Patient Safety Organization Glossary

2017-2018

MHA
MISSOURI HOSPITAL ASSOCIATION

Glossary

Adverse Drug Event (ADE)
An adverse event involving the use of medications or the failure to use appropriate medications when indicated.

Administration Error
An error in the phase of the medication use process where the drug product and patient interface.

Adverse Drug Reaction (ADR)
An adverse effect produced by the use of a medication in the recommended manner. ADRs may range from "nuisance effects" (e.g., dry mouth with anticholinergic medications) to severe reactions, such as anaphylaxis to penicillin.

Adverse Event (AE)
Any injury caused by medical care. An adverse event does not imply error, negligence or poor quality care, but indicates that an undesirable clinical outcome resulted from some aspect of diagnosis or therapy, not an underlying disease process.

AHRQ
Agency for Healthcare Research and Quality www.ahrq.gov

Benchmark
In health care, a benchmark is the best in industry measurement that can lead to superior performance. Three principles of benchmarking are maintaining quality, customer satisfaction and continuous improvement.

Call Out
A strategy used to communicate important or critical information.

Close Call
An event or situation that did not produce patient injury, but only because of chance. The close call may be attributed to the robustness of the patient or a fortuitous, timely intervention. Close calls are also called "near miss" incidents.

CPOE (Computerized Physician Order Entry)
A computer based system for ordering medications and/or other tests in which physicians directly enter orders into a computer system.

Crew Resource Management (CRM)
A range of approaches to training groups, originally developed in aviation, to function as teams, rather than as collections of individuals that emphasizes the role of "human factors" and the impact of different management styles and organizational cultures in high-stress, high-risk environments. Also referred to as Crisis Resource Management.

Critical Incidents
Significant or pivotal occurrences in which significant harm or potential for harm occurred and have the potential to reveal important hazards in the organization and individual that can be remedied to prevent similar incidents in the future.

Culture of Safety
The result of an organizational commitment to safety permeating all levels from front-line personnel to executive management. Features of a culture of safety include acknowledgment of the high-risk, errorprone nature of an organization's activities, a just environment where individuals are able to report errors and near misses without fear of reprimand or punishment, an expectation of collaboration across ranks to seek solutions to vulnerabilities and a willingness on the part of the organization to direct resources for addressing safety concerns.

Dispensing Error
Deviations from the prescriber's order, made by staff in the pharmacy when distributing medication to nursing units or to patients in ambulatory settings.

EHR
Electronic Health Record

Error
An act of commission (doing something wrong) or omission (failing to do the right thing) that leads to an undesirable outcome or significant potential for such an outcome.

Event Reporting
The identification and reporting of occurrences that could have led, or did lead, to an undesirable outcome, typically from personnel directly involved in the incident or events leading up to the event. Also referred to as "occurrence reporting" or "incident reporting."

Failure Mode and Effects Analysis (FMEA)
A method to prospectively analyze errors to predict the likelihood of a particular process failure. Also combines an estimate of the relative impact of the error to produce a "criticality index" to allow for the prioritization of specific processes as quality improvement targets. Each step in a process is assigned a probability of failure and an impact score, so that all steps could be ranked according to the product of these two numbers. Steps ranked at the top (i.e., those with the highest "criticality indices") should be prioritized for error proofing.

Hazard Analysis
Process used to determine the potential severity of the loss from an identified risk, the probability a loss will happen, and alternatives for dealing with the risk. Also referred to as Risk Analysis.

Health Literacy
The ability of an individual to find, process, and comprehend the basic health information necessary to act on medical instructions and make decisions about their health.

High Alert Medications
Drugs that bear a heightened risk of causing injury when misused, consequences of errors with these drugs may be more devastating.

High Reliability Organizations (HROs)
Organizations or systems that operate in hazardous conditions but conduct relatively error-free operations. Examples of HROs are air traffic control systems, nuclear power plants, and naval aircraft carriers. Studies reveal HROs have 5 common features, including a preoccupation with failure, resists over-simplification, commitment to resilience, sensitivity to operations and looks to expertise not rank to inform decisions.

HIT
Health Information Technology

Human Factors (or Human Factors Engineering)
The study of human abilities and characteristics as they affect the design and operation of equipment, systems, and jobs, includes considerations of the strengths and weaknesses of human physical and mental abilities and how these affect the systems design.

IHI
Institute for Healthcare Improvement www.ihi.org

Incident Reporting
The identification and reporting of occurrences that could have led, or did lead, to an undesirable outcome, typically from personnel directly involved in the incident or events leading up to the event. Also referred to as "occurrence reporting" or "event reporting."

ISMP
Institute for Safe Medication Practices www.ismp.org/

Just Culture
A culture in which front-line personnel are comfortable disclosing errors, including their own, while maintaining professional accountability, recognizing individual practitioners should not be held accountable for system failings over which they have no control, yet does not tolerate conscious disregard of clear risks to patients or gross misconduct.

Latent Error (or Latent Condition)
An error resulting from organizational factors or systems, literally "accidents waiting to happen," errors at the "blunt end," referring to layers of the health care system that affect the person providing direct care to patients, at the "sharp end."

Medical Emergency Team - MET
A team, similar in concept to a cardiac arrest team, with more liberal calling criteria for responding to a wide range of worrisome, acute changes in patients' clinical status, such as low blood pressure, difficulty breathing, or altered mental status, de-emphasizing the traditional hierarchy in patient care, allowing anyone to call for the team. Sometimes referred to as a Rapid Response Teams.

Medication Reconciliation
A process to review patients' medications at the time of transfer to another level of care or discharge and comparing them with medications prior to hospitalization or transfer in order to identify and address discrepancies.

Medication Safety
Freedom from accidental injury during the course of medication use; activities to avoid, prevent, or correct adverse drug events which may result from the use of medications.

Near Miss
An event or situation that did not produce patient injury, but only because of chance, also called a "close call."

NPSF
National Patient Safety Foundation www.npsf.org

NPSG
National Patient Safety Goals - goals established by The Joint Commission to help its accredited organizations address specific areas of concern in regards to patient safety.
www.jointcommission.org/standards_information/npsgs.aspx

NQF
National Quality Forum www.qualityforum.org

Occurrence Reporting
The identification and reporting of occurrences that could have led, or did lead, to an undesirable outcome, typically from personnel directly involved in the incident or events leading up to the event. Also referred to as "event reporting" or "incident reporting."

Patient Safety
Freedom from accidental or preventable injuries produced by medical care; activities to avoid, prevent or correct adverse outcomes which may result from the delivery of health care.

PHI
Personal Health Information

Prescribing Error
Mistakes made by the prescriber when ordering a medication.

Read-Backs
A process or protocol by which the listener repeats key information back to the transmitter of the information, so that the transmitter can confirm its correctness.

Red Rules
Rules that must be followed to the letter, relate to important and risky processes, must be simple and easy to remember, should be known organization-wide, should foster a culture of patient safety.

Risk Analysis
Process used to determine the potential severity of the loss from an identified risk, the probability a loss will happen, and alternatives for dealing with the risk. Also referred to as Hazard Analysis.

Risk Assessment
Qualitative or quantitative estimation of the likelihood of adverse effects that may result from exposure to specified health hazards or from the absence of beneficial influences.

Risk Identification
Process used to identify situations, policies or practices that could result in the risk of patient harm and/or financial loss to the institution.

Risk Management
Clinical and business techniques employed to prevent or reduce risk of injury to patients, staff, visitors, and prevent or reduce organization losses and preserve the organization's assets.

Root Cause Analysis (RCA)
A structured process used to identify causal or contributing factors underlying adverse events or other critical incidents, uses a pre-defined protocol for identifying specific contributing factors in various causal categories (e.g., personnel, training, equipment, protocols, scheduling) resulting in a detailed account of the events that led up to the incident to assist in identifying areas of focus for improvement to prevent the event from reoccurring.

Safety Culture
The result of an organizational commitment to safety permeating all levels from front-line personnel to executive management. Features of a culture of safety include acknowledgment of the high-risk, errorprone nature of an organization's activities, a just environment where individuals are able to report errors and near misses without fear of reprimand or punishment, an expectation of collaboration across ranks to seek solutions to vulnerabilities and a willingness on the part of the organization to direct resources for addressing safety concerns.

SBAR
A standardized method of communication between patient care providers including explanation of the situation, background, assessment and recommendations. This tool helps individuals communicate in a concise and structured format with a shared set of expectations. It also improves efficiency and accuracy.

Sentinel Event
Term used by The Joint Commission to define an adverse event in which death or serious harm occurred, usually referring to events that are unexpected or unacceptable.

Situational Awareness
The degree to which one's perception of a situation matches reality. Maintaining situational awareness might be the equivalent of keeping the "big picture" in mind.

Six Sigma
A metric that indicates how well a process is performing. The higher the sigma value, the higher the performance quality of the organization's process. Sigma measures the capability of the process to perform defect-free work, with a defect being anything that results in customer dissatisfaction. Six sigma targets a defect rate or level of quality that only permits 3.4 errors (or variations) per million opportunities, 6 sigma. Six sigma typically strives for quantum leaps in improvement.

STEP
A tool for monitoring situations in the delivery of health care – Status of the patient, Team members, Environment, Progress toward goal.

Swiss Cheese Model
James Reason's Swiss Cheese Model has become a dominant paradigm for analyzing medical errors and patient safety incidents. The model illustrates how analyses of major accidents and catastrophic systems failures tend to reveal multiple, smaller failures leading up to the actual hazard. Each slice of cheese represents a safety barrier or precaution relevant to a particular hazard with no single barrier being foolproof. In health care many of the slices of cheese already have their holes aligned so one slice of cheese may be all that is left between the patient and the significant hazard.

System
Interdependent elements (human and non-human) interacting to achieve a common aim.

System-thinking
An approach to risk prevention that looks at how individual processes connect or are interrelated and how flaws in the process or "system" may be at the root of many, seemingly unrelated events that result or have the potential to result in human injury. It provides a framework for seeing changing patterns and structures that underlie complex situations.

Systems Approach
An approach with the view that most errors reflect predictable human failings in the context of poorly designed systems (e.g., expected lapses in human vigilance in the face of long work hours or predictable mistakes on the part of relatively inexperienced personnel faced with cognitively complex situations). Rather than focusing corrective efforts on reprimanding individuals or pursuing remedial education, the systems approach seeks to identify situations or factors likely to give rise to human error and implement

"systems changes" that will reduce their occurrence or minimize their impact on patients. This "systems focus" includes paying attention to human factors engineering, including the design of protocols, schedules, and other factors that are routinely addressed in other high-risk industries.

TeamSTEPPS™
Patient safety training offered by AHRQ - Team Strategies and Tools to Enhance Performance and Patient Safety www.ahrq.gov

Time Outs
Planned periods of quiet and/or interdisciplinary discussion focused on ensuring that key procedural details have been addressed. Taking the time to focus on listening and communicating the plans as a team can rectify miscommunications and misunderstandings before a procedure gets underway.

The Joint Commission
An independent, not-for-profit organization that accredits and certifies more than 15,000 health care organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards. www.jointcommission.org/

Transcription Error
An error in the phase of the medication use process that involves anything related to the act of interpreting an order by someone other than the prescriber for order processing. Transcription may be electronic or manual from the patient's record.

Triggers
Signals for detecting likely adverse events. In many studies, triggers alert providers involved in patient safety activities to probable adverse events so they can review the medical record to determine if an actual or potential adverse event has occurred. In cases in which the trigger correctly identified an adverse event, causative factors can be identified and, over time, interventions developed to reduce the frequency of particularly common causes of adverse events. In these studies, the triggers provide an efficient means of identifying potential adverse events after the fact.

Underuse, Overuse, Misuse
Activities resulting in quality problems. "Underuse" refers to the failure to provide a health care service when it would have produced a favorable outcome for a patient. "Overuse" refers to providing a process of care in circumstances where the potential for harm exceeds the potential for benefit.
"Misuse" occurs when an appropriate process of care has been selected but a preventable complication occurs and the patient does not receive the full potential benefit of the service.

USP
United States Pharmacopeia www.usp.org