Academia Mexicana de Cirugía
Fundación Academia Aesculap México, A. C.

Protocolos de la aplicación de la Taxonomía

Dr. David Valdez Méndez.

México, D. F. 27 de octubre de 2009

Octubre 2004.
Alianza para la Seguridad del paciente.

Clasificación Internacional para la Seguridad
Del Paciente – **Taxonomía**—

Objetivos:

Facilitar la descripción, comparación, medición, monitoreo, análisis e interpretación de la información provista en la seguridad del paciente.

Categorizar la información respecto de la seguridad del paciente para la planeación de investigadores y profesionales de la salud en el desarrollo de políticas.

Proveer las bases para el desarrollo de un currículum de seguridad del paciente que describa el conocimiento en materia de seguridad del paciente.

Clasificación Internacional para la seguridad del paciente.

- Evaluación cultural y lingüística con expertos Españoles y Latinoamericanos. Madrid, octubre 15, 2008.

- Evaluación cultural y lingüística con expertos franceses. París, octubre 13, 2008.

- Reunión de la Alianza Mundial en Seguridad del Paciente con expertos del Sureste de Asia y oeste del Pacífico. Noviembre 26, 2007.

Protocolos de Taxonomía

- Departamento de Práctica General y Cuidados Primarios y Departamento de Salud Social y Comunitaria, Universidad de Auckland, Auckland, Nueva Zelanda.

- Error en el paciente: Una taxonomía preliminar.

- 11 grupos de profesionales de la salud, 2007.
- Taxonomía del error en el paciente.
- Sistema de 3 niveles y 70 potenciales errores.

Table 2. Taxonomy of Patient Error

Level 1	Level 2	Level 3	Examples* Type of Error	Participant Comment
Action errors				
1. Attendance errors	1.1 Underattendance	1.1.1 Nonattendance	Refusal of visits	"If it runs through the family we seek no help" (group 2)
		1.1.2 Insufficient attendance	Less frequent attendance than recommended	"(Not) following your gut instinct and not seeking a second opinion" (group 8)
	1.2 Untimely attendance	1.2.1 Early attendance	Attendance for self-limiting conditions	"Hypochondriacal behavior" (group 5)
		1.2.2 Late attendance	Deferral of visit	"Delay in visiting the doctor when you know you're sick" (group 2)
	1.3 Overattendance	1.3.1 Frequent attendance	More frequent attendance than required	"Overattendance (eg, because the doctor is cute)" (group 2)
	1.4 Misattendance	1.4.1 Inappropriate type of visit	Demand for a home visit by a patient who could have safely come to the clinic	Irregularity (group 2)
		1.4.2 No usual provider chosen	Frequently changing providers	"Consulting multiple doctors" (group 9)
		1.4.3 Use of unqualified sources	Use of unqualified complementary sources	Taking advice from marginal sources: "over the fence, nonqualified practitioners, TV adverts" (group 9)
		1.4.4. Refusals during visits	Refusal to be examined by a student doctor	"Refusing to be checked by the doctor" (group 1)
		1.4.5 No escort when needed	No interpreter	"Not coming in with an interpreter (friend/relative) when their communication in English is suboptimal" (group 9)
		1.4.6 Inappropriate escort/chaperone	Child	"Not telling doctor what their real concerns are" (group 9)
2. Assertion errors	2.1 Taciturnity	2.1.1 Nondisclosure of relevant information	Not updating contact information	"Not telling the doctor all your symptoms" (group 7)
		2.1.2 Nonquestioning	Not asking for clarification of confusing information	"Not questioning professionals if instructions are unclear or they do not understand" (group 10)
	2.2 Verbosity	2.2.1 Excessive talk	Not giving the clinician sufficient time to meet concerns	"Telling doctor what I want but not giving much time for him to tell me what he would like" (group 3)
	2.3 Extraneous talk	2.3.1 Irrelevant talk	Trying too hard to recall details	"No relationship with doctor, so just say 'yes' to everything" (group 1)
	2.4 Erroneous talk	2.4.1 Inaccurate talk	Contradicting medical advice to family or friends	"Inaccurate/false responses" (group 2)
	2.5 Inarticulateness	2.5.1 Inability to express thoughts clearly	Limited language skills; translation errors.	Inability to describe your sickness" (group 7)
	2.6 Disrespect	2.6.1 Lack of caring	Lack of regard for interests of clinician	"Making 1 appointment for 2 to 4 people" (group 10)
		2.6.2 Discourtesy	Cell phone on during visits	"Not notifying if late or, need to miss, appointments" (group 10)
		2.6.3 Abusiveness	Violent patient	"Being drunk and abusive" (group 6)
	2.7 Artfulness	2.7.1 Dishonesty	Distortion of information given	"Lying about symptoms to jump queue" (group 4)
		2.7.2 Pretense of sickness	Benefits of sick role	"Pretending to be ill to take the day off school" (group 7)
		2.7.3 Manipulation of system	False claims for compensation	"Seeks to manipulate the outflow of information from the medical record" (group 9)
3. Adherence errors	3.1 Collection errors	3.1.1 Prescriptions not redeemed	Prescribed medications not collected from pharmacies	"Only getting medications they can afford for now" (group 10)
	3.2 Storage errors	3.2.1 Storage errors	Storage of medications past expiration date	"Accumulating discontinued medications" (group 9)
	3.3 Self-administration	3.3.1 No treatment	Failure to take recommended treatment	"Running out of medications" (group 10)
		3.3.2 Wrong treatment	Taking discontinued treatment	"Using old medication" (group 6)
		3.3.3 Dosage errors	Excessive dosage	"Doubling up treatment if going away" (group 3)

ACADEMIA AESCULAP

Table 2. Taxonomy of Patient Error *(continued)*

Level 1	Level 2	Level 3	Examples* Type of Error	Participant Comment
Action errors (continued)				
		3.3.4 Timing errors	Taking medication at incorrect times	"Taking medication in wrong order" (group 11)
		3.3.5 Duration errors	Treatment duration is shorter than recommended	"Stopping too soon" (group 11)
		3.3.6 Hazardous interactions	Interactions of over-the-counter and prescribed treatments	"Mixing pills and alcohol" (group 6)
	3.4 Other delivery errors	3.4.1 Sharing of medication	Sharing medication with family or friends	"Sharing resources with relatives, eg, 'rescue' asthma inhalers" (group 10)
Mental errors: proximate determinants				
4. Memory errors	4.1 Memory lapses	4.1.1 Forgetfulness	Forgetting to take medication	"Forgetting to collect the medication" (group 11)
		4.1.2 Misrecalling information	Misrecalling when to attend for care	"Turn up at wrong time" (group 1)
5. Mindfulness errors	5.1 Inattention	5.1.1 Failure to notice	Not perceiving	"Not listening to what the doctor says" (group 8)
		5.1.2 Recognize incorrectly	Misreading of symptoms	"Over-reacting to children's symptoms" (group 4)
	5.2 Overattentiveness	5.2.1 Hypervigilance	Overattentiveness to variations in normal function	"Hyperchondriacal behavior" (group 5)
6. Misjudgments	6.1 Assessment errors	6.1.1 Failure to check	Failure to check on laboratory results	"Not checking pills from chemist" (group 3)
		6.1.2 Failure to monitor	Failure to monitor weight	"Not monitoring blood glucose as recommended" (group 10)
		6.1.3 Failure to record	Failure to keep a patient diary when requested	"Not recording symptoms when asked, or bringing record back as asked" (group 9)
		6.1.4 Wrong assessment	Misreading of instructions	"Stopping medication just because you feel better" (group 1)
	6.2 Unrealistic expectations	6.2.1 Overexpectation of others	Immediate cure	"Expecting the doctor to read their mind" (group 9)
		6.2.2 Overexpectation of self	Self-diagnosis	"Using the internet for self-diagnosis and self-treatment" (group 10)
		6.2.3 Underexpectation of others	Expected inability of clinician to help	"Having no faith in doctors" (group 8)
		6.2.4 Underexpectation of self	Expected inability of self to cope or share responsibilities	"Inability to cope with new presentations" (group 11)
Memory errors: background determinants				
7. Knowledge deficits	7.1 Knowledge errors	7.1.1 Low literacy	Poor language skills	"Inability to read and understand instructions" (group 1)
		7.1.2 Low health literacy	Not knowing the name of medications	"Confusion over brand, shape, color and name (especially when these change" (group 11)
		7.1.3 Low numeracy	Inability to budget	"Not budgeting and not having an emergency fund for medical care" (group 8)
	7.2 Comprehension errors	7.2.1 Lack of understanding	Failure to understand instructions	"Not understanding instructions (eg, re: casts, equipment)" (group 10)
	7.3 Logic errors	7.3.1 Reasoning errors	Considering that a medication imparts absolute protection	"Assuming that must be OK because feeling good" (group 2)
8. Attitudes not conducive to health	8.1 Selfishness	8.3.1 Excessive pride	Reluctance to ask for, or accept help	"Reluctance to ask for help (eg, credit) because of pride" (group 8)
		8.3.2 Dishonesty	Lying	"Lying about symptoms to jump queue" (group 4)
		8.3.3 Self-pity	Feeling a victim	"Feeling self-pity; becoming a victim" (group 1)
		8.3.4 Hedonism	Willingness to drink alcohol inappropriately	"Taking medicines for recreational use (eg, too much insulin to get a high)" (group 11)

ACADEMIA
AESCULAP

Table 2. Taxonomy of Patient Error *(continued)*

Level 1	Level 2	Level 3	Examples* Type of Error	Participant Comment
Memory errors: background determinants (continued)				
	8.2 Self-neglect	8.2.1 Excessive selflessness	Carriage of other people's burdens	"Putting other people's needs first" (group 2)
		8.2.2 Lack of self-regard	Shyness at visits	"Forget to love oneself; putting other people before yourself" (group 4)
		8.2.3 Carelessness	Carelessness	"Losing instructions" (group 2)
		8.2.4 Embarrassment	Shame	"Not taking medications because you think your friends might mock you" (group 7)
	8.3 Carelessness	8.4.1 Inattention	Distractedness or absent-mindedness	"Patient distracted—not engaging in the consultation" (group 10)
		8.4.2 Thoughtlessness regarding others	Sharing food and drink while infectious	"Not staying home when feeling sick (so spreading influenza)" (group 8)
		8.4.3 Excessive risk taking	"She'll be OK" attitude	"Taking risks with your health when sick" (group 5)
		8.4.4 Apathy	Laziness in getting medication	"Noncollection of medicines because of sloth" (group 11)
		8.4.5 Unreliability	Inconsistency in passing on messages	"Inconsistent with medication" (group 3)
	8.5 Distrust	8.5.1 Disbelief	Suspicion of health professionals	"Not believing the doctor" (group 2)
		8.5.2 Fearfulness	Fear of needles	"Staying with an unhelpful doctor because of familiarity and fear of change" (group 1)
		8.5.3 Uncooperative-ness	Unwillingness to negotiate	"Refusing to be checked by the doctor" (group 1)
		8.5.4 Pessimism	Feeling of helplessness	"Giving up hope" (group 1)
	8.6 Anger	8.6.1 Impatience	Impatience while waiting for care	"Not having patience while waiting" (group 6)
		8.6.2 Intolerance	Prejudice against doctors with non-English speaking backgrounds	"Stressing out on things that you have forgotten to do" (group 4)
	8.7 Other priorities	8.7.1 Cultural priorities	Mourning takes priority over medication adherence	"Tangi [funeral] disrupts medical/health needs" (group 3)

Protocolos de Taxonomía

Taxonomía del error en el paciente

		Nivel 1	Nivel 2	Ejemplo
1	Errores en la acción	Errores de atención	Desatención	Atención menos frecuente que la necesaria
			Sobreatención	Atención mayor a la requerida
		Errores en la afirmación	Verbosidad	Habla excesiva
			Habla errónea	Contradicción en indicaciones médicas con familia o amigos.
			Faltas de respeto	Falta de interes ante el médico
		Errores de adherencia	Errores de recolección	Prescripción de fármacos de difícil adquisición
			Errores de almacenaje	Almacenaje más allá de la caducidad.
			Auto administración	Interrupción de tratamientos.
2	Errores mentales	Errores de memoria	Lapsos de memoria	Olvido al tomar medicamentos.
		Errores de conciencia	Inatención	No entiende lo que dice el médico
		Errores de juicio	Expectativas no reales	Fallas en el control de peso (percepción)
3	Errores de memoria	Déficit de conocimiento	Errores de comprensión	Pobre lenguaje
		Actitides contrarias a la salud	Egoismo	Sentimiento de víctima.

Protocolos de Taxonomía

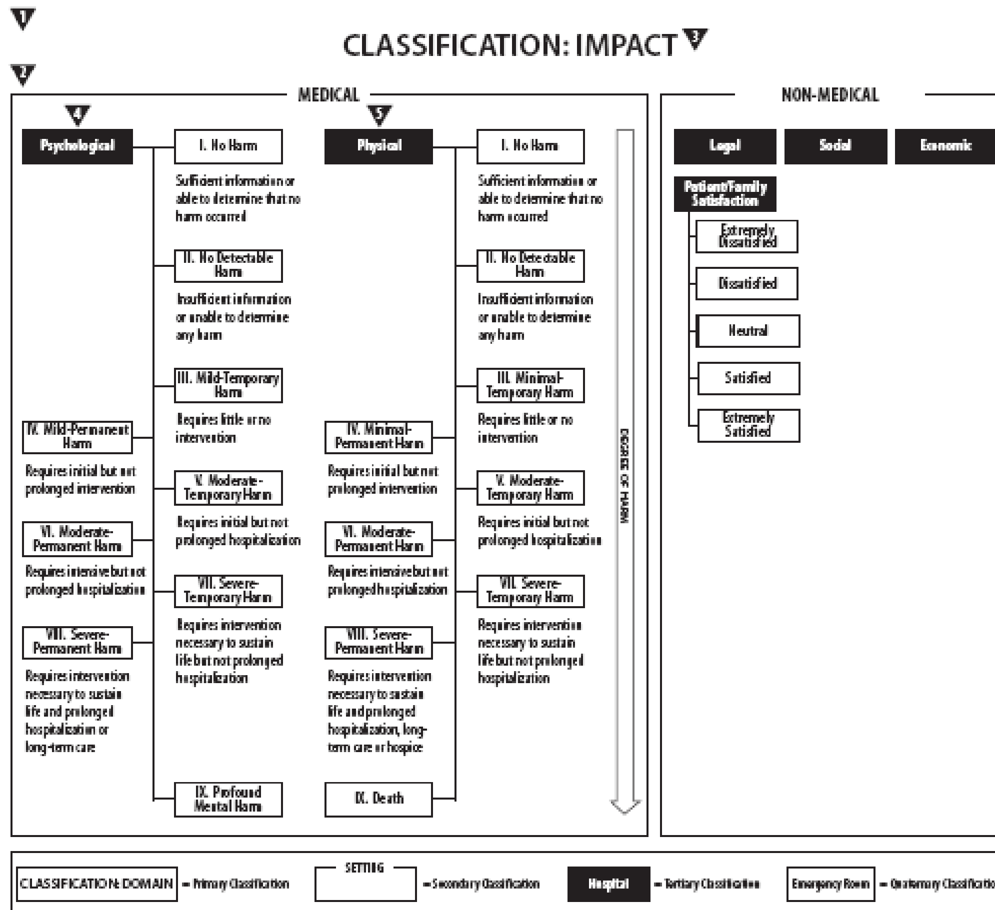
- National Quality Forum - The Joint Commission of Accreditation of Healthcare Organizations:

  Patient Safety Event Taxonomy (PSET), Washington, 2006.

- Entidades federales de cuidado a la Salud.
- Institutos de Medicina E. U. A.

- Evaluación de taxonomías enviadas por correo electrónico a 265 miembros del NQF.

Figure A-1 – Classification: Impact



(PLEASE REFER TO LARGER DIAGRAM FOR DETAILS)

1 FRAMEWORK CLASSIFICATION
The model taxonomy is categorized into five classifications: domain, cause, type, impact, and prevention and mitigation. A failure may be applicable to more than one classification; when this occurs, the primary classification is listed first.

2 SUBCATEGORIES
The model taxonomy is further subdivided into subcategories within the framework classification. These subcategories are depicted below the framework classification. A process failure may be applicable to more than one subcategory. For example, a failure may occur at the hospital, practitioner office, and nursing home.

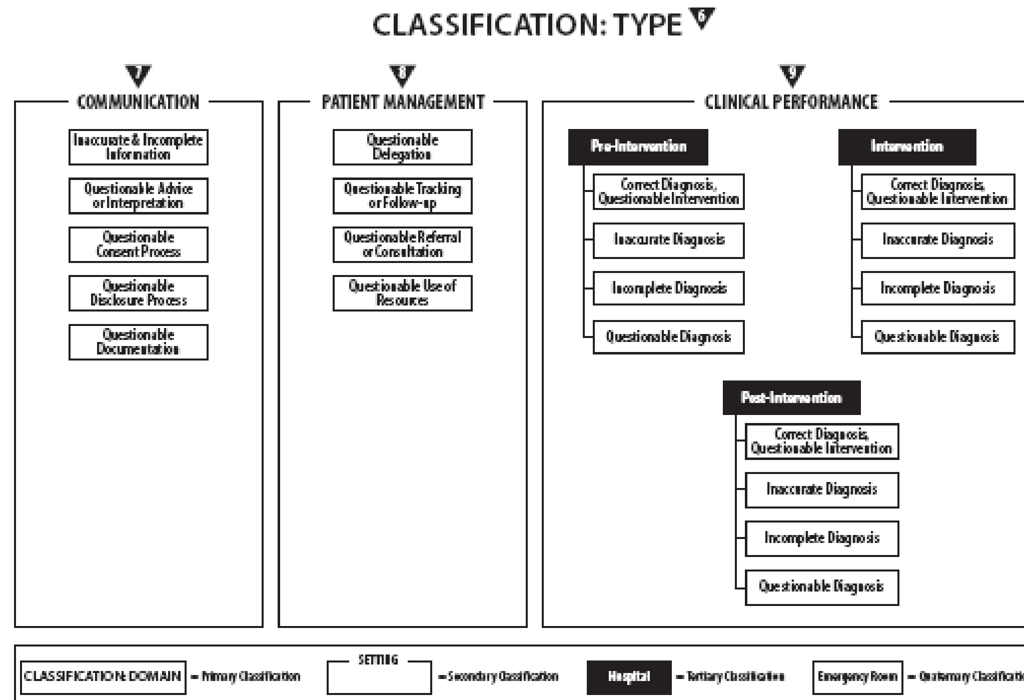
3 IMPACT
Outcome or effect of process failure, commonly referred to as harm. Harm has been defined as temporary or permanent impairment of physical or psychological body functions or structure. Some classification schemes define impact in terms of degree of harm.

4 PSYCHOLOGICAL
Identifies the severity of psychological harm, from the least harm to the most harm, resulting from process failure.

5 PHYSICAL
Identifies the severity of physical harm, ranging from the least harm to the most harm, resulting from process failure.

ACADEMIA AESCULAP

Figure A-2 – Classification: Type



6 TYPE
Perceptible, outward, or visible expression of process failure commonly referred to as error. Most classification schemes define this expression in terms of type of error.

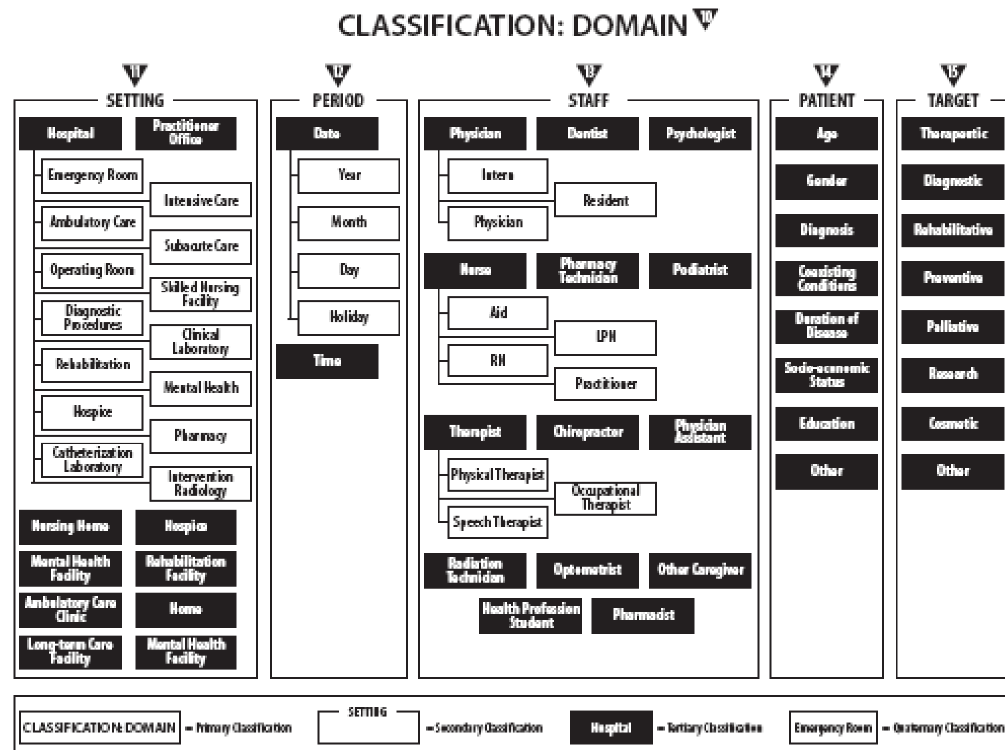
7 COMMUNICATION
Identifies failure in communication that exists between patient and practitioner, patient's proxy and practitioner, practitioner and non-medical staff, and among practitioners.

8 PATIENT MANAGEMENT
Identifies substandard patient management that involves improper delegation, failure in tracking or follow-up, wrong referral or consultation, or wrong use of resources.

9 CLINICAL PERFORMANCE
Identifies the full range of failures resulting from direct clinical care of a patient, and involves pre-intervention, intervention and post-intervention.

ACADEMIA AESCULAP

Figure A-3 – Classification: Domain



(PLEASE REFER TO LARGER DIAGRAM FOR DETAILS)

10 DOMAIN
Identifies where a process failure occurred and the initial intended target for patient care interventions.

11 SETTING
Identifies the full range of healthcare delivery settings where process failure can exist and the type of individual involved.

12 PERIOD
Information on the time and date that the event occurred and the time and date that the event was reported.

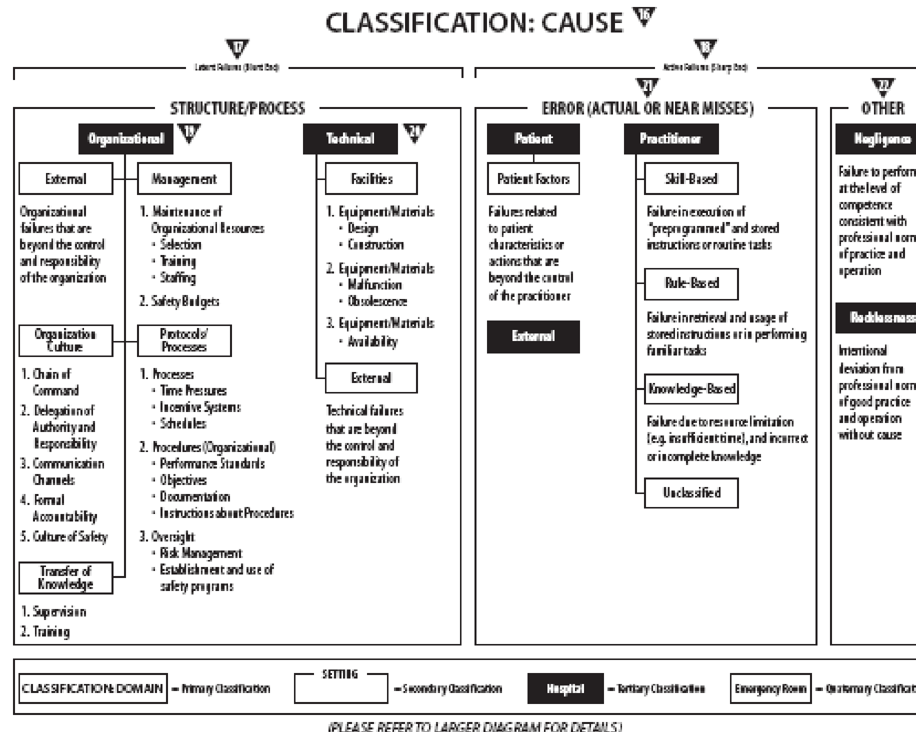
13 STAFF
The personnel who carry out the enterprise of healthcare.

14 PATIENT
Characteristics of the patient who was involved in the event.

15 TARGET
The original clinical reason why the patient who was involved in the incident entered the healthcare system during this clinical encounter.

ACADEMIA AESCULAP

Figure A-4 – Classification: Cause



(PLEASE REFER TO LARGER DIAGRAM FOR DETAILS)

16 CAUSE
Factors and agents that bring about a process failure.

17 LATENT FAILURE – BLUNT END
Present or potential failure but not evident or active. It is removed from the direct control of the practitioner and is usually the distal cause of process failure. Individuals at the blunt end take actions and/or make decisions that affect technical and organization policy and procedures and allocate resources.

18 ACTIVE FAILURE – SHARP END
Process failure that occurs at the level of the practitioner. Effects are felt almost immediately (Immediate cause of failure). Individuals at the sharp end are in direct contact with the patient-system interface, i.e., they administer care to patients.

19 ORGANIZATIONAL/SYSTEM FAILURE
Latent organizational failure that involves five areas:
1) management, 2) organizational culture, 3) protocols/processes, 4) transfer of knowledge, and 5) external factors.

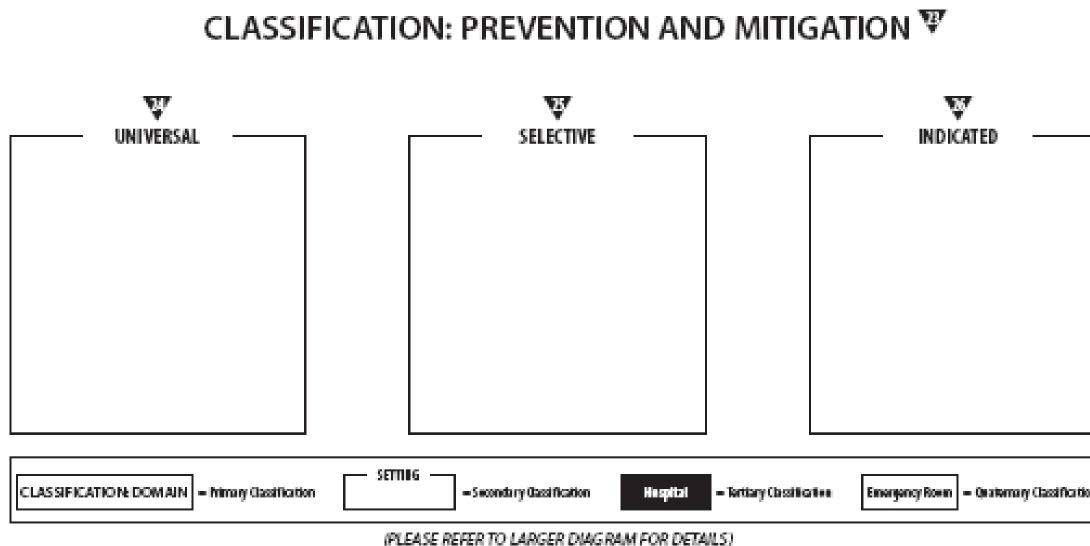
20 TECHNICAL FAILURE
Latent technical failure that involves two areas: 1) facilities, and 2) external factors.

21 ERROR
Failure to perform a task satisfactorily against customary standards and that failure cannot be attributed to causes beyond the patient or provider.

22 OTHER
Failures not attributable to structure/process or human error.

ACADEMIA AESCULAP

Figure A-5 – Classification: Prevention and Mitigation



23 PREVENTION AND MITIGATION
Those activities an organization undertakes to prevent or attempt to lessen the severity and impact of a potential adverse event.

24 UNIVERSAL
Activities that can be implemented across departments within an organization and across all relevant healthcare settings.

25 SELECTIVE
Activities that can be implemented within certain departments or clinical areas, and potentially across all relevant healthcare settings.

26 INDICATED
Activities that can be implemented to improve a specific clinical or organizational process within a department in a specific healthcare organization.

Protocolos de Taxonomía

- Edinburg Incident Classification. ICU, Western General Hospital, Edinburgh, UK, 1898.

- Reporte y análisis de “incidentes críticos” en la unidad de terapia intensiva, relacionado con errores humanos y falla de equipos.

Protocolos de Taxonomía

Factores inesperados en ejecución:

1. Inexperiencia con equipos
2. Entrenamiento incompleto del staff.
3. Turno nocturno.
4. Fatiga.
5. Pobre diseño de equipos
6. Unidad llena.
7. Enfermera de Agencia
8. Falta de equipo apropiado.
9. Falla en chequeo de equipos.
10. Falla en chequeo horario.
11. Pobre comunicación
12. Falta de consideración.

Ambiente y factores de tareas específicas:

1. Presencia de estudiantes/residentes.
2. Mucha gente presente.
3. Pobre visibilidad.
4. Paciente obeso.
5. Cambio de paciente.
6. Paciente mal sedado.
7. Líneas venosas no bien fijas.
8. Monitor PIC incorrecto.
9. Tubo endotraqueal no bien colocado.
10. Tubo torácico no bien colocado.
11. SNG no bien asegurado.

Protocolos de Taxonomía

- International Taxonomy for Errors in General Practice, Departament of General Practice, University of Sydney, Australia, 2002.
- Diseñada para clasificar los tipos de errores que ocurren en la práctica general y puede aplicarse en múltiples países con estándares de cuidado general similares.
- Cinco niveles con 171 tipos de error.

Protocolos de Taxonomía

- Classification of Medical Errors and preventable adverse events in pimary care, Cincinnati, Ohio, 2002.

  Auxiliar para médicos familiares en el entendimiento de la ocurrencia de errores en la atención primaria.

- Taxonomy for error reporting, Root causa analysis and Analysis of Practice Responsibility (TERCAP). University of California, San Francisco, CA, 2002.

- Generic Occurrence Classification for Incidents and Accidents in the Health Care System, Autralian Patient Safety Foundation, Adelaide, Australia, 1998.

Recomendaciones para una Taxonomía Internacional:

- Uso de vocabulario claro, no ambiguo, y acorde con la evidencia científica más reciente disponible, basada en la ciencia epidemiológica.
- Incluir un rango amplio de temas de seguridad del paciente, incluyendo los diversos sistemas internacionales de cuidado de la salud.
- Es necesario que la complejidad de la nomenclatura se reduzca al mínimo.
- Deberá excluir términos que generen confusión, evitar la innecesaria generación de términos, y ser estable.
- Deberá facilitar el reporte, monitoreo e investigación de los eventos adversos de la medicina pública, y proveer un análisis consistente en la presentación de los datos.
- Deberá mitigar el subregistro de eventos adversos y ser acorde con los reportes requeridos por los Ministerios de Salud y Agencias Gubernamentales en un formato estándar.

Gracias