établissements de soins primaires du monde entier pour améliorer la détection et la prévention des incidents qui provoquent les plus graves dommages pour les patients.

Resumen
Clasificación de incidentes que afectan a la seguridad del paciente en la atención primaria
La atención primaria queda por debajo de la atención secundaria en la notificación y el aprendizaje de incidentes que ponen en riesgo la seguridad del paciente. En la atención primaria, no existe un enfoque universalmente aceptado para clasificar la gravedad del daño que surge de tales incidentes que afectan a la seguridad del paciente. Esta falta de un enfoque consensuado limita el aprendizaje que podría conducir a la prevención de lesiones a los pacientes. En una revisión de la investigación sobre la seguridad del paciente en la atención primaria, se identificaron 21 enfoques existentes para la clasificación de la gravedad del daño. Con la Clasificación Internacional para la Seguridad del Paciente de la OMS y teniendo en cuenta no solo la hospitalización y el estrés psicológico, sino también los denominados casi accidentes y los resultados inciertos. Los constructos descritos tienen el potencial de aplicarse internacionalmente, en entornos de atención primaria, para mejorar tanto la detección como la prevención de incidentes que causan los daños más graves a los pacientes.

References


