

Patient Safety Nomenclature

Glossary

Adverse event - An event that results in unintended harm to the patient, and is related to the care and/or services provided to the patient rather than to the patient's underlying medical condition.

ARC - A team communication tool. The acronym stands for: **A**sk a question, **R**equ^est a change, voice a **C**oncern.

Authority gradient - Balance of decision-making power or the steepness of command and hierarchy in a given situation.

Briefing- A structured communication used to share information, often before an activity (e.g., a surgical time out)

CHAT - A communication tool for monitoring a situation. The acronym stands for: Context, **H**istory, **A**ssessment, **T**entative plan.

Close call – An event with the potential for harm that did not result in harm because it did not reach the patient due to timely intervention or good fortune (sometimes called a near miss). The term “good catch” is a common colloquialism to indicate the just-in-time detection of a potential adverse event.

Cognitive biases - Mental shortcuts or heuristics that can lead to error such as a pilot who is so focused on malfunctioning landing gear that she runs out of fuel.

Cultural competency- The ability to interact successfully with people from cultures other than one's own.

Culture of patient safety - A health care organizational approach in which the provision of safe care is a guiding principle. A culture of safety reflects the knowledge, skills and commitment of all leaders, management, health care professionals and staff to the provision of the safest possible patient care. The culture appropriately and adequately supports providers in the provision of safe care, including continuous professional development. The culture encourages learning from adverse events and close calls to strengthen the system. Where appropriate, it supports and educates health care providers to help prevent similar events in the future. Justice is an important element; all are aware of what is expected, and are held professionally accountable in a fair way. Fairness and due process are fundamental to the determination of the reasons for adverse events. The interests of both patients and providers are protected.²

CUS - A mutual support communication tool. The acronym stands for: I am **C**oncerned, this is **U**nsafe, I am **S**cared.

DESC Script - A constructive approach to managing and resolving conflict. The acronym stands for: Describe the specific situation or behaviour; provide concrete data, Express how the situation makes you feel / what your concerns are, Suggest other alternatives and seek agreement, Consequences should be stated in terms of impact on established team goals, Strive for consensus.

Disclosure - The process by which an adverse event is communicated to the patient by health care providers.

Initial disclosure: The first communication made with the patient as soon as reasonably possible after an adverse event, focusing on the known facts and the provision of further clinical care.

Post-analysis disclosure: Subsequent communications with the patient about known facts related to the reasons for the harm after an appropriate analysis of the adverse event.

Ergonomics – The application of the science concerning human limitations to the design of objects, systems and the environment for human use.

Error, provider (medical) - An act (plan, decision, choice, action or inaction) that when viewed in retrospect was not correct and resulted in an adverse event or a close call.

Event - A significant occurrence.

Fatigue - Extreme tiredness that results in diminished ability to perform both cognitive and physical tasks.

Harm - An outcome that negatively affects the patient's health and/or quality of life.

Health care providers - Health care professionals who work as part of the patient care team

High reliability organization (HRO)- An organization with fewer than normal accidents in an environment where accidents can be expected in view of inherent risk factors and the complexity of the activity, and in an industry where errors have a high potential to result in disastrous consequences. Examples of HROs include organizations within the aviation, nuclear power and space industries.

Human factors and human factors engineering - Study of human abilities and characteristics as they affect the design and smooth operation of equipment, systems and jobs. In North America the term human factors engineering is used to reflect psychological work, whereas the term ergonomics is used to refer to physical work. The two terms are often used synonymously. In Europe, ergonomics is the preferred term that refers to both.

I'M SAFE - A self-assessment tool to help monitor a situation. The acronym stands for: Illness, Medication, Stress, Alcohol and drugs, Fatigue, Eating and Elimination.

Interdisciplinary - Cutting across or integrating multiple subspecialties of a single profession.

Interprofessional - Cutting across or integrating multiple professions.

Interprofessional education - Occasions when two or more professions learn with, from and about each other to improve collaboration and the quality of care.

I PASS THE BATON - A handover communication tool. The acronym stands for: Introduction, Patient, Assessment, Situation, Safety concerns, THE, Background, Actions, Timing, Ownership, Next.

Just culture - A phrase that refers to the principles for achieving a culture in which front line personnel feel comfortable with errors, including their own, while maintaining professional accountability.

Multidisciplinary - Involving multiple subspecialties of a profession.

No-harm event - An event that reaches the patient but does not result in harm.

Normalization of deviance - The tendency to regularly bend the rules to achieve best performance and the acceptance of this deviance as normal required behaviour.

Patient safety - The pursuit of the reduction and mitigation of unsafe acts within the health care system, as well as the use of best practices shown to lead to optimal patient outcomes.

Reporting - The communication of information about an adverse event or close call by health care providers through appropriate channels inside or outside of health care organizations for the purpose of reducing the risk of adverse events in the future.

Safety - Freedom from the occurrence or risk of injury, danger, or loss.

Situational awareness - The degree to which one's perception of a situation matches reality.

Sleep deprivation - A lack of regular sleep during a 24-hour cycle.

Sleep debt - Cumulative sleep deprivation.

STAR - A thinking tool. The acronym stands for: Stop, Think, Assess/Act, Review.³

Substitute decision-maker - A person who is legally authorized to make decisions on behalf of the patient. This authority may be granted by the patient himself or herself with a legal document such as an advance medical directive, by provincial/territorial legislation, or by the courts.

Surge conditions - An increase in patient and/or health care flow during particular periods.

System failure - The lack, malfunction or failure of policies, operational processes, or supporting infrastructure for the provision of health care.

Technology - A piece of equipment or a tool used to perform an activity. This includes the simplest tools to the most complex engineered and designed devices and systems used to accomplish human tasks, activities and goals (e.g., ranging from allergy alert wrist bands to CT scanners to computerized physician order entry systems).

Work flow - The way that work is completed over time.

Other patient safety terms and definitions can be referenced in the Canadian Patient Safety Dictionary.