PATIENT SAFETY TERMS GLOSSARY

NEBRASKA COALTION FOR PATIENT SAFETY

Patient Safety Terms Glossary

Active Error – An error which occurs at the point of contact between a human and some aspect of a larger system. These types of error are generally readily apparent and almost always involve someone at the frontline. These are sometimes described as errors at the sharp end when a scalpel is used as a metaphor for patient harm. Errors at the sharp end are noticed first because they a committed by the person closest to the patient.

Advocacy and Assertion – (TeamSTEPPS® Mutual Support tools). Used when a team members' viewpoint does not coincide with that of a decisionmaker. In advocating for the patient and asserting a corrective action, the team member has an opportunity to correct errors or the loss of situation awareness.

Agency for Health Research and Quality (AHRQ) – A federal governmental agency whose mission is to produce evidence to make health care safer, higher quality, more accessible, equitable and affordable, and to work within the U.S. Department of Health and Human Services and with other partners to make sure that the evidence is understood and used.

Brief – (TeamSTEPPS® Team Event tool) Short session prior to a start to share the plan, discuss team formation, assign roles and responsibilities, establish expectations and climate, and anticipate outcomes and likely contingencies.

Brief Checklist – (TeamSTEPPS® Team Event tool) A structured list of items to include in an effective team briefing.

Call-out – (TeamSTEPPS® Communication tool) A strategy used to communicate important or critical information. Call outs:

- Inform all team members simultaneously during situations.
- Help team members anticipate next steps.
- Direct responsibility by name to the specific individual responsible for carrying out the task.

Causal Statement –A statement that describes the cause and effect relationship between two or more variables or events. It can be used to summarize the findings of a root cause analysis.

Cause Diagramming or Mapping – A visual model of the cause and effect relationships between variables in a system.

Check-back – (TeamSTEPPS® Communication tool) A closed-loop communication strategy used to ensure that information conveyed by the sender is correctly understood by the receiver.

Closed Loop Communication – Using verbal feedback to ensure that messages are correctly understood by recipients using methods including call-outs, check-backs, and teach-backs.

Common Formats – AHRQ developed common set of standardized definitions and formats that make it possible to collect, aggregate, and analyze uniformly structured information from events of patient harm.

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Contributing Factors (RCA^2 term) – A condition or circumstance that influences the likelihood of an event; they can affect the severity of consequences or increase the effect in time. Eliminating a contributing factor will not eliminate the effect.

Cross-monitoring – (TeamSTEPPS® Situation Monitoring tool) A harm error reduction strategy that involves:

- monitoring actions and stress levels of other team members
- providing a safety net within the team
- ensuring that mistakes or oversights are caught quickly and easily.
- "watching each other's back".

Cumulative or Aggregate RCA – A tool used to identify trends and system issues across groupings of similar events. Staff time is used efficiently by analyzing trends in events, rather than an in-depth analysis of each case.

CUS – (TeamSTEPPS® Mutual Support tool) Assertive statements:

- I am **C**oncerned
- I am **U**ncomfortable
- This is a **S**afety Issue

"Stop the Line"

De-brief – (TeamSTEPPS® Team Event tool) A structured, intentional yet informal, quick information exchange session designed to improve team performance and effectiveness through lessons learned and reinforcement of positive behaviors.

De-brief Checklist – (TeamSTEPPS® Team Event tool) A structured list of items to include in an effective team de-briefing.

De-identified Event – A shared learning resources based on an event reported to NCPS. This resource include links to best practice recommendations and other patient safety-related resources, references, and an organization self-assessment tool to enable our members to proactively identify risk and develop mitigation strategies to prevent the event from occurring in their healthcare setting. Shared learning opportunities always ask the question, "Could this happen in your organization?"

DESC - (TeamSTEPPS® Mutual Support tool) A constructive approach for managing and resolving conflict.

- **D**escribe the specific situation or behavior; provide concrete data
- **E**xpress how the situation makes you feel/what your concerns are
- **S**uggest other alternatives and seek agreement
- **C**onsequences should be stated in terms of impact on the patient and established team goals; strive for consensus.

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Donabedian Model – The foundation for quality assessment in health care. It is structured as:

- **S**tructure – How care is delivered, organized, financed
  People, equipment, policies/procedures
  Equivalent to system design capacity for work
- **P**rocess – Tasks performed that are intended to produce an outcome
  Most closely related to outcomes
  Causal relationship between process and outcomes
- **O**utcome – Changes in individuals and populations due to health care
  Time to develop, multipfactorial, random component

Fast Thinking (System 1) – Human thinking that works instinctively and requires very little effort; the part of the brain that acts intuitively and suddenly, often without conscious control.

Formative Feedback – (TeamSTEPPS® Mutual Support tool) Feedback is information provided to team members through verbal or nonverbal communication, either intentionally or unintentionally. Formative feedback is shared to improve team performance. Formative feedback should be:

- Appreciative—expresses gratitude and notes actions that team members do well.
- Timely— given soon after the target behavior has occurred.
- Respectful—focuses on behaviors, not personal attributes.
- Specific—relates to a specific task or behavior that requires correction or improvement.
- Directed toward improvement—provides directions for future improvement.
- Considerate—considers a team member's feelings and delivers negative information with fairness and respect.
- Patient focused— addresses impact of team behaviors on the patient's well-being.

Handoff – (TeamSTEPPS® Communication tool) A standardized method for transferring information (along with authority and responsibility) during transitions in patient care. A proper handoff includes the following:

- Transfer of responsibility and accountability
- Clarity of information
- Verbal communication of information,
- Acknowledgment by receiver
- Opportunity to ask questions and review.

Huddle – (TeamSTEPPS® Team Event tool) An ad hoc meeting to ensure continual progression of care to the goal. Used to re-establish or affirm situational awareness, reinforce the plan in place, or assess the need to augment or adjust to optimize outcomes.

Human Factors Engineering – A discipline concerned with the design of tools, machines, and systems that take into account human capabilities, limitations, and characteristics. The goal is to design for safe, comfortable, and effective human use.

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I'M SAFE Checklist – (TeamSTEPPS® Situation Monitoring tool) A simple checklist that can be used to determine the ability of you or your team members to perform safely.

- **I**llness
- **M**edication
- **S**tress
- **A**lcohol and Drugs,
- **F**atigue
- **E**ating and **E**limination

I-PASS – (TeamSTEPPS® Communication tool) The preferred handoff tool for patient transitions in care.

- **I**llness **Severity** (stable, watcher, unstable)
- **P**atient **Summary** (summary statement, events leading up to admission or care transition, hospital course or treatment plan, ongoing assessment, contingency plan
- **A**ction **List** (to-do list, timelines and ownership)
- **S**ituation **Awareness & Contingency Planning** (know what's going on, plan for what might happen)
- **S**ynthesis **by Receiver** (receiver summarizes what was heard, asks questions, restates key actions/to-do items)

Just Culture – A system of shared accountability in which the organization is accountable for system design and responding to employee behaviors in a fair and just manner. In turn, employees are accountable for Behavioral choices, reporting their errors, and reporting system vulnerabilities.

Latent Error – A gap in the design of a system that contributes to the occurrence of errors or allows them to cause harm to patients. These errors are often not apparent to the front- line worker. These are sometimes described as errors at the blunt end when a scalpel is used as a metaphor for patient harm. The blunt end is a distance away from where the actual harm occurs.

Legal Counsel Update – The quarterly virtual meeting the Alliance for Quality Improvement and Patient Safety (AQIPS) provides for all member PSOs and their affiliated members. The meeting covers updates to current case law and other relevant topics related to the Patient Safety and Quality Improvement Act, and best practices for PSO and Patient Safety Evaluation System (PSES) operations.

Mutual Support – (TeamSTEPPS® tool) Also called "backup behavior," mutual support involves team members assisting one another, providing and receiving feedback on performance, and advocating assertively when patient safety is threatened.

NCPS Education Committee – An interprofessional group of clinical professionals that work to provide adult learners from diverse healthcare settings with evidence-based continuing education opportunities that improve the safety and quality of patient care.

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NCPS Reporting Committee - An interprofessional group of clinical subject matter experts which meet quarterly to review selected events reported to NCPS. They discuss identified causal factors, the overall thoroughness of the information reported, and identify risk mitigation strategies to share with all NCPS members.

Near Miss – An event or a situation that could have caused harm to a patient, but did not, either by chance or by timely intervention. These events are important to report and analyze because they can reveal errors and gaps in the system that need to be corrected.

Never Events – Adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability.

Objective Voice – (Just Culture term) The reasonable person standard, or substitution test, used for judging a person's behavior as at-risk or reckless.

Patient Safety Activities – The eight patient safety activities that are carried out by, or on behalf of a PSO, or a healthcare provider. Include are the following:

1. Efforts to improve patient safety and the quality of healthcare delivery.
2. The collection and analysis of patient safety work product (PSWP).
3. The development and dissemination of information regarding patient safety, such as recommendations, protocols, or information regarding best practices.
4. The utilization of PSWP for the purpose of encouraging a culture of safety as well as providing feedback and assistance to effectively minimize risk.
5. The maintenance of procedures to preserve confidentiality with respect to PSWP.
6. The provision of appropriate security measures with respect to PSWP.
7. The utilization of qualified staff.
8. Activities related to the operation of a patient safety evaluation system and to the provision of feedback to participants in a patient safety evaluation system.

Patient Safety Alert – A shared learning resource NCPS provides to its members that describes a specific type of event, and provides a comprehensive review and analysis of all similar events that have been reported, including contributing factors and actions taken to prevent future events.

Patient Safety and Quality Improvement Act (PSQIA)– legislation passed in 2005 which established a voluntary reporting system for healthcare providers to enhance the data about quality and patient safety issues.

Patient Safety Brief - A shared learning resource NCPS provides to its members which cover a wide range of topics that are important in maintaining a safe patient care delivery system. It describes a specific patient safety topic and provides a comprehensive review of current literature.

Patient Safety Evaluation System – The collection, management, or analysis of safety-related information for reporting to or by a patient safety organization.

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Patient Safety Organization (PSO) – An organization which works with healthcare providers to help them improve patient safety and healthcare quality and encourage a culture of safety. PSOs analyze data voluntarily reported by providers and provide feedback aimed at promoting learning and minimizing patient risk.

Patient Safety Organization Privacy Protection Center (PSOPPC) – An agency within AHRQ which is responsible for providing technical assistance to PSOs to ensure that patient safety event data is rendered nonidentifiable in a consistent manner for submission/reporting to the Network of Patient Safety Databases (NPSD). The PSOPPC also offers technical assistance on the use of AHRQ's Common Formats.

Patient Safety Rule - Published in the Federal Register in 2008 to implement the PSQIA. It provides the requirement for patient safety organizations (PSO) to be listed under the Agency for Healthcare Quality and Research (AHRQ); describes privilege and confidentiality protections; describes patient safety activities of a PSO; establishes the framework for Health and Human Services to monitor compliance with PSO programs, confidentiality provisions, impose penalties, etc.

Patient Safety Work Product – Information developed in your organization that can be used to improve patient safety and quality and is reported to a Patient Safety Organization (PSO). It also includes information developed by the PSO for patient safety activities; deliberations and analysis information providers create as they review events is protected even prior to reporting to their PSO. (see the Code of Federal Regulations for the legal definition).

Performance Shaping Factors - External or internal factors that affect how a person perceives a situation and causes them to respond in a certain way.

PIDA Model – (Perception, Interpretation, Decision, Action) The model used to explain how humans perceive what is going on around us, interpret the signals and then decide how to respond.

Reporting Committee Summary – A shared learning resource NCPS provides to its members which provides a comprehensive overview of several of the safety events that were discussed at a quarterly Reporting Committee meeting. This resource is developed within the framework of an organizational self-assessment tool which asks, "***"Could this happen in your organization?"*** This framework, and the inclusion of links to best practice recommendations and other patient safety-related resources enables our members to proactively identify risk and develop mitigation strategies to prevent the events from occurring in their healthcare setting.

Root Cause Analysis Squared (RCA^2) – A method to analyze the causes of an event of patient harm and then take action to correct the system breakdown(s) which allowed the harm, or near harm, to occur.

Safety Assessment Code Matrix (SAC Matrix) – A scoring matrix that evaluates the probability and severity of a patient harm event in determining if the event should be examined with an RCA^2.

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SBAR – (TeamSTEPPS® Communication tool) A technique for communicating critical information that requires immediate attention and action concerning a patient's condition.

- **S**ituation – What is going on with the patient?
- **B**ackground – What is the clinical background or context?
- **A**ssessment – What do I think the problem is?
- **R**ecommendation or **R**equest – What would I do to correct it?

Sentinel Event - Any unanticipated event in a healthcare setting that results in death or serious physical or psychological injury to a patient, not related to the natural course of the patient's illness.

Shared Mental Model – (TeamSTEPPS® term) A mental picture or sketch of the relevant facts and relationships defining an event, situation, or problem. Shared mental models:

- consist of the relevant facts and interrelationships among tasks and situations the team is dealing with in their care of a patient or response to a defined issue.
- provide team members with a common understanding of who is responsible for which task and what the information requirements are for each task.
- enable the team to anticipate and predict each other's needs; identify changes in the team, task, or teammates; and adjust the course of action or strategies as needed.

Situation Monitoring Process– (TeamSTEPPS® tool) A three-part process in which the individual skill of situation monitoring fosters situational awareness. Collective situational awareness fosters a shared mental model needed for effective teamwork.

- **Situation monitoring** (an individual skill): The process of continually scanning and assessing a situation to gain and maintain an understanding of what's going on around you.
- **Situation awareness** (an individual outcome): The state of knowing what's going on around you regarding the patient, other team members, the environment, and progress toward goals.
- **Shared mental models** (a team outcome): Results from each team member maintaining situation awareness and communicating to ensure that all team members are "on the same page."

Slow Thinking (System 2) – This type of human thinking works more meticulously and requires more concentration; it occurs in the part of the brain responsible for an individual's decision-making, reasoning, and beliefs. It controls conscious activities of the mind such as self-control, choice, and intentional focus.

STAR – (TeamSTEPPS® Situation Monitoring tool) A tool that is used to elicit and share key information about activities and their consequences. Each team member must self-check and:

- STOP – pause to focus on the immediate task
- THINK – think methodically and identify correct action
- ACT – perform the act
- REVIEW – confirm anticipated result has occurred or apply contingency if required

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STEP – (TeamSTEPPS® Situation Monitoring tool) A tool to help individuals monitor critical elements of a situation and the overall environment:

- **Status of the patient**: Patient history, vital signs, medications, physical exam, plan of care, psychosocial issues, patient preferences or concerns
- **Team members**: Fatigue, workload, task performance, skill, stress level
- **Environment**: Facility information, administrative information, human resources, triage acuity, equipment
- **Progress toward the goal**: Status of team's patient(s), established goals of team, tasks/actions of team, plan still appropriate

Subjective Voice – (Just Culture term) The perspective of the person whose behavior is being judged as human error, at-risk, or reckless.

Survey on Patient Safety (SOPS) – This is a self-administered questionnaire that measures 12 dimensions of safety culture and aims to assess the perceptions and attitudes of providers and other staff regarding patient safety issues. It was developed by the Agency for Healthcare Research and Quality. Specific surveys are available for hospitals, medical offices, nursing homes, community pharmacies, and ambulatory surgery centers.

Swiss Cheese Model – An accident causation model which illustrates that although many layers of defense lie between hazards and accidents, there are flaws in each layer (holes in the cheese) that, if aligned, can allow the accident to occur.

System – Any collection of two or more parts interacting to achieve a common aim. This interdependent group of items forms a unified whole and the components may be both human and non-human.

System Thinking – Considering how all of the elements in a system interact dynamically to produce an outcome.

Task Assistance - – (TeamSTEPPS® Mutual Support tool) Helping others with tasks builds a strong, trusting team. Key strategies include:

- Team members foster psychological safety and protect each other from work overload.
- Effective teams place all offers and requests for assistance in the context of patient safety.
- Team members foster a climate where it is expected that assistance will be actively sought and offered.
- Resilient teams are willing to ask for help and lean into being responsible for facing challenges and finding solutions.
- Assistance is sought from and provided to patients and family caregivers.

Teach-back – (TeamSTEPPS® Communication tool) A method to confirm that the sender has explained information clearly and that patients or family members have a clear understanding of what the sender has told them. In a teach-back, the sender asks the patient or family member to explain the information they need to know or actions they need to take, in their own words.

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TeamSTEPPS®– An evidence-based set of team tools, aimed at optimizing patient outcomes by improving communication and teamwork skills among healthcare teams, including patients and family caregivers.

Threshold Investigation – (Just Culture term) The beginning step in the review of an undesired outcome when utilizing the Just Culture™ Algorithm. The following are the questions to be answered:

- What happened?
- What normally happens?
- What does procedure require?
- Why did it happen?
- How were we managing it?

Two-Challenge Rule - (TeamSTEPPS® Mutual Support tool) This tool empowers all team members to *"stop the line"* if they sense or discover an essential safety breach. When an initial assertive statement is ignored:

- It is your responsibility to assertively restate the concern.
- The team member being challenged must acknowledge that they heard and understood your concern.
- If the response does not clarify and alleviate concern, rephrase the anticipated danger.
- If the safety issue still hasn't been addressed:
  - ✓ Take a stronger course of action
  - ✓ Engage other team members
  - ✓ Use supervisor or chain of command

Sources for these definitions include:

Agency for Healthcare Research and Quality	https://www.ahrq.gov/
Joint Commission	https://www.jointcommission.org/
LeapFrog Group	https://www.leapfroggroup.org/
The Just Culture Company	https://www.justculture.com/
World Health Organization	https://www.who.int/

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