

QUALITY AND PATIENT SAFETY DEFINITIONS

Adverse Event: Any untoward incident, therapeutic misadventure, iatrogenic injury or other undesirable occurrence directly associated with care or services

Aim: A written, measurable, and time-sensitive statement of the expected results of an improvement process.

Assessment: A systematic process of collecting and analyzing data to determine the current, historical or projected status of an organization.

Benchmark: To measure according to specified standards in order to compare with and improve one's own performance to those considered to be healthcare leaders.

Best Practices: The most up-to-date patient care interventions, scientifically proven to result in the best patient outcomes and minimize patients' risk of death or complications. A superior method or innovative practice that contributes to the improved performance of an organization, usually recognized as "best" by other peer organizations.

Cause: An identified reason for the presence of a defect or problem.

Champion: A leader or senior manager who ensures that resources are available for training and projects, and who is involved in the project and /or reviews.

Clinical Measures: Measures representing processes of care and patient outcomes widely accepted as important to quality care, consistently and accurately tracked in order to determine quality performance in a given clinical area, such as heart attack, pneumonia or hip and knee replacement.

Clinical Guideline: A treatment regime, agreed upon by consensus, which includes all the elements of care regardless of the effect on patient outcomes. Also called a clinical pathway.

Core Measures: Specific clinical measures that, when viewed together, permit a robust assessment of the quality of care provided in a given focus area, such as acute myocardial infarction (AMI).

Criteria: Expected levels of achievement or specifications against which performance or quality may be compared. For example, criteria for appropriate initial care of a patient with a headache may be a measurement of body temperature and blood pressure and performance of a neurological examination.

Effectiveness: The degree to which care is provided in the correct manner, given the current state of knowledge, to achieve the desired or projected outcome(s) for the patient.

Evidence-Based Medicine: The wise and careful use of the best available scientific research and practices with proven effectiveness in daily medical decision-making, including individual clinical practice decisions, by well-trained, experienced clinicians. Evidence-based medicine that is best-practice integrates best research evidence with clinical expertise and patient values.

Healthcare Failure Mode and Effect Analysis (HFMEA): 1. A prospective assessment that identifies and improves steps in a process, thereby reasonably ensuring a safe and clinically desirable outcome.
2. A systematic approach to identify and prevent product and process problems before they occur.

Improvement: The positive effect of a process change effort.

Indicator: 1. A measure used to determine, over time, performance of functions, processes and outcomes. 2. A statistical value that provides an indication of the condition or direction over time of performance of a defined process or achievement of a defined outcome.

Lean manufacturing: Initiative focused on eliminating all waste in manufacturing processes. Principles of lean include zero waiting time, zero inventory, scheduling (internal customer pull instead of push system), batch to flow (cut batch sizes), line balancing and cutting actual process times.

Outcome Measure: A measure that indicates the result of the performance (or non-performance) of a function(s) or process(es).

Patient-Centered Care: Care that is respectful of and responsive to individual patient preferences, needs and values and ensures patient values guide all clinical decisions; care that is coordinated, communicative and supportive.

Patient Values: The unique preferences, concerns and expectations that each patient brings to a clinical encounter that must be integrated into clinical decisions if they are to serve the patient.

Pay for Performance: A direct financial reward model or quality bonus; incentive and reward models where there are direct provider dollars at stake for quality improvement.

Performance Measure: A quantitative tool (for example, rate, ratio, index or percentage) that provides an indication of an organization's performance in relation to a specified process or outcome.

Plan-do-study-act (PDSA) cycle: A four-step process for quality improvement. In the first step (plan), a plan to effect improvement is developed. In the second step (do), the plan is carried out, preferably on a small scale. In the third step (check), the effects of the plan are observed and what is learned is summarized. In the last step (act), the results are studied to determine what was learned and what can be predicted. The Associates in Process Improvement developed the plan-do-study-act cycle. Also called the plan-do-check-act (PDCA) cycle.

Preventive action: Action taken to remove or improve a process to prevent potential future occurrences of a nonconformance.

Process: A goal directed, interrelated series of actions, events, mechanisms or steps.

Process improvement: The application of the plan-do-study-act (PDSA) philosophy to processes to produce positive improvement and better meet the needs and expectations of customers (see "plan-do-study-act cycle").

Patient Safety: Safety, the first domain of quality, refers to "freedom from accidental injury" and is stated from the patient's perspective.

Quality: The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Root Cause Analysis: A process for identifying the basic or causal factor(s) that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event.

Safe Practices: Practices that reduce the risk of harm from the processes, practices or systems of healthcare, the standardization of which is likely to have significant benefit for patient safety if fully implemented.

Satisfaction Measures: Measures that address the extent to which the patients/enrollees, practitioners and/or purchasers perceive their needs to be met.

Sentinel Event: An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called "sentinel" because they signal the need for immediate investigation and response.

Standard of Quality: A generally accepted, objective standard of measurement such as a performance standard supported through findings from expert consensus, based on specific research and/or documentation in scientific literature, against which an individual's or organization's level of performance may be compared.

Variation: The differences in results obtained in measuring the same phenomenon more than once. The sources of variation in a process over time can be grouped into two major classes: common causes and special causes. Excessive variation frequently leads to waste and loss, such as the occurrence of undesirable patient health outcomes and increased cost of health services. *Common-cause variation*, also called endogenous cause variation or systemic cause variation, in a process is due to the process itself and is produced by interactions of variables of that process is inherent in all processes, not a disturbance in the process. It can be removed only by making basic changes in the process. *Special-cause variation*, also called exogenous-cause variation or extrasystemic cause variation, in performance results from assignable causes. Special-cause variation is intermittent, unpredictable, and unstable. It is not inherently present in a system; rather, it arises from causes that are not part of the system as designed.

Whole System Measures: A set of measures focused on quality of care as defined by the IOM six dimensions. The measures can be combined with existing measures (for example, financial results) that are already used within an organization to evaluate the overall performance of a health system.

SOURCES:

American Society for Quality (ASQ)
Institute for Healthcare Improvement (IHI)
Premier, Inc.
Centers for Medicare & Medicaid Services
Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
Leapfrog Group
Institute of Medicine
National Quality Forum
Department of Veterans Affairs, National Center for Patient Safety