Minimal Information Model for Patient Safety Incident Reporting and Learning Systems

USER GUIDE

World Health Organization

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Introduction

Things go wrong in health care with unacceptable frequency for many individuals seeking preventive, diagnostic, curative or rehabilitative health services. When this happens, it is essential to understand the causes and contributory factors, as well as the consequences and possible mitigating actions and solutions that could prevent that type of event from happening again.

One of the major challenges of patient safety incident reporting and learning systems lies in the difficulties of extracting sound and practical information from the vast amount of data collected. For many years, health information systems have focused on classifying occurrences of adverse events in patient safety for statistical and comparison purposes, which can then also provide a basis for policy decision-making.

A large amount of data related to adverse events has been collected in parallel to the growing interest for quality and safety in health care. On the other hand, comparison of data collected from different systems has become extremely difficult due to the lack of universal concepts and definitions to name and report patient safety incidents. Developing and maintaining a classification presents many challenges: agreeing on a common reference nomenclature, aligning to medical progress, cross-cultural implementation, etc.

The World Health Organization (WHO) has been a world leader in examining patient safety incident reporting and learning systems, beginning with its *Draft Guidelines for Reporting and Learning Systems* and the Global Community of Practice in 2005. Then, the *Conceptual Framework (CF) for the International Classification for Patient Safety (ICPS)* [1] was developed in 2009. This CF provided a list of the conceptual instances, or terms, used in adverse event reports, with narrative descriptions of their meaning.

In 2010, a formal representation (categorial structure) of the conceptual framework categories in machine-readable form was generated, based on international standards and using state-of-the-art technologies [2]. This

categorial (information categories) structure had been examined in several countries for a number of years, inputting real data from existing reporting systems. Finally, this information model has been found computable (translatable with an information technology vocabulary) in 2013.

This information model, renamed the Minimal Information Model for Patient Safety (MIM PS) Incident Reporting and Learning Systems was validated in ten European countries, through a joint project of EU and WHO supported financially by the European Commission (Directorate-General for Health and Food Safety – DG-SANTE) in 2014-15. Through this validation process, more than four hundred anonymous data sets were collected from diverse existing reporting systems and the incident types used in those reporting systems were analysed. The results led to the minimal information model format and field guidance presented in this document.

Minimal Information Model For Patient Safety Incident Reporting and Learning Systems (MIM PS)

The purpose of the MIM PS is to provide a list of information categories that should be collected as a minimum, when reporting an adverse event.

The reason for this is that adverse event reporting is nowadays increasingly seen, in the patient safety community, as a tool not only for assessing the patient safety situation at any one point in time, but also to contribute to sharing anonymous safety incident information with others, in a mutually understandable format, as part of a continuous learning process, in order to encourage to policy change