Diagnosis Error Evaluation and Research (DEER) Taxonomy WHERE IN THE DIAGNOSTIC PROCESS AN ERROR MAY HAVE OCCURRED

1. Access/Presentation	a. Failure/delay in presentationb. Failure/denied care access
2. History	 a. Failure/delay in eliciting critical piece of history data b. Inaccurate/misinterpreted/overlooked critical piece of history data c. Failure in weighing critical piece of history data d. Failure/delay to follow-up critical piece of history data
3. Physical exam	 a. Failure/delay in eliciting critical physical exam finding b. Inaccurate/misinterpreted/overlooked critical physical exam finding c. Failure in weighing critical physical exam finding d. Failure/delay to follow-up critical physical exam finding
4. Tests (lab/radiology)	Ordering (traditionally called "pre-analytic phase")a.Failure/delay in ordering needed test(s)b.Failure/delay in performing ordered test(s)c.Error in test sequencingd.Ordering of wrong test(s)e.Tests ordered wrong wayPerformance (traditionally called "analytic phase")f.Sample mix-up/mislabeled (e.g., wrong patient/test)g.Specimen delivery problemh.Technical errors/poor processing of specimen/testi.Erroneous lab/radiology reading of testj.Failed/delayed reporting of result to clinicianClinician Processing (traditionally called "post-analytic phase")k.Failed/delayed follow-up of (abnormal) test resultl.Error in clinician interpretation of test
5. Assessment	 Hypothesis Generation a. Failure/delay in considering the diagnosis Suboptimal weighing/prioritizing b. Too little consideration/weight given to the diagnosis c. Too much weight on competing/coexisting diagnosis Recognizing urgency/complications d. Failed/delayed follow-up of (abnormal) test result e. Error in clinician interpretation of test
6. Referral consultation	 a. Failure/delay in ordering referral/consult b. Failure/delay in obtaining/scheduling ordered referral c. Error/suboptimal quality in diagnostic consultation performance d. Failed/delayed communication/follow-up of consultation
7. Follow-up	 a. Failure/delay in timely follow-up/rechecking of patient b. Failure to refer patient to close/safe setting/monitoring c. Failure/delay in needed monitoring or lab (BP, INR, repeat CXR) d. Failure/delay in communicating findings among healthcare providers

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