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PATIENT SAFETY ORGANIZATION TERMINOLOGY AND ACRONYMS

Active Error

An error that occurs at the point of contact. Active errors are generally readily apparent (e.g., pushing an incorrect button, ignoring a warning light) and almost always involve someone at the front line. Active failures are sometimes referred to as errors at the sharp end.

ADE - Adverse Drug Event

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.

ADR - Adverse Drug Reaction

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.

AE - Adverse Event

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

Bar Code

graphic representation of data (alpha, numeric, or both) that is machine readable; a method of encoding numbers or alphabetic characters using wide and narrow bars and spaces according to a set of rules called symbols. Scanning of a bar code gives instant access to information in an associated database.

Benchmark

In healthcare, 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.

Blunt End

The "blunt end" refers to the many layers of the health care system not in direct contact with patients, but which influence the personnel and equipment at the point of contact, the "sharp end". The blunt end refers to those who set policy, manage health care institutions, design medical devices, and other people and forces, which, though removed from direct patient care, affect how care is delivered.

Call out

A strategy used to communicate important or critical information.

Check-Back

A process of using closed-loop communication to ensure that information conveyed by the sender is understood by the receiver as intended.

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.

Competency

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 a fortuitous, timely intervention. Close calls are also called "near miss" incidents.

Complexity Science (or Complexity Theory)

An approach to understanding the behavior of systems that exhibit non-linear dynamics, or the ways in which some Adaptive systems produce novel behavior not expected from the properties of their individual components. Such behaviors emerge as a result of interactions between agents at a local level in the complex system and between the system and its environment.

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 frontline personnel to executive management. Features of a culture of safety include acknowledgment of the high-risk, error-prone 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.

CUS

A method to express concern about an unsafe situation – I am Concerned, I am Uncomfortable!, This is a Safety issue!

Decision Support

Any system for advising or providing guidance about a particular clinical decision at the point of care, typically responding to a "trigger" or "flag" and providing information or recommendations directly relevant to the specific encounter.

DESC Script

A constructive approval for managing and resolving conflict – Describe the situation or behavior, Express how the situation makes you feel/your concerns, Suggest other alternatives and seek agreement, Consequences should be stated in terms of impact and strive for consensus.

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.

Error Chain

A series of events leading to an adverse outcome, typically uncovered by a root cause analysis.

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.

Failure to Rescue

The failure by a provider to prevent a clinically important deterioration, such as death or permanent disability, from occurring as a result of a complication of an underlying illness or a complication of medical care. Failure to rescue rates provide a measure of the degree to which providers respond to adverse occurrences by identifying that a complication occurred and the response to that complication.

Forcing Function

An aspect of a system design that prevents a target action from being performed or allows its performance only if another specific action is performed first.

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.

Heuristic

A loosely defined or informal rule often arrived at through experience or trial and error. Heuristics provide cognitive shortcuts in the face of complex situations.

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.

Hindsight Bias

The inclination to see events that have already occurred as being more predictable than they were before they took place. The tendency is to judge the events leading up to an accident as errors because the bad outcome is known. The more severe the outcome, the more likely that decisions leading up to the outcome will be judged as errors, which implies that the outcome was preventable. Those reviewing events after the fact see the outcome as more foreseeable and therefore more preventable than they would have appreciated in real time.

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.

I PASS the BATON

A strategy designed to enhance information exchanged during transitions in care – Introduction, Patient, Assessment, Situation, SAFETY Concerns (the) Background, Actions, Timing, Ownership, Next.

Iatrogenic

An adverse effect of medical care, rather than of the underlying disease, equivalent to an adverse event.

I'M SAFE

A method for individual situation monitoring of human aspects that may impact an individual's ability to function safely - Illness, Medication, Stress, Alcohol and Drugs, Fatigue, Eating and Elimination.

IHI

Institute for Healthcare Improvement www.ihl.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 frontline 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

Mental Models

Psychological representations of real, hypothetical, or imaginary situations resulting in the creation of differing expectations, suggesting different courses of action.

Metacognition

Thinking about thinking, reflecting on the thought processes that led to a particular diagnosis or decision to consider whether biases or cognitive short cuts may have had a detrimental effect, the general process of reflecting on the possibility of cognitive biases affecting clinical diagnoses and decisions.

Mistakes

One of two categories of error in addition to “slips”. Unlike slips, mistakes are failures during attentional behaviors, or incorrect choices typically involving insufficient knowledge, failure to correctly interpret available information, or application of the wrong cognitive “heuristic” or rule, often reflecting a lack of experience or insufficient training. Reducing the likelihood of mistakes typically requires more training or supervision, unlike a “slip”. Historically, all errors have been treated as mistakes resulting in remedial training or increased supervision.

Near Miss

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

Normalization of Deviance

The gradual shift in what is regarded as normal after repeated exposures to “deviant behavior” (behavior straying from correct [or safe] operating procedure) resulting in corners being cut, safety checks bypassed, and alarms ignored or turned off, and these behaviors subsequently becoming normal.

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

Potential ADE

Potential adverse drug event is a medication error or other drug-related mishap that reached the patient but happened not to produce harm.

Prescribing Error

Mistakes made by the prescriber when ordering a medication.

Preventable Adverse Drug Event

An adverse drug event caused by an error.

Preventable Adverse Event

An adverse event that can be contributed to an error.

Production Pressure

Pressure to put quantity of output, for a product or a service, ahead of safety; in health care, production pressure refers to delivery of services, often producing an organizational culture in which front line personnel, often managers as well, are reluctant to suggest any course of action that compromises productivity.

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 frontline personnel to executive management. Features of a culture of safety include acknowledgment of the high-risk, error-prone 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.

Sensemaking

An organizational theory term that refers to the processes by which an organization takes in information to make Sense of its environment, to generate knowledge, and to make decisions. It constructs the shared meanings that define the organization's purpose and frame the perception of problems or opportunities that the organization needs to work on.

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.

Sharp End

The individuals and part of the health care system in direct contact with patients. The sharp end corresponds with errors resulting from "active failures".

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.

Slips (or Lapses)

One of two categories of error in addition to “mistakes”. Unlike mistakes, slips are failures of schematic behaviors, or lapses in concentration. Slips occur in the face of competing sensory or emotional distractions, fatigue, and stress, Reducing the risk of slips requires attention to the design of protocols, devices, and work environment conditions, removing unnecessary variation in the design of key devices, eliminating distractions from areas where work requires intense concentration, and other redesign strategies. Historically, all errors including slips have been treated as mistakes resulting in remedial training or increased supervision.

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