Glossary of Terms

Accreditation—Voluntary process wherein a health care organization meets established standards or criteria as determined through initial and periodic reviews.

Adverse Drug Event—Harm resulting from use of a medication.

Adverse Drug Reaction—An idiosyncratic reaction or other adverse effect of a medication that is not preventable (i.e., not a medication error).

Adverse Event—An undesirable occurrence associated with the use of a medical product in a patient, directly associated with care or services provided within the jurisdiction of a medical facility.

Alert Fatigue—Tendency to disregard or not thoroughly review pop-up alerts/warnings in an information system due to high-volume, low-significance, or nuisance alerts.

Balanced Scorecard—A tool to display and link the organization's mission and vision to the strategic goals and objectives.

Blame and Train Culture—A culture in which the person is assumed to be able to perform without error, if properly educated and motivated. Latent failures are not considered. Errors are attributed to laziness, negligence, or incompetence, resulting in blaming and/or retraining the person that made the error.

Change—To transform or guide into a different direction.

Common Cause Analysis—A technique used to review information from multiple events to identify their common causes; also referred to as an *aggregate root cause analysis*.

Computerized Provider Order Entry (CPOE)—Direct entry of medical orders into a health care system's electronic health records by licensed independent practitioners or other staff with specific ordering privileges and not by clinical or administrative support staff; may or may not include direct integration with other information systems such as pharmacy, laboratory, or radiology.

Continuous Quality Improvement—A systematic, organized approach for continually improving processes to deliver quality services and products.

Dashboard—An "at-a-glance" visual display of selected metrics or key performance indicators often used to track the individual initiatives, goals, and objectives at a more local level.

Data Mining—The process of extracting meaningful (useful and potentially actionable) information from large databases such as administrative and clinical health records (sifting through volumes of data to find hidden material of value).

Detection Sensitivity Level—The rate at which errors that occur are actually reported and recognized by the organization. A high detection sensitivity level is demonstrated through a high error reporting rate.

End-User—Primary user of a technology product, often frontline staff involved in direct patient care.

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Error Trap—Component of failure mode and effects analysis that seeks to prevent error through mechanisms aimed at detecting the error; elimination of alternatives or choices that may lead to error or potential mix-up/confusion; preventing actions that would result in or contribute to the error; and/or minimizing error consequence should it occur.

Failure Mode and Effects Analysis—Problem-solving tool used to analyze a process or system to identify possible modes of failure, and potential consequences of those failures.

Focused Standards Assessment (FSA)—The Joint Commission online tool for subscribers; annual process of performing a gap analysis between practice in your organization and regulatory requirements and correcting deficiencies by developing and completing actions plans with measures of success when indicated.

FOCUS-PDCA Cycle—A nine-step process (Find-Organize-Clarify-Understand-Select-Plan-Do-Check-Act) that emphasizes work teams, data-driven analysis, careful planning, organized implementation, and measurement of results.

Food and Drug Administration MedWatch—The Food and Drug Administration safety information and adverse event reporting program.

Forcing Function—A design feature that, when employed by the user, will automatically guide the proper use of a device or process to prevent error.

Gap Analysis—A process tool to evaluate and compare differences between two items; often used to compare actual performance with desired performance and to identify action steps needed to achieve the desired state.

Global Trigger Tool—A tool developed by the Institute for Healthcare Improvement that assists with identification of adverse events. This tool's methodology allows for the identification of various "triggers" when reviewing charts in order to determine the presence of adverse events. Examples of triggers include an abnormal lab result, a stop order, or administration of an antidote.

Handoff—The process of transferring responsibility for care; the interactive transfer of information, allowing for questioning between the giver and receiver(s).

High Reliability Organization—A complex organization with high risk for catastrophic error, with a very successful track record of maintaining a high level of safety over a long period of time.

High-Alert or High-Risk Medications—High-alert or high-risk medications have a greater capacity to cause significant patient harm if used incorrectly.

Hindsight Bias—The tendency for those evaluating an error to overestimate what they would have known, and what others should have known at the time of the error.

Human Error—The failure of planned actions to achieve their desired ends, without the intervention of some unforeseeable event. Human errors can be further divided into slips, lapses, and mistakes.

Human Factors—"The scientific discipline concerned with the understanding of interactions among humans and other elements of a system, and the profession that applies theory, principles, data, and methods to design in order to optimize human well-being and overall system performance."

Inattentional Blindness—The person performing a task fails to see what should have been plainly visible and, later, he or she cannot explain the lapse.

Just Culture—A culture that recognizes the contribution of systems in error along with a focus on behavioral choices and accountability. Just Culture distinguishes between acceptable and unacceptable behavior, between unsafe acts and the blatant disregard of safety

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procedures with which most peers would comply. Just Culture is one component of an overarching safety culture.

Look-Alike/Sound-Alike Medications—Similar medication names, either written or spoken, which may lead to potentially harmful medication errors when they are confused with each other.

Meaningful Use—Term used to describe a component of the 2009 American Recovery and Reinvestment Act that provides governmental monetary incentives for health care organizations that implement specific levels and elements of an electronic health record and various health care technologies.

Medication—According to The Joint Commission, any prescription medications, sample medications, herbal remedies, vitamins, nutraceuticals, vaccines, or over-the-counter drugs; diagnostic and contrast agents used on or administered to persons to diagnose, treat, or prevent disease or other abnormal conditions; radioactive medications, respiratory therapy treatments, parenteral nutrition, blood derivatives, and intravenous solutions (plain, with electrolytes and/or drugs); and any product designated by the Food and Drug Administration (FDA) as a drug. This definition of medication does not include enteral nutrition solutions (which are considered food products), oxygen, and other medical gases.

Medication Error—An error occurring in any step of the medication-use process; any preventable event that may result in incorrect medication use or patient harm.

Mistake/Error-Proofing—Implementation of fail-safe mechanisms to prevent errors from occurring with a process; for example, an ATM that gives the debit card back before the cash so that the card is not forgotten.

National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP)—This is an independent body of 27 national organizations (e.g., The Joint Commission, American Hospital Association) whose mission is to maximize the safe use of medications and to increase awareness of medication errors through open communication, increased reporting, and promotion of medication error prevention strategies.

Near Miss—An error process that is stopped or interrupted either by chance or through a check-and-balance in the medication-use process, such as recognition of the problem and intervention by an experienced practitioner. Other similar terms include *close call* and *good catch*.

Non-Punitive—An approach that uses positive feedback to individuals who report errors (including self-reports) rather than punishment when an error is detected and contributes to a culture where open communication about errors is encouraged.

Override—A function related to patient-profiled automated dispensing cabinets (ADC) that allows the user (e.g., nurse) to have access to a medication prior to verification by a pharmacist.

Patient Safety Organizations—Entities registered with and listed with the Agency for Healthcare Research and Quality under the Patient Safety Act and Patient Safety Rule, which provide confidentiality and privilege protections for patient safety work product.

PDCA Cycle—A quality improvement methodology involving Plan-Do-Check-Act steps for planning, implementing, evaluating, and changing a process or system.

Regulation—A government-imposed requirement for which compliance is mandatory.

Requirement for Improvement (RFI)—Citation for a standard found that is out of compliance during an accreditation survey. Also referred to as a *finding*.

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Risk Mitigation Strategies—Tactics utilized to avoid system failures and prevent errors. Risk mitigation strategies may be implemented in response to a recent event or utilized as a proactive strategy. Multiple risk mitigation strategies are often needed to fully address potential failure points. Examples include forcing functions, automation, double checks, and provider education.

Root Cause—Any identified reason in the sequence of events that, if prevented, will stop a recurrence of the particular event. There must be a clear cause and effect such that if you eliminate the identified cause, future events will be prevented.

Root Cause Analysis (RCA)—A systematic process utilized to determine the primary cause of system failures. The goal is to define the root causes and develop an action plan to prevent recurrence or mitigate a future event.

Safe Culture—Shared values and beliefs of an organization that result in a common goal among frontline staff and leadership to consistently improve and maintain a safe environment for both its workforce and patients. In a safe culture, the organization is committed to continuous improvement and encourages reporting of potential or actual hazards in this effort.

Safety—The degree to which the risk of an intervention (for example, use of a drug, or a procedure) and risk in the care environment are reduced for a patient and other persons, including health care practitioners. Safety risks may arise from the performance of tasks, from the structure of the physical environment, or from situations beyond the organization's control (such as weather).

Sentinel Event—"An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof," as defined by The Joint Commission.

Simulation—Imitation of the operation of a system or process, using a model that represents key characteristics of the selected system or process.

Slips and Lapses—A human error whereby the action deviates from the intention. A *slip* is when an action is carried forth, but deviated from the intention. A *lapse* is when there was an intention of an action, but the action was forgotten.

Stakeholder—A person, group, or organization that will be affected by or can themselves affect a process.

Standardize—To remove variations and irregularities; to bring into conformity with another.

Standards—A set of rules or principles established by consensus and approved by a recognized body that describes services, systems, or practices to meet a certain level of quality; in health care, to provide safe patient care in a secure environment.

Statistical Process Control Chart—A statistical graph that helps to detect process variation over time and is a tool for monitoring the ongoing stability of a process, distinguishing variation due to causes common to the process versus special (potentially actionable) causes.

Super-User—An individual, often an end-user, who has received additional training in use of a particular technology and functions as a resource for purposes of training or problem-solving/trouble-shooting.

Symmetry Bias—The tendency to assign blame for an error in a manner that is proportional to the severity of the outcome (also called *Severity Bias*).

System—A set of interacting, interrelated, or interdependent elements that work together in a particular environment to perform the functions required to achieve the system's aim.

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Systems Thinking—Evaluating the whole process rather than a particular single part, since all parts are inter-related. This approach includes consideration of everyone who could potentially influence the process.

Taxonomy—The practice and science of classification. The National Coordinating Council for Medication Error Reporting and Prevention taxonomy is a classification system to describe and analyze the details around individual medication error events.

Team Charter—A written document defining a team's mission, scope, structure, and objectives; serves to communicate the team's focus and direction for team members, organizational leaders, and other work groups.

Tracer—An evaluation method that uses the medical record as a guide to follow a patient through transitions in the course of an episode of care to assess compliance with standards. This methodology may also be used to assess the medication management process and other organizational systems to provide or evaluate patient care.

Unit Dose—Medication to be given to a particular patient at a specific time packaged in the exact dosage required for that time.

Violation—The action of bypassing a rule, standard, or safe operating procedure. Violations can be further divided into optimizing violations, necessary violations, and routine violations.

Walk Round—A tool that assists with discussion between leadership and frontline staff in order to raise awareness of needed system changes, promote accountability for creating a safe environment, and support decisions for future system improvements and resource allocation.

Workaround—A method for achieving a task by not following proper procedures; a shortcut; often a creative solution to circumvent a problem without eliminating the problem.

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