Appendix - Classification System – Incident Reports
Pediatric Emergency Care Applied Research Network Safety Working Group

Table1. Incident types and subtypes. Asterisked subtypes have further sub-classifications that are not shown. Each subtype also contained a category for "Other," not shown in this table.

Incident type	Incident subtype
Behavior	Interpersonal assault
	Elopement
	Professional misconduct
Blood product	Delayed or missed
	Adverse reaction*
	Wrong patient
	Wrong product
Environmental safety	Elements (fire flood, odor, smoke, irritants)
Equipment/medical devices	Not available
	Broken
	Alarm malfunction
Laboratory	Delayed result or lost specimen
	Wrong patient
	Unlabeled specimen
	Mislabeled specimen
Medications	Allergy*
	Delayed or missing dose
	Adverse reaction*
	Wrong dose*
	Wrong medication*
	Wrong patient
	Wrong route
Medical procedure	Complication
	Wrong patient
	Wrong procedure
	Wrong site
	IV infiltrate
Process variance	Confidentiality violation/consent issue
	Infection control*
	Patient flow/delay*
	Patient identification*
Radiology	Delay in test
	Delay in results
	Misreading/changed reading
Other	Wrong patient, Wrong site

Table 2. Severity of harm.

A	Potentially risky situation that could contribute to an adverse event
B1	Near-miss. An event occurred but did not reach the patient because of chance alone.
B2	Near-miss. An event occurred but did not reach the patient because of active recovery efforts by caregivers (intercepted event).
C	No harm, no increased monitoring.
D	No harm, increased monitoring or treatment to prevent harm.
E	Temporary harm, required treatment.
F	Temporary harm, required hospitalization or prolonged hospitalization.
G	Permanent harm.
H	Near death.
I	Death.
0	Unknown impact on patient.

Table 3. Contributing factors.

- **Environmental (ergonomics, design of space, adequacy of infrastructure) (free text)**
- **Equipment (free text)**
- **Human (employee)**
  - Calculations
  - Clinical judgment
  - Communications / interpersonal skills
    - Hand-off between services
    - Hand-off within the ED
    - Other (specify with free text)
  - Compliance with established procedure
    - Wrong ID or no ID
    - Other
  - Fatigue, stress, and distractions
  - Legibility
  - Other (specify with free text)
- **Information Technology Systems**
  - Hardware malfunction or system downtime (specify with free text)
  - Software design or malfunction (specify with free text)
  - Other (specify with free text)
- **Patient or guardian**
  - Behavioral
  - Compliance
  - Developmental
  - Other (specify with free text)
- **Systems**
  - Availability of needed equipment or other resources
  - Policies or procedures not available or unclear
  - Communication systems
  - Staff experience
  - Staffing levels
  - Other (specify with free text)