

PATIENT SAFETY DEFINITIONS AND CLASSIFICATIONS*

Prologue

The following collection of definitions and classifications is designed to facilitate a culture of safety in the End Stage Renal Disease (ESRD) medical environment, through the development of a common language for discussing patient safety and the prevention of medical error. The initial set of definitions provides a broad background for patient safety, and the second set provides a more specific focus. This collection promotes the message that safety in the healthcare system can be greatly improved if we identify the many factors that contribute to error, as opposed to finding fault and placing blame.

Patients and health care practitioners can make the greatest contributions in analyzing patient safety. We feel it is critical to receive timely information from these people through reporting, and that having a common language is an important step in developing this system. However, we also feel it is important to allow individuals to provide a description in their own words- not just a checklist of terms. Over time, various taxonomic terms will be added, subtracted, or modified. For this reason, the textual description will be especially critical to effective root cause analysis. Ultimately, the utilization of this common framework will lead to identification and rectification of patient safety issues in the renal community.**

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Allina Health Systems, *Definitions and Terminology*
American Society of Testing and Materials (ASTM), *Standards*
BJC Healthcare, *Patient Safety Terms Glossary*
Institute of Medicine (IOM), *To Err is Human: Building a Safer Health System*
The Joint Commission of Accreditation and Hospital Organizations (JCAHO), *Glossary of Terms*
The National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP),
Medication Error Index
The National Patient Safety Foundation (NPSF), *Current Research on Patient Safety in the United States, A Tale of Two Stories: Contrasting Views of Patient Safety*
Quality Interagency Coordination Task Force (QuIC), *Report to the President*
U.S. Food and Drug Administration (FDA), *MedWatch: FDA's 'Heads Up' on medical Product Safety*, by John Henkel
USP Quality Review, *Definition of Medication Errors and Medication Error Index*
Christine Diehl, *Hospital Systems that Put People at Risk*
John Gosbee, *RCA Categories and Keywords (working lists)*
Robert Helmreich, *On Error Management: Lessons from Aviation*

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BASIC PATIENT SAFETY TERMS

Quality of Care: Degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

System: set of interdependent elements interacting to achieve a common aim. These elements may be both human and non-human (equipment, technologies, etc.).

Patient Safety: Freedom from accidental injury stemming from the processes of health care. These events include “errors,” “deviations,” and “accidents.” Safety emerges from the interaction of the components of the system; it does not reside in a person, device or department. Improving safety depends on learning how safety emerges from the interactions of the components and processes that minimize the likelihood of errors and maximize the likelihood of intercepting them before they occur. Patient safety is a subset of healthcare quality.

Risk management: Clinical, administrative and manufacturing activities undertaken to identify, evaluate, and reduce the risk of injury to patients, staff, and visitors and the risk of loss to the organization itself. **Risk containment:** reflects a subset of immediate actions taken to safeguard patients from a repetition of an unwanted occurrence. Actions may involve removing and sequestering drug stocks from pharmacy shelves and checking or replacing oxygen supplies or specific medical devices.

Near Miss (Close Call): an event or situation that could have resulted in an accident, injury or illness, but did not, either by chance or through timely intervention. Also known as close call or near hit.

Error: The failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Errors can include problems in practice, products, procedures, and systems.

Adverse Event: Untoward, undesirable, and usually unanticipated event directly associated with care or services provided within the jurisdiction of a medical center, outpatient clinic or other facility. Examples of common adverse events include: patient falls, medication errors, unexpected reactions or complications, procedural errors or complications, completed suicides, parasuicidal behaviors (attempts/gestures/threats), and missing patient events.

Sentinel Events: An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called "sentinel" because they signal the need for immediate investigation and response.

Phenotype: The phenotype of an incident is what happens, what people actually do or what they do wrong, what you can observe. They are specific to the local situation and context – the surface appearance of an incident. **Thus the complete text of an event is critical to describe its phenotype.**

Genotype: The genotype of an incident is the characteristic collection of factors that lead to the surface, phenotypical appearance of the event. They refer to patterns of contributing factors.

Root Cause: A root cause is the most fundamental reason an event has occurred.

EXTENSIVE LIST OF TERMS

The following list of terms is an effort to capture the breadth of current terms applied to the topic of patient safety and to provide additional acceptable descriptors that are found in the literature. In our effort to be inclusive, we sacrificed efforts to avoid redundancy or to establish a single recommended set of terms.

Safety Science Terms

- **Quality of Care:** Degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.
- **Patient Safety:** Freedom from accidental injury stemming from the processes of health care. These events include “errors,” “deviations,” and “accidents.” Safety emerges from the interaction of the components of the system; it does not reside in a person, device or department. Improving safety depends on learning how safety emerges from the interactions of the components and processes that minimize the likelihood of errors and maximize the likelihood of intercepting them before they occur. Patient safety is a subset of healthcare quality.
- **Safety Culture:** There are the 5 high level attributes of a “safety culture.” (Allina Health System – Incident Quality Council)
 - Prioritizes safety above financial and operational goals
 - Provides appropriate resources, structure and accountability to maintain effective safety systems
 - ALL workers (including front line staff, physicians, and administrators) accept responsibility for the safety of themselves, their co-workers, patients, and visitors.
 - Provides for organizational learning from accidents
 - Encourages and rewards the identification, communication, and resolution of safety issues
- **System:** set of interdependent elements interacting to achieve a common aim. These elements may be both human and non-human (equipment, technologies, etc.).
- **Components of a Safety Management System (Allina Health Systems):**
 - Leadership (accountability, measurement, participation, resources, etc.)
 - Management responsibility to prioritize and implement initiatives (communication, identify critical needs and oversight responsibilities, structure and processes to support team work, etc.)
 - Safety training (safety competencies for administrators, directors, managers, and front-line staff – MDs, RNs, others)
 - Employee involvement (participation in all aspects of safety systems)
 - Hazard prevention (tracking of ongoing quality improvement and best practice implementation)
 - Workplace analysis (accident investigation, systems analysis, inspections, reporting systems)

- **Standard:** A minimum level of acceptable performance or results *or* excellent levels of performance *or* the range of acceptable performance or results. The following represents the six types of standards (ASTM):
 - **Standard Test Method:** A definitive procedure for the identification, measurement, and evaluation of one or more qualities, characteristics, or properties of a material, product, system, or service that produces a test result.
 - **Standard Specification:** A precise statement of a set of requirements to be satisfied by a material, product, system, or service that also indicates the procedures for determining whether each of the requirements is satisfied.
 - **Standard Practice:** A definitive procedure for performing one or more specific operations or functions that does not produce a test result.
 - **Standard Terminology:** A document comprised of terms, definitions of terms, descriptions of terms, explanations of symbols, abbreviations, or acronyms.
 - **Standard Guide:** A series of options or instructions that do not recommend a specific course of action.
 - **Standard Classification:** A systematic arrangement or division of materials, products, systems, or services into groups based on similar characteristics such as origin, composition, properties, or use.

An example of the above is the **AAMI** standards for ESRD medical devices.

- **Phenotype:** The phenotype of an incident is what happens, what people actually do or what they do wrong, what you can observe. They are specific to the local situation and context – the surface appearance of an incident. **Thus the complete text of an event is critical to describe its phenotype.**
- **Genotype:** The genotype of an incident is the characteristic collection of factors that lead to the surface, phenotypical appearance of the event. They refer to patterns of contributing factors.
- **Human factors:** Study of the interrelationships between humans, the equipment and methods they use, and the environment in which they live and work.
- **Classification system:** The categorizing of errors into distinguishing levels.
- **Sharp end of healthcare system:** Practitioners at the sharp end actually interact with the hazardous process in their roles. In medicine, these practitioners are anesthesiologists, surgeons, nurses, and some technicians who are physically and temporally close to the patient (Reason, taken from Cook and Woods, 1994)
- **Blunt end of healthcare system:** Those at the blunt end of the system affect safety through their effect on the constraints and resources acting on the practitioners at the sharp end. In medicine, the blunt end includes government regulators, hospital administrators, nursing managers, and insurance companies (Reason, taken from Cook and Woods, 1994).

Types of Events

- **Adverse Event:** Untoward, undesirable, and usually unanticipated event directly associated with care or services provided within the jurisdiction of a medical center, outpatient clinic or other facility. Examples of common adverse events include: patient falls, medication errors, unexpected reactions or complications, procedural errors or complications, completed suicides, parasuicidal behaviors (attempts/gestures/threats), and missing patient events.
 - In the ESRD setting, all of the above are possible adverse events. Anticipated complications, such as hypotension, would generally not be classified as an adverse event.
- **Unpreventable adverse event:** an adverse event resulting from a complication that cannot be prevented given the current state of knowledge. (QuIC)

- **Adverse drug event (adverse drug error):** Any incident in which the use of a medication (drug or biologic) at any dose, a drug-dispensing medical device, or a special nutritional product (e.g., dietary supplement, infant formula, medical food) may have resulted in an adverse outcome in a patient. (JCAHO)
- **Adverse Device Event:** Any incident in which the use of medical equipment may have resulted in an adverse outcome for the patient.
- **Adverse drug reaction (ADR):** An undesirable response associated with use of a drug that either compromises therapeutic efficacy, enhances toxicity, or both. (JCAHO)
- **Adverse Outcome:** Includes prolonged hospitalization, disability or death at the time of discharge (Brennan et al., 1991)
- **Near Miss (Close Call):** an event or situation that could have resulted in an accident, injury or illness, but did not, either by chance or through timely intervention. Also known as close call or near hit.
 - For ESRD, close calls could include events such as tubing disconnections and/or other problems that are detected by equipment prior to causing harm.
- **Sentinel event:** An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called "sentinel" because they signal the need for immediate investigation and response. (JCAHO)
- **Dangerous Situation:** Both active and latent failures exist that create a hazard increasing the risk of harm (AHRQ)
- **Complication:** A detrimental patient condition that arises during the process of providing health care, regardless of the setting in which the care is provided.. A complication may prolong an inpatient's length of stay or lead to other undesirable outcomes.
 - For ESRD, complications could include blood stream infections (hemodialysis) and peritonitis (peritoneal dialysis).
- **Accidents:** A series of events that involves damage to a defined system disrupting the ongoing or future output of the system (IOM).

Types of Error

- **Error:** The failure of a planned action to be completed as intended or the use of an inappropriate plan to achieve an aim. Errors can include problems in practice, products, procedures, and systems. (QuIC Report)
 - **Medical error:** an adverse event or near miss that is preventable with the current state of medical knowledge. These include events of omission or commission.
- **Medication Errors:** A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing; order communication; product labeling, packing and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use. (USP Quality Review)
 - ***harm:** death, or temporary or permanent impairment of body function/structure requiring intervention
- **Systems error:** an error that is not the result of an individual's actions, but the predictable outcome of a series of actions and factors that comprise a diagnostic or treatment process. (QuIC Report)
- **Latent Systems Failures:** Small, individually innocuous systems faults that, if occurring in specific combination, can lead to catastrophic events. (Allina Health Systems)

- **Error of commission:** An error occurring as a result of an action taken. Examples include when a drug is administered at the wrong time, in the wrong dosage, or using the wrong route; surgeries performed on the wrong part of the body; and transfusion errors involving blood cross-matched for another patient. (JCAHO)
Commission: Failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim (BJC Healthcare)
- **Error of omission:** An error which occurs as a result of an action not taken, for example, , when a nurse omits a dose of a medication that should be administered, or when a patient suicide is associated with a lapse in carrying out frequent patient checks in a psychiatric unit. Errors of omission may or may not lead to adverse outcomes. (JCAHO)
Omission: Failure to carry out some of the actions necessary to achieve a desired goal (Reason)
- **Active error:** An error that occurs at the level of the frontline operator and whose effects are felt almost immediately. (IOM)
Active failure: An error precipitated by the commission of errors and violations. These are difficult to anticipate and have an immediate adverse impact on safety by breaching, bypassing, or disabling existing defenses. (JCAHO)
- **Latent error:** Errors in the design, organization, training, or maintenance that lead to operator errors and whose effects typically lie dormant in the system for lengthy periods of time. (IOM)
Latent failure: An error precipitated by a consequence of management and organizational processes and poses the greatest danger to complex systems. Latent failures cannot be foreseen but, if detected, they can be corrected before they contribute to mishaps. (JCAHO)
- **Proximate cause:** An act or omission that naturally and directly produces a consequence. It is the superficial or obvious cause for an occurrence. Treating only the "symptoms," or the proximate special cause, may lead to some short-term improvements, but will not prevent the variation from recurring. (JCAHO)
- **Proximal Cause:** Not "true" cause but the areas where the cause most likely exists (BJC)
- **Underlying causes:** The systems or process causes that allow for the proximate cause of an event to occur. Underlying causes may involve special-cause variation, common-cause variation, or both. (JCAHO)
- **Root Cause:** The most fundamental reason an event has occurred.
- **Negligence:** Failure to use such care as a reasonably prudent and careful person would use under similar circumstances. (JCAHO)

Causes of Error - Categories

- **Safety Concerns:** Protocols, procedures, products, or equipment that are problem prone, or risk-generating processes that may degrade our ability to provide optimal patient care (adapted from Allina Health Systems)
 - **Equipment Design Deficiencies:** Devices that are confusing to operate, lack safety features, and/or fail to alert users about equipment failures. Equipment should be designed and evaluated for ease-of-use and safety before purchase. In addition, when complete failures do occur, response plans should be available.
 - **Communication breakdown (related to treatment plan):** Discrepancies in communication of treatment plan between caregiver and patient, or between two caregivers.
 - **Constraint and forcing strategies not available:** There were no checkpoints or required steps that would force individuals to recognize and prevent the pending mistake. Some activities can be engineered so that it is impossible to make a mistake – e.g. it is

impossible to attach an oxygen connector to the suction outlet because the connector is designed to fit only the O2 outlet.

- **Environmental Stressors:** Workload, workspace, staffing, time pressures, noise, heat. Please identify specific factors contributing to the event.
- **Equipment Not available:** Humans are prone to taking short cuts when appropriate equipment is not available.
- **Excessive Handoffs:** Information transfers and task handoffs become more error prone each time a hand-off occurs. Examples: change of shift issues, lunch breaks, unit secretaries performing order entry.
- **Lack of Training:** Lack of training or inadequate training can leave our employees unprepared to perform. Staff not oriented or not understanding the process.
- **Lack of/limited Access to Information:** No information or limited information available at the time. Our information systems, medical records, decision support systems should give our employee the information they need when they need it. Examples: missing allergy information could contribute to a medication error.
- **Look alike or sound alike situation:** Ambiguous labeling and non-distinct storage containers can lead to inappropriate use of medications or products. Examples: drug names may look or sound similar, intravenous fluids may be packaged alike, reagent bottles may be the same size and color, or two devices look alike but operate differently.
- **Multiple entry:** Multiple entry points for identical information can lead to conflicting or ambiguous data, or omissions. Examples: allergy, height and weight information may be entered into the patient record at multiple points in our system.
- **Non-standard process:** No procedure or process exists. When processes are improvised there can be subtle differences between standard and non-standard process that are missed in time pressured situations. Examples: micro-waving gel-packs when not the manufacturer's recommended warming method can result in burns; taking shortcuts on procedures; relying on folklore nursing techniques rather than following protocols.
- **Protocol/Checklist inadequate:** Checklists or user instructions often are not provided or are incomplete, difficult to understand and/or not used..
- **Indicators of Failure Absent or not Effective:** Our systems should be designed so that our people can easily recognize when systems begin to fail or have failed. For example, procedures should be in place to alert staff that a patient about to receive an MRI is wearing a pacemaker.
- **Reliance on human checks (or rechecks):** processes that rely on double-checking or triple-checking are prone to error. Where feasible, automation may be added to reduce the need for checks. However, not everything can be safely and effectively automated.
- **Reliance on memory:** Memory aids not provided or, if provided, not used. (Human memory degrades as time goes by. Reliance on memory during multi-tasking is highly error prone). Examples: Not checking MAR; Verbal hand-offs vs. written; didn't refer to an available protocol; or using an automated device lacking sufficient information or "prompts."
- **System complexity:** Process with multiple steps and/or decision points. (Complex systems require excessive attention and can be tightly coupled). Examples: a surgical tray arrives missing a critical component; or a delayed or erroneous lab result, if there are no contingencies for these types of events they could be significant consequences.

- **Categories of error (from aviation):**
 - **Violation:** conscious failure to adhere to procedures or regulation (performing a checklist from memory).
 - **Procedural:** followed procedures with wrong execution (wrong entry into computer)
 - **Communications:** missing or wrong information exchange or misinterpretation Misunderstanding.
 - **Proficiency:** error due to lack of knowledge or skill (inability to program automation)
 - **Decision:** decision that unnecessarily increases risk (unnecessary navigation through adverse weather).
- **Behaviors that increase risk (from aviation):**
 - **Communication:**
 - Failure to inform team of patient's problem – for example, surgeon fails to inform anesthetist of use of drug before blood pressure is seriously affected.
 - Failure to discuss alternative procedures
 - **Leadership:**
 - Failure to establish leadership for operating room team
 - **Interpersonal relations, conflict:**
 - Overt hostility and frustration – for example, patient deteriorates while surgeon and anesthetist are in conflict over whether to terminate surgery after pneumothorax.
 - **Preparation, planning, vigilance:**
 - Failure to plan for contingencies in treatment plan
 - Failure to monitor situation and other team's activities – for example, distracted anesthetist fails to note drop in blood pressure after monitor's power fails.
- **Lab errors (causes and examples, from Christine Diehl)**
 - **Lab test knowledge:** Physicians unaware of a specific lab test and when to order
 - **Patient Information availability:** Patient history was not available to the clinician when needed
 - **Order Transcription:** Manually transcribed order leads to misinterpretation
 - **Interservice Communication:** Poor communication between departments in the hospital
 - **Device Use:** Improper specimen container for collection
 - **Collection Times for Drug Levels:** Dosing times are not a standard protocol in all hospitals
 - **Standardization of Procedures in hospitals:** Different procedures exist from one unit to another
 - **Transfers/Transition problems:** Identification errors when patients are transferred
 - **Conflict Resolution:** Many of the staff unaware of policies or procedures
 - **Staffing/Work Assignments:** Inability to match staffing to the current clinical load

Responses to/Prevention of Error

- **Forcing Functions:** Something that prevents the behavior from continuing until the problem has been corrected (Reason, Human Error)
- **Intervention:** may include monitoring the patient's condition, change in therapy, or active medical or surgical treatment.

- **Risk management:** Clinical, administrative and manufacturing activities undertaken to identify, evaluate, and reduce the risk of injury to patients, staff, and visitors and the risk of loss to the organization itself.
Risk containment: reflects a subset of immediate actions taken to safeguard patients from a repetition of an unwanted occurrence. Actions may involve removing and sequestering drug stocks from pharmacy shelves and checking or replacing oxygen supplies or specific medical devices.
- **Root Cause Analysis:** A process for identifying the basic or causal factor(s) that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event (JCAHO)
- **Causal Analysis Investigation:** A process to investigate and analyze patient injuries and visitor incidents that identifies latent system failures and their causes. The process generally involves gathering information surrounding the event, diagramming the steps preceding and following the event, reviewing the event with content experts (2-3) to identify the causal factors responsible for latent systems failures.)
- **Hindsight Bias:** refers to our tendency to oversimplify and assign simple (human error) causes to events during post-event investigations (i.e. knowing the outcome of an event skews our perception of contributing factors). Structured analysis techniques help counteract these tendencies by forcing us to look, beyond human error, for the latent systems deficiencies that can lead our employees toward failure.

Severity Indexes

- **Error Severity Codes (Allina Health Systems):**
 - **Did not reach patient, potential injury**
Example: prescription bottle labeled correctly but nurse notices wrong pills in bottle, wrong medications loaded in Pyxis or med drawer, nursing station keeps all multidose medication vials in same the same drawer or bin. The patient has to tell lab tech not to take blood from a specific arm, no signs or notes on order or care plan, no sign in room.
 - **Reach patient-No Injury or effect on patient**
Example: Missed antibiotics, double dose of pain meds, wrong lab tests done, Wrong limb x-rayed, diagnostic test done incorrectly.
 - **Emotional injury**
Example: Elopement or AMA, behavior health altercation between peers, wrongful confinement to a mental hospital, wrongful birth (birth after vasectomy, etc.), and fright, as well as 5th degree sexual conduct (touching or unacceptable sexual behavior, with no physical harm). Use of restraints.
 - **Minor Temporary:** Minor patient injury or increased patient monitoring or change in treatment plan (with or without injury). Length of stay increased by less than 1 day.
Example: error in setting or monitoring heparin levels requiring increased number of lab tests, missed insulin dose requiring change in dosing for next administration and/or increased glucose checks. Bruising, abrasions, skin tear, complaints of pain, small number of non-facial sutures. Minor self- inflicted injury, (scratches or cutting.)
 - **Major Temporary:** A temporary injury that exceeds minor temporary or increases length of stay one day or more.
Examples: facial sutures, minor fractures, severe drug reaction.
 - **Minor Permanent:** A permanent injury that does not compromise basic functions of daily living.
Examples: Loss of finger, loss of testicle or ovary, removal of bowel due to circulatory compromise, loss of teeth, 2nd degree sexual conduct (forced sexual contact via threat of

violence or weapon, forced sexual contact that causes injury, or sexual contact with someone < 16 years old), retained sponge/needle.

- **Major Permanent:** Permanent injury that affects basic functions of daily living. Examples: Hip fracture, nerve damage from improper surgical positioning, missing limb, damage to sensory organ, 1st degree sexual assault (forced sexual penetration via threat of violence or weapon, forced sexual penetration that causes injury, or sexual penetration of someone under 16 years old).
- **Extreme:** Example: Brain damage, severe paralysis, death.

➤ **Reportable occurrence:** An event, situation, or process that contributes to, or has the potential to contribute to, a patient or visitor injury, or degrade our ability to provide optimal patient care. Reportable occurrences can generally be divided into the following types based on severity (Adapted from Allina Health Systems):

- **Sentinel events:** Any unanticipated death or serious injury resulting in a major permanent loss of function not attributed to the natural course of affected person's illness or underlying condition.
- **Patient and visitor injuries** [adverse events]: An unanticipated physical or emotional patient injury not attributed to the natural course of affected person's illness or underlying condition
- **Nears misses:** An event of situation, in the patient care environment, that could have resulted in a patient injury or visitor incident, but did not, either by chance or through timely intervention.
- **Safety concerns:** Protocols, procedures, products, or equipment that are problem prone, or risk-generating processes that may degrade our ability to provide optimal patient care.

➤ **Serious Adverse Reaction:** Include (FDA)

- **Death:** If an adverse reaction to a medical product is a suspected cause of a patient's death.
- **Life-threatening hazard:** If the patient was at risk of dying at the time of the adverse reaction or if it is suspected that continued use of a product would cause death (examples: pacemaker breakdown or failure of an intravenous (IV) pump that could cause excessive drug dosing).
- **Hospitalization:** If a patient is admitted or has a prolonged hospital stay because of a serious adverse reaction (example: a serious allergic reaction to a product such as latex).
- **Disability:** If the adverse reaction caused a significant or permanent change in a patient's body function, physical activities, or quality of life (examples: strokes or nervous system disorders brought on by drug therapy).
- **Birth defects, miscarriage, stillbirth or birth with disease:** If exposure to a medical product before conception or during pregnancy is suspected of causing an adverse outcome in the child (example: malformation in the child caused by the acne drug Accutane, or isotretinoin).
- **Needs intervention to avoid permanent damage:** If use of a medical product required medical or surgical treatment to prevent impairment (examples: burns from radiation equipment or breakage of a screw supporting a bone fracture).

➤ **Medication Error Index (NCC MERP):**

- **No error**
 - Category A Circumstances or events that have the capacity to cause error
- **Error, no harm***
 - Category B An error occurred but the medication did not reach the patient
 - Category C An error occurred that reached the patient but did not cause patient harm
 - Category D An error occurred that resulted in the need for increased patient monitoring but no patient harm.
- **Error, harm**
 - Category E An error occurred that resulted in the need for treatment or intervention and caused temporary patient harm.
 - Category F An error occurred that resulted in initial or prolonged hospitalization
And caused temporary patient harm
 - Category G An error occurred that resulted in permanent patient harm
 - Category H An error occurred that resulted in a near-death event (e.g. cardiac arrest)
- **Error, death**
 - Category I An error occurred that resulted in patient death