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Classification of patient-safety incidents in primary care
Jennifer Cooper,a Huw Williams,b Peter Hibbert,c Adrian Edwards,a Asim Butt,b Fiona Wood,a Gareth Parry,d Pam Smith,a Aziz Sheikh,1 Liam Donaldsonb & Andrew Carson-Stevensa

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.1 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,2 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.3,4 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.1 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.5 In 2009, the World Health Organization (WHO) developed the International Classification for Patient Safety.6 This classification, hereafter called WHO’s International Classification, was based on several earlier conceptual approaches to patient safety7,8 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.9 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.10–12

In 2016, the results of the then-largest analysis of patient-safety incidents during primary care were reported.13 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.14 By 2016, there was no universally-agreed system for the

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Table 1. World Health Organization’s International Classification for Patient Safety: descriptions of harm severity

<table>
<thead>
<tr>
<th>Severity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>Outcome was not symptomatic or no symptoms were detected and no treatment was required.</td>
</tr>
<tr>
<td>Mild</td>
<td>Patient outcome was symptomatic, symptoms were mild, loss of function or harm was either minimal or intermediate but short-term and no intervention or only a minimal intervention, e.g. extra observation, investigation, review or minor treatment, was required.</td>
</tr>
<tr>
<td>Moderate</td>
<td>Patient outcome was symptomatic, required more than a minimal intervention, e.g. additional operative procedure or additional therapeutic treatment, and/or an increased length of stay and/or caused permanent or long-term harm or loss of function.</td>
</tr>
<tr>
<td>Severe</td>
<td>Patient outcome was symptomatic, required a life-saving or other major medical/surgical intervention, shortened life expectancy and/or caused major permanent or long-term harm or loss of function.</td>
</tr>
<tr>
<td>Death</td>
<td>On balance of probabilities, death was caused or brought forward in the short-term by the incident.</td>
</tr>
</tbody>
</table>

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.26

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.12,20–25 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),7,14,17,21–25,28,30,31,33 (ii) the duration of the symptoms (11/21),7,14–16,18,20,23–25,31,33 and/or (iii) the interventions required, e.g. investigation, treatment and/or hospitalization, as a result of the incident (14/21).7,14–19,21–23,31,32,33 Three of the 21 approaches were relatively simple and did not use any of these parameters.16,27,29

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.58 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.59 We ask users of our new classifi-

No harm

Any incident that ran to completion but no harm occurred to the patient

No harm outcome due to mitigating action

Any incident that had the potential to cause harm to a patient but resulted in no harm

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

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

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

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

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

Patient received azathioprine but missed routine haematological monitoring for several months. No harm incurred

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Severity</th>
<th>Definition</th>
<th>Examples</th>
</tr>
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<tr>
<td>No harm</td>
<td>Any incident that ran to completion but no harm occurred to the patient</td>
<td>Patient received azathioprine but missed routine haematological monitoring for several months. No harm incurred</td>
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<td>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</td>
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<tr>
<td>Moderate harm</td>
<td>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</td>
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<td>Incident in which, on the balance of probabilities, death of the patient was caused or brought forward in the short term by the incident</td>
<td>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</td>
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<td>A patient provided samples for histology and cytology, but the provider collecting the samples in specimen pots forgot to label the pots</td>
</tr>
</tbody>
</table>

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 for a dying relative (Table 1) should be considered to have suffered only mild 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 health-care professionals and risk managers who, when struggling to evaluate the level of psychological harm, will often be able to obtain clarification after more 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 Linneaus-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.

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 to learn from patient-safety incidents, WHO’s Minimal Information Model for Reporting Patient Safety Incidents encourages the use of a standardized essential data set, with harm severity as a key component. Advances in the methods of analysis of incident reports from primary-care facilities should facilitate the scopin of action to reduce risk and improve patient safety, including the planning for research that could lead to more effective interventions.

Our new classification system for harm severity is a starting point for a learning process that should lead from the more effective analysis of reports on patient-safety incidents, to the prevention of such incidents and the associated harm, in the future. Health systems already operating or developing systems for the reporting of patient-safety incidents that are compatible with WHO’s International Classification should find our classification system relatively easy to apply, since our system is builds on WHO’s International Classification. If applied universally, our new classification system will allow temporal and geographical comparisons of the severity of patient-safety incidents occurring in different primary-care systems.

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 lengthier and 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 Samiruwo, 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.

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Résumé

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'identification 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 this study, we reviewed the existing evidence on the classification of patient harm in primary care. We found that few existing frameworks exist for classifying harm severity, and that most current frameworks use symptoms and the duration of their presence to determine severity. A new classification system is needed to better capture the full range of harm experienced by patients in primary care. We developed a new classification system that takes into account the extent of harm, the duration of symptoms, and the need for intervention. This system can help primary care providers to better understand the full impact of harm on their patients and to develop more effective interventions to prevent and manage harm.


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Policy & practice

Classifying harm severity in primary care

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.

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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 Organización Mundial de la Salud (OMS) como referencia, se llevó a cabo un análisis del marco de estos enfoques. A continuación, se desarrolló un nuevo sistema para la clasificación de la gravedad del daño. Para evaluar y clasificar el daño, la mayoría de los enfoques existentes usan medidas de la duración de los síntomas (11/21), la gravedad de los síntomas (11/21) y/o el nivel de intervención necesario para gestionar el daño (14/21). Sin embargo, pocos de estos enfoques explican los efectos nocivos de la hospitalización o el estrés psicológico que pueden experimentar los pacientes y/o sus familiares. El nuevo sistema de clasificación desarrollado se basa en la Clasificación Internacional para la Seguridad del Paciente de la OMS y tiene 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 daños más graves a los pacientes.


