PATIENT SAFETY ACRONYMS, TERMS AND DEFINITIONS

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 frontline. 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.

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

Aim: A written, measurable, and time-sensitive statement of the expected results of an improvement process.

Assessment: A systematic process of collecting and analyzing data to determine the current, historical or projected status of an organization.

Authority Gradient – the balance of decision-making power or the steepness of command hierarchy in a given situation.

Bar Code – a 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 symbologies. Scanning of a bar code gives instant access to information in an associated database.

Benchmark – in health care, “benchmark” refers to an attribute or achievement that serves as a standard for other providers or institutions to emulate.

Best Practices: The most up-to-date patient care interventions, scientifically proven to result in the best patient outcomes and minimize patients' risk of death or complications. A superior method or innovative practice that contributes to the improved performance of an organization, usually recognized as "best" by other peer organizations.

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.

Cause: An identified reason for the presence of a defect or problem.

Champion: A leader or senior manager who ensures that resources are available for training and projects, and who is involved in the project and /or reviews.

Clinical Decision Support System (CDSS) – any system designed to improve clinical decision making related to diagnostic or therapeutic processes of care. Such systems may range from the selection of drugs or diagnostic tests to detailed support for optimal drug dosing and support for resolving diagnostic dilemmas.

Clinical Guideline: A treatment regime, agreed upon by consensus, which includes all the elements of care regardless of the effect on patient outcomes. Also called a clinical pathway.

Core Measures: Specific clinical measures that, when viewed together, permit a robust assessment of the quality of care provided in a given focus area, such as acute myocardial infarction (AMI).

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

Competency – having the necessary knowledge or technical skill to perform a given procedure within the bounds of success and failure rates deemed compatible with acceptable care.

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.

CPR – Computerized Physician Record

Crew Resource Management (CRM or crisis resource management) – 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.

Criteria: Expected levels of achievement or specifications against which performance or quality may be compared. For example, criteria for appropriate initial care of a patient with a headache may be a measurement of body temperature and blood pressure and performance of a neurological examination.

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 of an organization, 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 blame-free environment where individuals are able to report errors or close calls 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.

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.

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.

Evidence-Based Medicine: The wise and careful use of the best available scientific research and practices with proven effectiveness in daily medical decision-making, including individual clinical practice decisions, by well-trained, experienced clinicians. Evidence-based medicine that is best-practice integrates best research evidence with clinical expertise and patient values.

Face Validity – the extent to which a technical concept, instrument, or study result is plausible, usually because its findings are consistent with prior assumptions and expectations.

FMEA - Failure Mode and Effects Analysis – a method to prospective error analysis to predict "error modes" in which the likelihood of a particular process failure is combined with an estimate of the relative impact of that 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 – See Risk Analysis

HIT – Health Information Technology

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

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 Reliability Organizations (HROs) –organizations or systems that operate in hazardous conditions but have fewer than their fair share of adverse events. Commonly discussed examples of HROs are air traffic control systems, nuclear power plants, and naval aircraft carriers. Studies reveal HROs to have common

features, including a preoccupation with failure, commitment to resilience, sensitivity to operations and culture of safety.

Hindsight Bias – the tendency 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, judging the antecedent decisions as errors 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.

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

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

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.

ISMP – Institute for Safe Medication Practices

JC – Joint Commission *(formerly JCAHO, Joint Commission on the Accreditation of Healthcare Organizations)*

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”.

Medication Error – any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient or consumer.

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.

NPSF – National Patient Safety Foundation

NPSG – National Patient Safety Goals

NQF – National Quality Forum

Near Miss – an event or situation that did not produce patient injury, but only because of chance, 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.

Patient-Centered Care: Care that is respectful of and responsive to individual patient preferences, needs and values and ensures patient values guide all clinical decisions; care that is coordinated, communicative and supportive.

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.

Pay for Performance: A direct financial reward model or quality bonus; incentive and reward models where there are direct provider dollars at stake for quality improvement.

Performance Measure: A quantitative tool (for example, rate, ratio, index or percentage) that provides an indication of an organization's performance in relation to a specified process or outcome.

Plan-do-study-act (PDSA) cycle: A four-step process for quality improvement. In the first step (plan), a plan to effect improvement is developed. In the second step (do), the plan is carried out, preferably on a small scale. In the third step (check), the effects of the plan are observed and what is learned is summarized. In the last step (act), the results are studied to determine what was learned and what can be predicted. The Associates in Process Improvement developed the plan-do-study-act cycle. Also called the plan-do-check-act (PDCA) cycle.

PHR – Personal health record

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 Event – an adverse event that can be contributed to an error.

Preventable Adverse Drug Event – an adverse drug event caused by 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 frontline personnel, often managers as well, are reluctant to suggest any course of action that compromises productivity.

Quality: The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Rapid Response Team – 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.

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, and 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.

Safe Practices: Practices that reduce the risk of harm from the processes, practices or systems of healthcare, the standardization of which is likely to have significant benefit for patient safety if fully implemented.

Safety Culture – same as "culture of safety"

Sentinel Event – An adverse event in which death or serious harm occurred, usually referring to events that are unexpected or unacceptable.

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.

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.

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.

Swiss Cheese Model – a model of analyses of major accidents and catastrophic systems failures to reveal multiple, smaller failures leading up to the actual hazard. In the model, each slice of many slices of cheese represents a safety barrier or precaution relevant to a particular hazard with no single barrier being foolproof; they each have “holes”. For some serious events, even though the holes will align infrequently, even rare cases of harm (errors making it "through the cheese") will be unacceptable. In health care, such failure modes, in which slices of the cheese line up more often than one would expect if the location of their holes were independent of each other, occur distressingly commonly.

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.

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.

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

Variation: The differences in results obtained in measuring the same phenomenon more than once. The sources of variation in a process over time can be grouped into two major classes: common causes and special causes. Excessive variation frequently leads to waste and loss, such as the occurrence of undesirable patient health outcomes and increased cost of health services. Common-cause variation, also called endogenous cause variation or systemic cause variation, in a process is due to the process itself and is produced by interactions of variables of that process is inherent in all processes, not a disturbance in the process. It can be removed only by making basic changes in the process. Special-cause variation, also called exogenous-cause variation or extrasystemic cause variation, in performance results from assignable causes. Special-cause variation is intermittent, unpredictable, and unstable. It is not inherently present in a system; rather, it arises from causes that are not part of the system as designed.

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