GLOSSARY OF TERMS

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.[3,4]

Close call
The event did not reach the patient because of timely intervention or good fortune. (The term is often equated to a near miss or near hit.)[3]

Disclosure
The process by which an adverse event is communicated to the patient by healthcare providers.[3]

- *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.

Harm
An outcome that negatively affects the patient's health and/or quality of life.[3]

Just culture of safety
A healthcare approach in which the provision of safe care is a core value of the organization. The culture encourages and develops the knowledge, skills and commitment of all leaders, management, health care providers, staff, and patients for the provision of safe patient care. Opportunities to proactively improve the safety of care are constantly identified and acted on. Providers and patients are appropriately and adequately supported in the pursuit of safe care. The culture encourages learning from adverse events and close calls to strengthen the system, and where appropriate, supports and educates health care providers and patients to help prevent similar events in the future. There is a shared commitment across the organization to implement improvements and to share the lessons learned. Justice is an important element. All are aware of what is expected, and when analyzing adverse events any professional accountability of health care providers is determined fairly. The interests of both patients and providers are protected.[4,5]

Patient safety
The pursuit of the reduction and mitigation of unsafe acts within the healthcare system, as well as the use of best practices shown to lead to optimal patient outcomes.[1,3,4,5]

Patient safety is the reduction of risk of unnecessary harm associated with healthcare to an acceptable minimum. An acceptable minimum refers to the collective notions of given current knowledge, resources available and the context in which care was delivered weighed against the risk of non-treatment or other treatment.[2]

GLOSSARY OF TERMS (Continued)

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.[2]

Quality Improvement Review
The analysis by healthcare organizations (usually by a quality improvement committee) of patient outcomes, clinical practices, and systems of care in order to recommend improvements. Quality improvement committees, as part of an ongoing program to improve patient care, should be structured under the relevant provincial/territorial legislation and include formal terms of reference. Quality improvement committees, depending on the province or territory, may have different titles, for example: Quality of Care, Critical Incident Review, Risk Management.[5]

Reporting
The communication of information about an adverse event or close call by healthcare providers through appropriate channels inside or outside of healthcare organizations for the purpose of reducing the risk of adverse events in the future.[3,4,5]

Root cause analysis
An analytic tool that can be used to perform a comprehensive, system-based review of critical incidents. It includes the identification of the root and contributory factors, identification of risk reduction strategies, and development of action plans along with measurement strategies, to evaluate the effectiveness of the plans.[3]

This glossary is not intended to be an exhaustive list of terms, but rather a concise list of key terms used throughout the toolkit. Users are suggested to refer to following reference documents listed in the toolkit for additional information:

[1] The Canadian Patient Safety Dictionary (Available at: http://rcpsc.medical.org/publications/PatientSafetyDictionary_e.pdf)

[2] World Health Organization's (WHO) International Classification for Patient Safety Key Concepts and Preferred Terms (Available at: http://www.who.int/patientsafety/taxonomy/icps_chapter3.pdf)

[3] Canadian Disclosure Guidelines (Available at: http://www.patientsafetyinstitute.ca/English/toolsResources/disclosure/Documents/CPSI%20-%20Canadian%20Disclosure%20Guidlines%20English.pdf)

[4] The Safety Competencies (Available at: http://www.patientsafetyinstitute.ca/English/education/safetyCompetencies/Documents/Safety%20Competencies.pdf)

[5] Learning from adverse events: Fostering a just culture of safety in Canadian hospitals and health care institutions. (Available at: http://www.cmpa-acpm.ca/cmpapd04/docs/submissions_papers/com_learning_from_adverse_events-e.cfm)