Patient Safety

A World Alliance for Safer Health Care

Definitions of Key Concepts from the WHO Patient Safety Curriculum Guide (2011)

1. **Adverse event:** an incident in which a patient is harmed.

2. **Adverse reaction**: unexpected harm resulting from a justified action where the correct process was followed for the context in which the event occurred.

3. **Agent**: a substance, object or system which acts to produce change.

4. **Attributes**: qualities, properties or features of someone or something.

5. **Change concept**: a general idea with proven merit and a sound scientific or logical foundation that can stimulate specific ideas for changes that lead to improvement.

6. **Circumstance**: a situation or factor that may influence an event, agent or person(s).

7. **Class**: a group or set of similar things.

8. **Classification**: an arrangement of **concepts** into **classes** and their subdivisions, linked so as to express the **semantic relationships** between them.

9. **Complaint:** expression of dissatisfaction by a patient, family member or carer with the provision of health care.

10. **Consent process:** enables patients (or their carers) to consider all the options they have in relation to their care and treatment, including alternatives to the course of treatment proposed.

11. **Concept**: a bearer or embodiment of meaning.

12. **Contributing factor**: a circumstance, action or influence that is thought to have played a part in the origin or development of an incident or to increase the risk of an incident.

13. **Coronial investigations:** investigation of death in situations where the cause of death is uncertain or thought to be due to unethical or illegal activity.

14. **Culture***:* language and customs, as well as values, beliefs, behaviours, practices, institutions and the ways in which people communicate.

15. **Cultural competence:** knowledge, skills and attitudes that a health-care worker needs in order to provide adequate and appropriate health-care services to all people in a way that respects and honours their particular culturally-based understandings and approaches to health and illness.

16. **Degree of harm**: the severity and duration of harm, and any treatment implications, that result from an incident.

17. **Detection**: an action or circumstance that results in the discovery of an incident.

18. **Disability**: any type of impairment of body structure or function, activity limitation and/or restriction of participation in society, associated with past or present harm.

19. **Open disclosure:** process of informing patients and their families of bad outcomes of treatment, as distinguished from bad outcomes that are expected from the disease or injury itself.

20. **Disease**: a physiological or psychological dysfunction.

21. **Error**: failure to carry out a planned action as intended or application of an incorrect plan.

22. **Event**: something that happens to or involves a **patient**.

23. **Evidence-based:** to apply the best available evidence gained from a scientific method to clinical decision making.

24. **Failure mode and effect analysis** (FMEA) is an approach that seeks to find and identify possible failures in the system and implement strategies to prevent the failures from occurring. FMEA is usually a component of larger quality-improvement efforts being undertaken by a health-care organization.

25. **Fitness to practise:** proof of competence of health-care professionals.

26. **Guideline:** an application of an abstract concept.

27. **Harm**: impairment of structure or function of the body and/or any deleterious effect arising there from. Harm includes **disease, injury, suffering, disability** and **death**.

28. **Harmful incident or adverse event**: an incident that resulted in harm to a patient.

29. **Hazard**: a circumstance, agent or action with the potential of causing harm.

30. **Health**: a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

31. **Health care**: services received by individuals or communities to promote, maintain, monitor or restore health.

32. **Incident:** An event or occurrence that may cause or causes an interruption or a crisis. In safety, an incident of workplace illness or injury.

33. **Incident characteristics**: the selected attributes of an incident.

34. **Incident reporting:** collecting and analysing information about an event that could have harmed or did harm a patient in a health-care setting.

35. **Incident type**: a descriptive term for a category made up of incidents of a common nature, grouped because of shared, agreed features.

36. **Injury:** damage to tissues caused by an **agent** or **event**.

37. **Mitigating factor**: an action or circumstance that prevents or moderates the progression of an incident towards harming a patient.

38. **Near miss**: an **incident** that did not reach the patient.

39. **No harm incident:** an **incident** that reached a patient, but no discernable harm resulted.

40. **Outcome:** result or consequence. Information, event, object or state of being produced as a result or consequence of a plan, process, accident, effort or other similar action or occurrence. There are 'Outcome', ' Process' and 'Balancing' measures.

41. **Patient**: a person who is the recipient of health care.

42. **Patient characteristics**: selected attributes of a patient.

43. **Patient outcome**: the impact upon a patient that is wholly or partially attributable to an **incident**.

44. **Patient safety**: the reduction of risk of unnecessary harm associated with health care to an acceptable minimum.

45. **Patient safety incident**: an event or circumstance that could have resulted, or did result, in unnecessary harm to a patient.

46. **Preventable**: accepted by the community as avoidable in the particular set of circumstances.

47. **Process measures:** refer to measurements of the workings of a system. These measures focus on the components of systems associated with a particular negative outcome, as opposed to the incidence of these events.

48. **Quality improvement**: any process or tool aimed at reducing a quality gap in systemic or organizational functions.

49. **Reportable circumstance**: a situation in which there was significant potential for harm, but no incident occurred.

50. **Risk**: the probability that an **incident** will occur.

51. **Root Cause Analysis (RCA):** is a defined process that seeks to explore all of the possible factors associated with an incident by asking what happened, why it happened and what can be done to prevent it from happening again.

52. **Safety**: the reduction of risk of unnecessary harm to an acceptable minimum.

53. **Semantic relationship**: the way in which things (such as classes or concepts) are associated with each other on the basis of their meaning.

54. **Sentinel Event:** an "adverse event that should never be allowed to happen", is usually unexpected and involving a patient death or serious physical or psychological injury to a patient.

55. **Side-effect**: a known effect, other than that primarily intended, related to the pharmacological properties of a medication.

56. **Suffering**: the experience of anything subjectively unpleasant.

57. **Violation**: deliberate deviation from an operating procedure, standard or rule.

Definitions from other sources

1. **Health care-associated infection**: an infection that was neither present nor incubating at the time of patient's admission, which normally manifests itself more than three nights after the patient's admission to hospital[i].

2. **Patient safety culture**: a culture that exhibits the following five high-level attributes that health-care professionals strive to operationalize through the implementation of strong safety management systems; (1) a culture where all health-care workers (including front-line staff, physicians, and administrators) accept responsibility for the safety of themselves, their co-workers, patients, and visitors; (2) a culture that prioritizes safety above financial and operational goals; (3) a culture that encourages and rewards the identification, communication, and resolution of safety issues; (4) a culture that provides for organizational learning from accidents; (5) a culture that provides appropriate resources, structure, and accountability to maintain effective safety systems[ii].

[i] Forum and End Stage Renal Disease Networks, National Patient Safety Foundation, Renal Physicians Association. National ESRD Patient Safety Initiative: Phase II Report. Chicago (2001).
[ii] National Audit Office. Department of Health. *A Safer Place for Patients: Learning to improve patient safety*. London: Comptroller and Auditor General (HC 456 Session 2005-2006).

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