Quality Terminology and Definitions

State Office of Rural Health and Texas Hospital Association
Critical Access Hospital Quality Improvement Boot Camp
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Quality: care that is safe, effective, patient-centered, timely, efficient, and equitable.

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.

Safety Culture: the result of an organizational commitment to safety permeating all levels from frontline 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 can 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.

Just Culture: a just culture recognizes that competent professionals make mistakes and acknowledges that even competent professionals will develop unhealthy norms (shortcuts, "routine rule violations"), but has zero tolerance for reckless behavior.

High Reliability Organization: Organizations or systems that operate in hazardous conditions but conduct relatively error-free operations. The five themes of HROs are: preoccupation with failure, resistance to over-simplification, commitment to resilience, sensitivity to operations and deference to expertise (not rank) to inform decisions.

Heuristics: Loosely defined or informal rules often arrived at through experience or trial and error that guide assessments and decisions; the rule of thumb”

Best Practice: generally accepted, standardized techniques, methods or processes that have proven themselves over time

Evidence Based Practice:
research-based practice that has been shown effective through rigorous scientific evaluation

Standard of Care:

Condition: the standard of care for a condition is well be defined in terms of the standard expected of a specialist, in which case a generalist would be expected to deliver the same care or make a timely referral to the appropriate specialist

Malpractice: standard of care is specific to a given specialty; it is often defined as the care expected of a reasonable practitioner with similar training practicing in the same location under the same circumstances.

Sharp End: the personnel or parts of the health care system in direct contact with patients. The sharp end corresponds with errors resulting from "active failures“

Blunt End: the many people and layers of the health care system not in direct contact with patients, but which influence the personnel and equipment in direct patient care.

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.

Adverse Event: harm or injury to a patient caused by medical care.

Sentinel Event: An adverse event in which death or serious harm to a patient has occurred; usually used to refer to events that are not at all expected or acceptable (an operation on the wrong patient or body part). The choice of the word sentinel reflects the egregiousness of the injury (e.g., amputation of the wrong leg) and the likelihood that investigation of such events will reveal serious problems in current policies or procedures.

Never Events: adverse events that are unambiguous, serious, and usually preventable. While most are rare, when never events occur, they are devastating to patients and indicate serious underlying organizational safety problems.

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.

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.

Active Error: occur at the point of contact between a human and some aspect of a larger system (equipment, EHR), are generally readily apparent (e.g., pushing an incorrect button, ignoring a warning light) and almost always involve someone at the frontline.

Latent Error: less apparent failures of organization or design that contributed to the occurrence of errors or allowed them to cause harm to patients.

Near Miss: An event or situation that did not produce patient injury, but only because of chance. (May also be referred to Close Call).

Common Cause: the same cause of error across multiple events or types of events; A condition that produces an effect; eliminating a cause(s) will eliminate the effect.

Contributing Factor: A condition that influences the effect by increasing its likelihood, accelerating the effect in time, affecting severity of the consequences, etc.; eliminating a contributing factor(s) won't eliminate the effect

Human Factors: Human factors engineering is the discipline that attempts to identify and address safety problems that arise due to the interaction between people, technology, and work environments.

Failure Mode and Effects Analysis: A common process used to prospectively identify error risk within a particular process. a complete process mapping that identifies all the steps that must occur for a given process to occur, then continues by identifying the ways in which each step can go wrong, the probability that each error will be detected, and the consequences or impact of the error not being detected. The estimates of the likelihood of a particular process failure, the chance of detecting such failure, and its impact are combined numerically to produce a criticality index. This criticality index provides a rough quantitative estimate of the magnitude of hazard posed by each step in a high-risk process. Assigning a criticality index to each step allows prioritization of targets for improvement.

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.

Informed Consent: The process whereby a physician informs a patient about the risks and benefits of a proposed therapy or test. Informed consent aims to provide sufficient information about the proposed treatment and any reasonable alternatives that the patient can exercise autonomy in deciding whether to proceed.

Handoff: The process when one health care professional updates another on the status of one or more patients for the purpose of taking over their care.

Decision Tree: A diagrammatic representation of the outcomes associated with chance events and voluntary actions

Failure to Rescue: failure to prevent clinically important deterioration from a complication of an underlying illness or a complication of medical care

Data: information gleaned from individual patients, as well as trend lines identified in specific populations and healthcare settings.

Benchmark: best in industry measurement that can lead to superior performance.

Quality Measure: tools that help us measure or quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care. These goals include effective, safe, efficient, patient-centered, equitable, and timely care.

Process Measure: indicate what a provider does to maintain or improve health, either for healthy people or for those diagnosed with a health care condition. inform consumers about medical care they may expect to receive for a given condition or disease, and can contribute toward improving health outcomes

Performance Measure: aggregated, quantified and analyzed data on a particular healthcare-related activity. Their purpose is to identify opportunities for reducing costs, improving quality of care and increasing efficiency of care delivery

Informatics: The science that studies the use and processing of data, information, and knowledge; the integration of healthcare sciences, computer science, information science, and cognitive science to assist in the management of healthcare information

Clinical Decision Support System: a system, based on "triggers", "flags," and "warnings," designed to improve clinical decision making related to diagnostic or therapeutic processes of care.

Interoperability: The ability of one computer system to exchange data with another computer system such that, at a minimum, the message from the sending system can be placed in the appropriate place in the receiving system.

Systems Approach: view that most errors reflect predictable human failings in the context of poorly designed systems.

Variation: an opportunity for improvement.

Workflow: the sequence of physical and mental tasks performed by various people within and between work environments. It can occur at several levels (one person, between people, across organizations) and can occur sequentially or simultaneously.

Workaround: the design of equipment or the policies governing work tasks can seem counterproductive; frontline personnel trying to accomplish their work frontline personnel trying to accomplish their work.

Normalized deviance: a gradual process in which an unacceptable practice or standards become acceptable. As the deviant behavior is repeated without catastrophic results, it becomes the social norm for the organization.

Patient Flow: the movement of patients through a healthcare facility. It involves the medical care, physical resources, and internal systems needed to get patients from the point of admission to the point of discharge while maintaining quality and patient/provider satisfaction.

Throughput: allows for the efficient flow of patients through the hospital, ensuring timely and appropriate level of care.

Change Management: systematic approach to dealing with the transition or transformation of an organization's goals, processes or technologies. The purpose of change management is to implement strategies for effecting change, controlling change and helping people to adapt to change.

Patient Centered Care: focus on the patient and the individual's particular health care needs and seeks to empower patients to become active participants in their care.

Confirmation Bias: the tendency to focus on evidence that supports a working hypothesis, rather than looking for evidence that refutes it or provides greater support to an alternative diagnosis.

Health Literacy: Individuals' ability to find, process, and comprehend the basic health information necessary to act on medical instructions and make decisions about their health.

Health Equity: achieved when every person, no matter their socially determined circumstances, can attain their full health potential.

Health Disparities: are reflected in differences in length of life; quality of life, rates of disease, disability, and death; severity of disease; and access to treatment.

Quality Improvement: the framework used to systematically improve care. Quality improvement seeks to standardize processes and structure to reduce variation, achieve predictable results, and improve outcomes for patients, healthcare systems, and organizations.

PDSA – Plan, Do, Study, Act: the cycle of activities advocated for achieving process or system improvement

Outcome: changes in health that result from measures or specific health care investments or interventions.

Return on Investment: analysis is a way to calculate your net financial gains (or losses), considering all the resources invested and all the amounts gained through increased revenue, reduced costs, or both.

Why is this important?

- Everyone is responsible for Quality and Patient Safety
- Informs nursing practice
- Actively engage in nursing profession
- Training and Onboarding

Resources

Agency for Healthcare Research and Quality: Patient Safety Network – Glossary

U.S. Department of Veterans Affairs National Center for Patient Safety – Glossary of Patient Safety Terms

Center for Patient Safety – Patient Safety Glossary

Thank you!