

## PENNSYLVANIA PATIENT SAFETY AUTHORITY HARM SCORE TAXONOMY

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| CODE                     | DEFINITION  |
|--------------------------|---|
| <b>Unsafe Conditions</b> |   |
| A                        | Circumstances that could cause adverse events (e.g., look-alike medications, confusing equipment).  |
| <b>Event, No Harm</b>    |   |
| B1                       | An event occurred but it did not reach the individual (“near miss” or “close call”) because of chance alone.  |
| B2                       | An event occurred but it did not reach the individual (“near miss” or “close call”) because of active recovery efforts by caregivers.   |
| C                        | An event occurred that reached the individual but did not cause harm and did not require increased monitoring (an error of omission, such as a missed medication dose, <i>does</i> reach the individual). |
| D                        | An event occurred that required monitoring to confirm that it resulted in no harm and/or required intervention to prevent harm.   |
| <b>Event, Harm</b>       |   |
| E                        | An event occurred that contributed to or resulted in temporary harm and required treatment or intervention.   |
| F                        | An event occurred that contributed to or resulted in temporary harm and required initial or prolonged hospitalization.  |
| G                        | An event occurred that contributed to or resulted in permanent harm.  |
| H                        | An event occurred that resulted in a near-death event (e.g., required intensive care unit care or other intervention necessary to sustain life).  |
| <b>Event, Death</b>      |   |
| I                        | An event occurred that contributed to or resulted in death.   |

Sources: National Coordinating Council for Medication Error Reporting and Prevention. NCC MERP index for categorizing medication errors [online]. 2001 Feb [cited 2015 Jan 13]. <http://www.nccmerp.org/medErrorCatIndex.html>; US Department of Veterans Affairs National Center for Patient Safety. Severity assessment code (SAC) matrix [online]. [cited 2015 Jan 13]. <http://www.patientsafety.va.gov/professionals/publications/matrix.asp>

For more information, visit <http://www.patientsafetyauthority.org>.

This table accompanies

Magee MC. Patient flow in the ED: phase II—diagnostic evaluation through disposition decision.

Pa Patient Saf Advis [online] 2015 Mar [cited 2015 Mar 12].

[http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2015/Mar;12\(1\)/Pages/home.aspx](http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2015/Mar;12(1)/Pages/home.aspx)