BETSY LEHMAN CENTER

Appendix

Key Terms Related to Patient Safety and a Culture of Safety

Based on AHRQ PSNet Glossary [nd], Runciman et al. 2009, and others as noted.

Adverse Event— Any injury caused by medical care. An undesirable clinical outcome that has resulted from some aspect of diagnosis or therapy, not an underlying disease process. Preventable adverse events are the subset that are caused by error.

Clinician— A health professional qualified in the clinical practice of medicine, such as a physician, nurse, pharmacist, or psychologist who is directly involved in patient care, as distinguished from one specializing in laboratory or research techniques or in theory.

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.

Harm— An impairment of structure or function of the body and/or any deleterious effect arising therefrom, including disease, injury, suffering, disability, and death. Harm may be physical, social, or psychological, and either temporary or permanent.

Inclusion— Positively striving to meet the needs of different people and taking deliberate action to create environments where everyone feels respected and able to achieve their full potential (National Institute for Health Research 2012).

Just Culture— A culture that recognizes that individual practitioners should not be held accountable for system failings over which they have no control. A just culture also recognizes that many individual or "active" errors represent predictable interactions between human operators and the systems in which they work. However, in contrast to a culture that touts "no blame" as its governing principle, a just culture does not tolerate blameworthy behavior such as conscious disregard of clear risks to patients or gross misconduct (e.g., falsifying a record, performing professional duties while intoxicated).

Patient Safety— Patient safety refers to freedom from accidental or preventable injuries produced by medical care. Thus, practices or interventions that improve patient safety are those that reduce the occurrence of preventable adverse events.

Psychological Safety— Individuals' perceptions about the consequences of interpersonal risks in their work environment. These perceptions include taken-for-granted beliefs about acceptable interactions with co-workers, superiors, and subordinates, and how others will respond when one puts oneself on the line, such as by asking a question, seeking feedback, reporting a mistake, or proposing a new idea (Edmondson 2011).

Respect— The treatment of others with deference in daily interactions, weighing their values, views, opinions and preferences (Sergen's Medical Dictionary 2012).

Safety Culture/Culture of Safety— The safety culture of an organization is the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the characteristics of the organization's health and safety management. Organizations with a positive safety culture are characterized by communications based on mutual trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of preventive measures (Health and Safety Commission 1993).

Total Systems Safety— Safety that is systematic and uniformly applied (across the total process) (Pronovost et al. 2013). A systems approach can help with the design and integration of people, processes, policies, and organizations to promote better health at lower cost.

Trust— The collective expectations by the public and other clinicians that health care providers will demonstrate knowledge, skill, and competence, and will act in the best interest of both patients and colleagues with beneficence, fairness, and integrity (Calnan 2008).

Workforce— Health professionals and all other workers employed in health service or other settings, including but not limited to clinicians, administrators, medical records personnel, and laboratory assistants.

Workforce Safety— Healthcare workforce safety refers to freedom from both physical and psychological harm for all those who work with patients as well as those who oversee or provide non-clinical support for those who work with patients.

Zero Harm/Free from Harm— The total absence of physical and psychological injury to patients and the workforce.