**Patient Safety and Quality Improvement Definitions 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.

**Adverse Drug Event:** An adverse event involving the use of medications or the failure to use appropriate medications when indicated.

**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.

**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.

**Availability Bias:** Judges diagnoses to be more likely or frequent because they readily come to mind or if they were recently seen.

**Anchoring Bias:** Locks onto initial impressions and foregoes new differential diagnoses in spite of new 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.

**Confirmation Bias:** Seeks confirming evidence to support a diagnosis rather than looking at all evidence objectively, even refuting evidence.

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

**Cognitive Factors:** Cognitive errors can occur in the process of diagnosis and can affect the formulation of differentials and ultimately decision-making. They can become sufficiently systematic such that clinicians can make the mistakes repeatedly.

**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!”

Diagnosis Momentum: Once labels or diagnoses are attached to patients (charts, previous providers, families) they tend to stick – if it had previously been a possibility, it gains momentum and becomes definite

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.

Fishbone Diagram (aka Ishikawa Diagram or Cause & Effect Diagram): When utilizing a team approach to problem solving, there are often many opinions as to the problem’s root cause. One way to capture these different ideas and stimulate the team’s brainstorming on root causes is the cause and effect diagram, commonly called a fishbone. The fishbone will help to visually display the many potential causes for a specific problem or effect. It is particularly useful in a group setting and for situations in which little quantitative data is available for analysis. Sample fishbone diagram available on the GME website.

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.

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".

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: 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".
Learn From Defects Tool: The purpose of this tool is to provide a structured approach to help staff and administrators identify the types of systems that contributed to the defect and to follow-up to ensure safety improvements are achieved. Sample tool available on the GME Website.

Meaningful participation: Defined as “The resident/fellow is able to verify and will attest that they have participated throughout the entire specified QI/PI initiative, met with others involved in the improvement activities, reviewed their performance data, helped develop and/or implement changes to the activities, and personally reflected on the impact of the initiative on their practice or organizational role. Reflection on further improvements, barriers to improvement, and sustaining achieved improvement is strongly encouraged.”

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.

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.

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

Premature Closure: Accepts a diagnosis before it has been fully verified; lose capacity to explore new differentials

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.

**Quality Improvement**: Systematic evaluation and modification of existing local practices to correct deficiencies and improve the system. Differentiate from research: systematic, hypothesis-driven investigation to develop or contribute to generalized knowledge.

**Read-Back**: 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.

**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.
**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.

**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.

**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.

**Systems Factor Examples:** Materials, may be defective, or in short supply; Personnel/people, lack of skills, knowledge, motivation or capacity; Processes, lack of an existing procedure or deviation from written procedure.

**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](http://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.

**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.

*Adapted from*
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