PSO Glossary

Administration Error
An error in the phase of the medication use process where the drug product and patient interface.

Adverse Drug Event (ADE)
An adverse event involving the use of medications or the failure to use appropriate medications when indicated.

Adverse Drug Reaction (ADR)
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 (AE)
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.

AHRQ
Agency for Healthcare Research and Quality. AHRQ is one of 11 operating divisions of the HHS. www.ahrq.gov

Benchmark
In health care, a benchmark is the best in industry measurement that can lead to superior performance. Three principles of benchmarking are maintaining quality, customer satisfaction and continuous improvement.

Call Out
A strategy used to communicate important or critical 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.

Common Formats
AHRQ created the Common Formats (common definitions and reporting Formats) to help uniformly report patient safety events and to improve health care providers' efforts to minimize and potentially eliminate harm. More information is available on the PSOPPC website (https://www.psoppc.org/psoppc_web/publicpages/commonFormatsOverview).

Confidentiality Protections
The Patient Safety Act provides confidentiality protections for PSWP at 42 U.S.C. 299b- 22(b). The confidentiality protections are incorporated into the Patient Safety Rule in Subpart C at section 3.206(a). In addition to reviewing Subpart C of the rule, it may be helpful to review the definitions of disclosure and affiliated provider in section 3.20

Continued Protection
With few exceptions, PSWP that is disclosed to another individual or entity pursuant to the disclosure permissions (exceptions) in sections 3.206(b) remains confidential and privileged in the possession of the receiving entity or individual. See section 3.208 of the Patient Safety Rule for the general principle and section 3.204 and 3.206 to review the specific disclosure permissions.

Copy
The Patient Safety Rule refers to the term "copy" in two ways in the definition of patient safety work product. First, when information meets all of the applicable requirements for protection as patient safety work product, any copy of the PSWP is also protected. Second, if information is not eligible for protection as PSWP (e.g., it is from the medical record or a report sent to regulatory authorities), the provider can still send a copy of the information to its PSO. While the copy held by the PSO or by the provider's PSES is protected, that protection does not apply to the original information that exists elsewhere (e.g., the medical record or the copy held by the regulator).

CPOE (Computerized Physician Order Entry)
A computer based system for ordering medications and/or other tests in which physicians directly enter orders into a computer system.

Crew Resource Management (CRM)
A range of approaches to training groups, originally developed in aviation, to function as teams, rather than as collections of individuals that emphasizes the role of "human factors" and the impact of different management styles and organizational cultures in high-stress, high-risk environments. Also referred to as Crisis Resource Management.

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 front-line 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 condition- I am Concerned,I am Uncomfortable, This is a Safety issue.

De-identification
De-identification is the term used for removing identifiers in protected health information (PHI) pursuant to the HIPAA Privacy Rule. The standard is found at 45 CFR 164.514. For more information: https://www.hhs.gov/hipaa/for-professionals/privacy/special-topics/de-identification/index.html.

Disclosure
The release, transfer, provision of access to, or divulging in any other manner of patient safety work product by:
(1) An entity or natural person holding the patient safety work product to another legally separate entity or natural person, other than a workforce member of, or a health care provider holding privileges with, the entity holding the patient safety work product; or

(2) A component PSO to another entity or natural person outside the component PSO and within the legal entity of which the component PSO is a part.

Dispensing Error
Deviations from the prescriber's order, made by staff in the pharmacy when distributing medication to nursing units or to patients in ambulatory settings.

Drop-Out
The Patient Safety Rule provides a limited opportunity for a provider to remove information that was PSWP from its PSES. The drop-out provision can be used for any reason, provided that the information is eligible for drop out, including that the information that the provider had placed in its PSES has not been reported to a PSO and the provider documents the action and its date. Upon removal, the information is no longer PSWP and is not confidential or privileged under the Patient Safety Act. The drop-out provision cannot be used if the information has been reported to a PSO, and it does not apply to information that describes or constitutes the deliberations or analyses of a PSES. The drop out provision is in paragraph (2)(ii) of the definition of PSWP in section 3.20 of the Patient Safety Rule.

ECRI
ECRI Institute PSO www.ecri.org

Equitable Relief
The Patient Safety Act prohibits a provider from taking an adverse employment action (specified in the Act) against an individual based upon the fact that the individual in good faith reported information to the provider with the intention of having the information reported to a patient safety organization; or directly to a patient safety organization (42 U.S.C. 299b-22(e)). Equitable relief refers to the relief that an individual may seek in a civil action to redress an adverse employment action that violatesthis prohibition (42 U.S.C. 299b-22(f)(4)).

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.

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.

Hazard 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 Risk Analysis.

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.

HIPAA Privacy Rule
The HIPAA Privacy Rule sets federal standards for the use and disclosure of individually identifiable health information, referred to as protected health information, held and maintained by covered entities, which are health plans, health care clearinghouses, and certain health care providers. Patient safety work product that contains protected health information (PHI) is subject to the requirements of the HIPAA Privacy Rule as well as the Patient Safety Rule. The HIPAA Security Rule may also apply.

High Alert Medications
Drugs that bear a heightened risk of causing injury when misused, consequences of errors with these drugs may be more devastating.

High Reliability Organizations (HROs)
Organizations or systems that operate in hazardous conditions but conduct relatively error-free operations. Examples of HROs are air traffic control systems, nuclear power plants, and naval aircraft carriers. Studies reveal HROs have 5 common features, including a preoccupation with

failure, resists over-simplification, commitment to resilience, sensitivity to operations and looks to expertise not rank to inform decisions.

Hindsight Bias
The inclination to see events that have already occurred as being more predictable than they were before they took place. The tendency is to judge the events leading up to an accident as errors because the bad outcome is known. The more severe the outcome, the more likely that decisions leading up to the outcome will be judged as errors, which implies that the outcome was preventable. Those reviewing events after the fact see the outcome as more foreseeable and therefore more preventable than they would have appreciated in real time.

HIT
Health Information Technology

Human Factors (or Human Factors Engineering)
The study of human abilities and characteristics as they affect the design and operation of equipment, systems, and jobs, includes considerations of the strengths and weaknesses of human physical and mental abilities and how these affect the systems design.

Identifiable Patient Safety Work Product
Identifiable PSWP is PSWP that: (1) is presented in a form and manner that: allows the identification of any provider that is a subject of the work product, or any providers that participate in, or are responsible for, activities that are a subject of the work product; (2) constitutes individually identifiable health information as that term is defined in the HIPAA Privacy Rule at 45 CFR 160.103; or (3) is presented in a form or manner that allows the identification of an individual who in good faith reported information directly to a PSO or to a provider with the intention of having the information reported to a PSO (‘‘reporter’’). Identifiable PSWP is confidential and privileged and may not be disclosed except as permitted by the Patient Safety Rule.

IHI
Institute for Healthcare Improvement www.ihi.org

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.”

ISMP
Institute for Safe Medication Practices www.ismp.org/

Just Culture
A culture in which front-line 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 (or Latent Condition)
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.”

Medical Emergency Team - MET
A team, similar in concept to a cardiac arrest team, with more liberal calling criteria for responding to a wide range of worrisome, acute changes in patients’ clinical status, such as low blood pressure, difficulty breathing, or altered mental status, de-emphasizing the traditional hierarchy in patient care, allowing anyone to call for the team. Sometimes referred to as a Rapid Response Teams.

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 sufficient 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 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.”

Non-identification
The process of removing identifiers in PSWP pursuant to the Patient Safety Rule’s standard at section 3.212 to render PSWP non-identifiable. Generally, non-identifiable PSWP is no longer privileged or confidential after being disclosed. The non-identification standard incorporates and preserves the HIPAA de-identification standard for application to patient information.

Network of Patient Safety Databases (NPSD)
The NPSD, required by the Patient Safety Act (42 U.S.C. 299b-23), will receive, analyze, and report on non-identifiable and aggregated patient safety event information. The goal of the

NPSD is to facilitate aggregation and analyses of patient safety event information to help reduce adverse events and improve health care quality.

NPSF
National Patient Safety Foundation www.npsf.org

NPSG
National Patient Safety Goals - goals established by The Joint Commission to help its accredited organizations address specific areas of concern in regards to patient safety. www.jointcommission.org/standards_information/npsgs.aspx

NQF
National Quality Forum www.qualityforum.org

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.

Patient Safety Act
The Patient Safety Act is an informal name of The Patient Safety and Quality Improvement Act of 2005 (P.L. 109-41), 42 USC 299b et seq

Patient Safety Act Guidance
HHS issues guidance to describe or explain certain aspects of the Patient Safety Act and Rule. Guidance documents may be found at the AHRQ PSO Web site (www.pso.ahrq.gov).

Patient Safety Evaluation System (PSES)
The collection, management, or analysis of information for reporting to or by a PSO. A provider's PSES is an important determinant of what can, and cannot, become patient safety work product. It may be helpful to read the definition of PSES in conjunction with the definition of patient safety work product; they can be found in section 3.20 of the rule.

Patient Safety Rule
The set of regulations at 42 CFR Part 3 that implement provisions of the Patient Safety Act.

Patient Safety Work Product (PSWP)
PSWP applies to information that is privileged and confidential under the Patient Safety Rule. For details on what information can, and cannot, become PSWP, the applicable process and purpose requirements, and the important role of the provider's patient safety evaluation system,

see the definition of patient safety work product in section 3.20 of the rule. It may be helpful to read the definition of PSWP in conjunction with the definition of a patient safety evaluation system; they can be found in section 3.20 of the rule.

PHI
Personal Health Information

Prescribing Error
Mistakes made by the prescriber when ordering a medication.

Privilege
The Patient Safety Act providesfederal privilege protectionsfor patientsafety work product (PSWP) at 42 U.S.C. 299b-22(a). The privilege protections are also included in the Patient Safety Rule for convenience and completeness(see section 3.204(a)); however, HHS does not have authority to enforce breaches of the privilege protections.

Production Pressure
Pressure to put quantity of output, for a product or a service, ahead of safety; in health care, production pressure refers to delivery of services, often producing an organizational culture in which front line personnel, often managers as well, are reluctant to suggest any course of action that compromises productivity.

Provider

In the private sector, a provider means:

1. an individual or entity licensed or otherwise authorized under State law to provide health care services and

2. a parent organization of one or more entities licensed or otherwise authorized to provide health care services.

The definition of provider in section 3.20 of the Patient Rule includes additional language specific to Federal, State, local, or Tribal governments. Consult the definition of provider in section 3.20 of the rule for the complete definition.

Read-Backs
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.

Red Rules
Rules that must be followed to the letter, relate to important and risky processes, must be simple and easy to remember, should be known organization-wide, should foster a culture of patient safety.

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 front-line 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.

Situational Awareness
The degree to which one's perception of a situation matches reality. Maintaining situational

awareness might be the equivalent of keeping the “big picture” in mind.

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 ben treated as mistakes resulting in remedial training or increased supervision.

STEP
A tool for monitoring situations in the delivery of health care – Status of the patient, Team members, Environment, Progress toward goal.

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.

System
Interdependent elements (human and non-human) interacting to achieve a common aim.

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

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.

The Joint Commission
An independent, not-for-profit organization that accredits and certifies more than 15,000 health care organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards. www.jointcommission.org/

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.

USP
United States Pharmacopeia www.usp.org