The JCAHO patient safety event taxonomy: a standardized terminology and classification schema for near misses and adverse events FREE

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Abstract

Background. The current US national discussions on patient safety are not based on a common language. This hinders systematic application of data obtained from incident reports, and learning from near misses and adverse events.

Objective. To develop a common terminology and classification schema (taxonomy) for collecting and organizing patient safety data.

Methods. The project comprised a systematic literature review; evaluation of existing patient safety terminologies and classifications, and identification of those that should be included in the core set of a standardized taxonomy; assessment of the taxonomy's face and content validity; the gathering of input from patient safety stakeholders in multiple disciplines; and a preliminary study of the taxonomy's comparative reliability.

Results. Elements (terms) and structures (data fields) from existing classification schemes and reporting systems could be grouped into five complementary root nodes or primary classifications: impact, type, domain, cause, and prevention and mitigation. The root nodes were then divided into 21 subclassifications which in turn are subdivided into more than 200 coded categories and an indefinite number of uncoded text fields to capture narrative information. An earlier version of the taxonomy (n = 111 coded categories) demonstrated acceptable comparability with the categorized data requirements of the ICU safety reporting system.

Conclusions. The results suggest that the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) *Patient Safety Event Taxonomy* could facilitate a common approach for patient safety information systems.

Having access to standardized data would make it easier to file patient safety event reports and to conduct root cause analyses in a consistent fashion.

Keywords: patient safety, standardized terminology and classification, taxonomy

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