National Patient Safety Foundation®

Glossary of Terms

Accident: A series of events that involves damage to a defined system disrupting the ongoing or future output of the system. (Kohn)

Adverse Event: An untoward, undesirable, and usually unanticipated event, such as death of a patient, an employee, or a visitor in a health care organization. Incidents such as patient falls or improper administration of medications are also considered adverse events even if there is no permanent effect on the patient. (The Joint Commission 2006)

Adverse Event: An injury resulting from a medical intervention. (Kohn) Identifying something as an adverse event does not imply "error," "negligence," or poor quality care. It simply indicates that an undesirable clinical outcome resulted from some aspect of diagnosis or therapy, not an underlying disease process. (AHRQ)

Adverse Drug Event: Any incident in which the use of a medication (drug or biologic) at any dose, a medical device, or a special nutritional product (for example, dietary supplement, infant formula, medical food) may have resulted in an adverse outcome in a patient. (The Joint Commission 2006)

Adverse Drug Event (ADE): An adverse event involving medication use…**ADE's** include expected adverse drug reactions (or "side effects")…as well as events due to error. (AHRQ PSNet)

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

Adverse Drug Reaction (ADR): An undesirable response associated with use of a drug that either compromises therapeutic efficacy, enhances toxicity, or both. (The Joint Commission 2006)

Bad Outcome: Failure to achieve a desired outcome of care. (Kohn)

Blunt End (*see also: Sharp End*): Complex systems such as health care or aviation have both a sharp end and a blunt end. The sharp end is where practitioners interact directly with the hazardous process in their roles as pilots, mechanics, air traffic controllers, and, in medicine, as nurses, physicians, technicians, pharmacists and others. At the blunt end of the health care system are regulators, administrators, economic policy makers, and technology suppliers. The blunt end of the system is the source of the resources and constraints that form the environment in which practitioners work. The blunt end is also the source of demands for production that sharp end practitioners must meet. The demands are often conflicted, as when the blunt end provides incentives for greater production while simultaneously demanding lower rates of failure. (Reason, taken from Cook, Woods & Miller)

Close Call: An event or situation that did not produce patient injury, but only because of chance. This good fortune might reflect robustness of the patient (e.g., a patient with penicillin allergy receives penicillin, but has no reaction) or a fortuitous, timely intervention (e.g., a nurse happens to realize that a physician wrote an order in the wrong chart). Such events have also been termed "near miss" incidents. (AHRQ PSNet)

Communication Breakdown: Discrepancies in communication of treatment plan between caregiver and patient, or between two caregivers. This is one cause of error. (ESRD)

Complication: A detrimental patient condition that arises during the process of providing health care, regardless of the setting in which the care is provided. For instance, perforation, hemorrhage, bacteremia, and adverse reactions to medication (particularly in the elderly) are four complications of colonoscopy and its associated anesthesia and sedation. A complication may prolong an inpatient's length of stay or lead to other undesirable outcomes. (The Joint Commission 2006)

Culture: A set of beliefs and exceptions about life within that organization. Culture is deeply rooted in *assumptions* which are “truths” taken for granted…from assumptions arise *values* and *norms.* (Behal)

Disclosure: Following serious unanticipated outcomes, including those that are clearly caused by systems failures, the patient and, as appropriate, the family should receive timely, transparent, and clear communication concerning what is known about the event. (NQF)

Disclosure: Providing information to a patient and/or family about an incident. Because this term suggests revealing of privileged information and implies an element of choice, in this document we use instead the term communication, by which we wish to convey a sense of openness and reciprocity. (MCPME)

Error: Failure of a planned action to be completed as intended or use of a wrong plan to achieve an aim; the accumulation of errors results in accidents. (Kohn)

Error: An error is defined as the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Errors can include problems in practice, products, procedures, and systems. (QuIC)

Error of Commission: An error which occurs as a result of an action taken. Examples include when a drug is administered at the wrong time, in the wrong dosage, or using the wrong route; surgeries performed on the wrong side of the body; and transfusion errors involving blood cross-matched for another patient. (The Joint Commission 2006)

Error of Omission: An error which occurs as a result of an action not taken, for example, when a delay in performing an indicated cesarean section results in a fetal death, when a nurse omits a dose of a medication that should be administered, or when a patient suicide is associated with a lapse in carrying out frequent patient checks in a psychiatric unit. Errors of omission may or may not lead to adverse outcomes. (The Joint Commission 2006)

Excessive Handoffs (Safety Concern): Information transfers and task handoffs become more error prone each time a hand-off occurs. Examples: change of shift issues, lunch breaks, ward secretaries performing order entry. (ESRD)

Failure Mode, Effect, and Criticality Analysis (FMECA): A systematic way of examining a design prospectively for possible ways in which failure can occur. It assumes that no matter how knowledgeable or careful people are, errors will occur in some situations and may even be likely to occur. (The Joint Commission 2006)

Harm: Temporary or permanent impairment of the physical, emotional, or psychological function or structure of the body and/or pain resulting there from requiring intervention. (NCC-MERP 1998)

Healthcare Organization: Entity that provides, coordinates, and/or insures health and medical services for people. (Kohn)

Health Literacy: Individuals' ability to find, process, and comprehend the basic health information necessary to act on medical instructions and make decisions about their health. (Council on Scientific Affairs)

Health Literacy: The degree to which individuals have the capacity to obtain, process and understand basic health information and services need to make appropriate health decisions. (IOM)

High-Reliability Organizations: Highly complex, technology-intensive organizations that must operate, as far as humanly possible, to a failure-free standard. (Reason)

High Reliability Organizations (HROs): High reliability organizations refer to organizations or systems that operate in hazardous conditions but have fewer than their fair share of adverse events. Commonly discussed examples include air traffic control systems, nuclear power plants, and naval aircraft carriers. HROs are considered to operate with nearly failure-free performance records, not simply better than average ones. (AHRQ)

Human Factors: Study of the interrelationships between humans, the tools they use, and the environment in which they live and work. (Kohn)

Iatrogenic: 1) Resulting from the professional activities of physicians, or more broadly, from the activities of health professionals. Originally applied to disorders induced in the patient by autosuggestion based on a physician's examination, manner or discussion, the term is currently applied to any undesirable condition in a patient occurring as a result of treatment by a physician (or other health professional), especially to infections acquired by the patient during the ocurse of treatment. 2) Pertaining to an illness or injury resulting from a procedure, therapy, or other element of care. (The Joint Commission 2006)

Incident Reporting: Refers to the identification of occurrences that could have led, or did lead, to an undesirable outcome. Reports usually come from personnel directly involved in the incident or events leading up to it (e.g., the nurse, pharmacist, or physician caring for a patient when a medication error occurred) rather than, for example, floor managers. (AHRQ PSNet)

Just Culture: A just culture does not tolerate conscious disregard of clear risks to patients or gross misconduct. In summary, a "just culture" recognizes that competent professionals make mistakes and acknowledges that even competent professionals will develop unhealthy norms (shortcuts, "routine rule violations"), but has zero tolerance for reckless behavior…A just culture also recognizes many individual or "active" errors represent predictable interactions between human operators and the systems in which they work. This term was popularized by David Marx in "Patient Safety and the "Just Culture": A Primer for Health Care Executives" advocating a culture in which frontline personnel feel comfortable disclosing errors—including their own—while maintaining professional accountability. (AHRQ PSNet)

Latent Error: Errors in the design, organization, training, or maintenance that lead to operator errors and whose effects typically lie dormant in the system for lengthy periods of time. (Kohn)

Latent Failure: Delayed-action consequences of decisions taken in the upper echelons of the organization of system. They relate to the design and construction of plant and equipment, the structure of the organization, planning and scheduling, training and selection, forecasting, budgeting, allocating resources and the like. The adverse safety effects of these decisions may lie dormant for a very long time. (Reason 1994)

Latent Failure: An error which is precipitated by a consequence of management and organizational processes and poses the greatest danger to complex systems. Latent failures cannot be foreseen but, if detected, they can be corrected before they contribute to mishaps. (JCAHO 2001 & 2006)

Latent Systems Failures: Small, individually innocuous systems faults that, if occurring in specific combination, can lead to catastrophic events. (ESRD)

Look-alike or Sound-alike Situation (Safety Concern): Ambiguous labeling and non-distinct storage containers can lead to inappropriate use of medications or products. Examples: drug names may look or sound similar, intravenous fluids may be packaged alike, reagent bottles may be the same size and color. (ESRD)

Malpractice: Improper or unethical conduct or unreasonable lack of skill by a holder of a professional or official position; often applied to physicians, dentists, lawyers, and public officials to denote negligent or unskillful performance of duties when professional skills are obligator. Malpractice is a cause of action for which damages are allowed. (The Joint Commission 2006)

Medical Error: The failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Medical errors include serious errors, minor errors, and near misses. (Note: A medical error may or may not cause harm. A medical error that does not cause harm does not result in an adverse event). (MCPME)

Medically Induced Trauma: An unexpected outcome that occurs during medical and/or surgical care that affects the emotional well being of the patient, family member, or clinician. (MITSS, 2002)

Medication Error: A medication error is 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. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing; order communication; product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use. (NCC MERP 2009)

Mistake: The actions may conform exactly to the plan, but the plan is inadequate to achieve its intended outcome. (Reason)

Mistake: Mistakes reflect failures during attentional behaviors, or incorrect choices. Rather than lapses in concentration (as with slips), mistakes typically involve insufficient knowledge, failure to correctly interpret available information, or application of the wrong cognitive “heuristic” or rule. Thus, choosing the wrong diagnostic test or ordering a suboptimal medication for a given condition represent mistakes…Mistakes refer to errors that arise in problem solving. Reason distinguishes rule-based errors and knowledge-based errors. Using this terminology, slips are characterized as skill-based errors. (AHRQ PSNet)

Near Miss: An event or situation that could have resulted in an accident, injury or illness, but did not, either by chance or through timely intervention. (QuIC)

Near Miss: An error that could have caused harm but did not reach the patient because it was intercepted. (MCPME)

Negligence: Failure to use such care as a reasonably prudent and careful person would use under similar circumstances. (The Joint Commission 2006)

Omission: Failure to carry out some of the actions necessary to achieve a desired goal. (Reason 1997)

Outcome: The result of the performance (or nonperformance) of a function(s) or process(es). (The Joint Commission 2006)

Patient: An individual who receives care or services, or one who may be represented by an appropriately authorized person. For hospice providers, the patient and family are considered a single unit of care. Synonyms used by various health care fields included client, resident, customer, individual served, patient and family unit, consumer or health care consumer. (JCAHO 2000)

Patient Advocate: Trained individual, such as the patient or someone specifically designated by the patient or family, to help oversee the patient's needs, care and safety while creating an objective partnership between patient, family and health care provider. (Corina & Shapiro)

Patient and Family Advisor: Any role that enables patients and family members to have direct input and influence on the policies, programs, and practices that affect the health care and services that individuals and families receive in a hospital, clinic, home, or other community setting. (IFCC)

Patient- and Family-Centered Care: An approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among patients, families, and health care providers. (IFCC)

Patient Safety: Freedom from accidental injury; ensuring patient safety involves the establishment of operational systems and processes that minimize the likelihood of errors and maximize the likelihood of intercepting them when they occur. (Kohn)

Patient Safety:

1. Patient safety has to do primarily with the avoidance, prevention, and amelioration of adverse outcomes or injuries stemming from the processes of health care itself. It should address events that span the continuum from what may be called "errors" and "deviations" to "accidents".

2. Safety emerges from the interaction of the components of the system. It is more than the absence of adverse outcomes and it is more than avoidance of identifiable "preventable" errors or occurrences. Safety does not reside in a person, device or department. Improving safety depends on learning how safety emerges from the interactions of the components.

3. Patient safety is related to "quality of care", but the two concepts are not synonymous. Safety is an important subset of quality. To date, activities to manage quality, such as quality assurance, continuous quality improvement, total quality management, etc. have not focused sufficiently on patient safety issues. (Cooper, et al)

Patient Safety: Actions undertaken by individuals and organizations to protect health care recipients from being harmed by the effects of health care services. (Spath)

Preventable Adverse Event: An injury (or complication) that results from an error or systems failure. Even if one agrees that individual errors are often the end result of systems failures, they are still perceived by patients and caregivers as very personal events. (MCPME)

Process: A goal-directed, interrelated series of actions, events, mechanisms, or steps. (The Joint Commission 2006)

Quality of Care: Degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. (Kohn)

Reportable Occurrence: An event, situation, or process that contributes to, or has the potential to contribute to, a patient or visitor injury, or degrade our ability to provide optimal patient care. Reportable occurences can generally be divided into the following types based on severity: Sentinel events, patient and visitor injuries [adverse events], nears misses, and safety concerns. (ESRD)

Risk Containment: Immediate actions taken to safeguard patients from a repetition of an unwanted occurrence. Actions may involve removing and sequestering drug stocks from pharmacy shelves and checking or replacing oxygen supplies or specific medical devices. (JCAHO 2001)

Risk Management: Clinical and administrative activities undertaken to identify, evaluate, and reduce the risk of injury to patients, staff, and visitors and the risk of loss to the organization itself. (JCAHO 2001)

Root Cause: The most fundamental reason for the failure or inefficiency of a process. (The Joint Commission 2006)

Root Cause Analysis: A process for identifying the basic or causal factor or factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. (The Joint Commission 2006)

Safety: The degree to which the risk of an intervention (for example, use of a drug or a procedure) and the risk in the care environment are reduced for patient and other persons, including health care practitioners. (JCAHO 2000)

Safety Concern: Protocols, procedures, products, or equipment that are problem-prone, or risk-generating processes that may degrade our ability to provide optimal patient care. (ESRD)

Safety Culture: The safety culture is an environment that strives for reliable processes, is committed to sharing information and learning, and is just, where words and action match in the unrelenting commitment to safety for patients and those who provide care and service. (NPSF 2007)

Safety Culture: A constant commitment to safety as a top-level priority, which permeates the entire organization. More concretely, noted components include: 1) acknowledgment of the high risk, error-prone nature of an organization's activities, 2) blame-free environment where individuals are able to report errors or close calls without punishment, 3) expectation of collaboration across ranks to seek solutions to vulnerabilities, and 4) willingness on the part of the organization to direct resources to address safety concerns. (AHRQ)

Safety Problems (as opposed to Underlying Mechanisms): Failures in specific health areas. Some refer to these as "phenotypes," i.e., the superficial characteristics of the system as opposed to Underlying Mechanisms:

- Prevalence and cause of medication errors by health care personnel
- in all settings;
- Surgery or procedure on wrong part of body;
- Errors in performance of hazardous activities (surgery, anesthesia, radiation therapy, etc.);
- Misdiagnosis;
- Selection of inappropriate treatment; and
- Nosocomial infection. (NPSF Agenda)

Sentinel Event (Adverse Sentinel Event): An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called "sentinel" because they signal the need for immediate investigation and response. (JCAHO 2001)

Sharp End (see also, Blunt End): Complex systems such as health care or aviation have both a sharp end and a blunt end. The sharp end is where practitioners interact directly with the hazardous process in their roles as pilots, mechanics, air traffic controllers, and, in medicine, as nurses, physicians, technicians, pharmacists and others. At the blunt end of the health care system are regulators, administrators, economic policy makers, and technology suppliers. The blunt end of the system is the source of the resources and constraints that form the environment in which practitioners work. The blunt end is also the source of demands for production that sharp end practitioners must meet. The demands are often conflicted, as when the blunt end provides incentives for greater production while simultaneously demanding lower rates of failure. (Cook, Woods & Miller)

Slip: Failures of schematic behaviors, or lapses in concentration (e.g., overlooking a step in a routine task due to a lapse in memory, an experienced surgeon nicking an adjacent organ during an operation due to a momentary lapse in concentration). Mistakes, by contrast, reflect incorrect choices. A mistake would be choosing the wrong diagnostic test or ordering a suboptimal medication for a given condition represent mistakes. Slips occur in the face of competing sensory or emotional distractions, fatigue, and stress; mistakes more often reflect lack of experience or insufficient training…Reducing the risk of slips requires attention to the designs of protocols, devices, and work. (AHRQ PSNet)

Standard: A minimum level of acceptable performance or results or excellent levels of performance or the range of acceptable performance or results. The American Society for Testing and Materials lists six types of standards: methods, specification, practice, terminology, guide, and classification. (Kohn)

Standard Practice: A definitive procedure for performing one or more specific operations or functions that does not produce a test result. (Kohn)

System: Set of interdependent elements interacting to achieve a common aim. These elements may be both human and non-human (equipment, technologies, etc). (Kohn)

Systems Approach: Medicine has traditionally treated quality problems and errors as failings on the part of individual providers, perhaps reflecting inadequate knowledge or skill levels. The "systems approach," by contrast, takes 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 view holds that efforts to catch human errors before they occur or block them from causing harm will ultimately be more fruitful than ones that seek to somehow create flawless providers. (AHRQ PSNet)

System Complexity (Safety Concern): Process with multiple steps and/or decision points. (Complex systems require excessive attention and can be tightly coupled). Examples: a surgical tray arrives missing a critical component; or a delayed or erroneous lab result, if there are no contingencies for these types of events they could be significant consequences. (ESRD)

Systems Error: An error that is not the result of an individual's actions, but the predictable outcome of a series of actions and factors that comprise a diagnostic or treatment process. (QuIC)

Transparency: The term “transparency” is widely used in describing pay-for-performance reports, in public reporting of care outcomes, and in explaining the prices charged in healthcare settings. These various uses of the term fit under the broad umbrella of transparency: full openness with patients and families, with the intent to mutually share all information. At its core, transparency fulfills the mandate of “nothing about me without me.” (NPSF)

Unanticipated Outcome: A result that differs significantly from what was anticipated to be the result of the treatment or procedure. (ASHRM)

Underlying Cause: The systems or process cause that allow for the proximate cause of an event to occur. Underlying causes may involve special-cause variation, common-cause variation, or both. (The Joint Commission 2006)

Underlying Mechanisms (for Safety Problems): Often called “genotypes” because they are more generic, deeply rooted characteristics of health care systems. (NPSF Agenda)

Unpreventable Adverse Event: An adverse event resulting from a complication that cannot be prevented given the current state of knowledge. (QuIC)

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