Professional Certificate in Clinical Risk Management

Clinical Governance and Quality Improvement

A

Adverse Event – related terms: incident, harm, patient safety. An adverse event is any unintended injury or complication caused by healthcare management rather than the underlying disease, which results in measurable harm to the patient. Example: A medication error leading to an allergic reaction. Challenges include under-reporting due to fear of blame and difficulty distinguishing preventable from non-preventable events.

Audit – related terms: clinical audit, quality audit, peer review. A systematic review of clinical performance against established standards, aimed at improving practice. Example: Reviewing postoperative infection rates against national benchmarks. Challenges include data collection consistency and ensuring audit findings translate into action.

Agency for Healthcare Research and Quality (AHRQ) – related terms: National Quality Measures, Patient Safety Network. A U.S. Federal agency that develops tools, research, and guidelines to improve the safety and quality of healthcare. Example: AHRQ's Hospital Survey on Patient Safety Culture. Challenges involve adapting U.S. Resources to different regulatory environments.

Action Plan – related terms: improvement plan, implementation strategy. A documented set of steps, responsibilities, timelines, and resources required to achieve a specific quality improvement goal. Example: An action plan to reduce falls in an elderly ward with designated leads and weekly progress reviews. Challenges include maintaining momentum and measuring intermediate outcomes.

Accountability – related terms: responsibility, transparency. The obligation of individuals and organizations to justify actions, decisions, and outcomes in relation to patient safety and quality standards. Example: A department head being required to report quarterly on infection control metrics. Challenges include aligning accountability with a non-punitive culture.

Adverse Drug Reaction (ADR) – related terms: pharmacovigilance, medication safety. Any harmful or unintended response to a medication at normal doses. Example: Liver toxicity after starting a new antihypertensive. Challenges include timely detection, reporting, and integrating ADR data into risk management.

Benchmarking – related terms: comparative analysis, performance standards. The process of comparing an organization's performance metrics with best-practice or peer data to identify gaps and opportunities for improvement. Example: Comparing surgical site infection rates with a national database. Challenges include data standardization and ensuring relevance of comparison groups.

Board of Directors – related terms: governance committee, executive leadership. The senior governing body responsible for setting strategic direction, overseeing risk management, and ensuring resources for quality

and safety initiatives. Example: A board approving a budget for a new patient safety officer. Challenges involve balancing clinical priorities with financial constraints.

Business Continuity Planning (BCP) – related terms: disaster recovery, resilience. A proactive process that ensures essential healthcare services can continue during and after an emergency. Example: Establishing backup electronic health record (EHR) servers. Challenges include maintaining up-to-date plans and testing them regularly.

C

Clinical Governance – related terms: quality assurance, patient safety, risk management. An integrated system through which healthcare organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care. Example: A hospital's governance framework that links clinical audit results to board reporting. Challenges include embedding governance across all professional groups and measuring its impact.

Clinical Indicator – related terms: performance metric, key performance indicator (KPI). A measurable element of practice that reflects the quality, safety, or efficiency of care. Example: The proportion of patients receiving prophylactic antibiotics within one hour of incision. Challenges involve selecting indicators that are clinically meaningful and data-driven.

Clinical Leadership – related terms: clinical champion, physician leader. The role of clinicians in influencing, directing, and supporting quality improvement initiatives and safety culture. Example: A senior nurse leading a project to reduce medication errors. Challenges include time constraints and aligning leadership with organisational goals.

Clinical Pathway – related terms: care pathway, standardised protocol. A multidisciplinary plan that outlines the optimal sequence and timing of interventions for a specific clinical condition. Example: An evidence-based pathway for managing community-acquired pneumonia. Challenges include keeping pathways current with evolving evidence and ensuring staff adherence.

Clinical Risk – related terms: patient safety risk, hazard. The probability that a patient will experience harm as a result of the delivery of healthcare. Example: The risk of pressure ulcers in immobile patients. Challenges include quantifying risk in complex clinical environments and integrating risk data into daily practice.

Clinical Risk Management (CRM) – related terms: risk assessment, incident reporting. The systematic process of identifying, analysing, and mitigating risks to patients, staff, and the organisation. Example: Using Failure Mode and Effects Analysis (FMEA) to anticipate errors in medication administration. Challenges include fostering a culture of open reporting and translating findings into sustainable change.

Clinical Safety – related terms: patient safety, quality of care. The discipline focused on preventing harm to patients during the provision of health services. Example: Implementing double-check procedures for high-alert medications. Challenges involve balancing safety measures with workflow efficiency.

Clinical Standards – related terms: guidelines, protocols. Explicit statements that define the expected level of

care for specific clinical situations, often based on best available evidence. Example: NICE guideline NG123 for sepsis management. Challenges include ensuring local relevance and monitoring compliance.

Clinical Variation – related terms: practice variation, unwarranted variation. Differences in the rate or manner of care delivery that cannot be explained by patient needs or preferences. Example: Wide disparity in elective surgery rates across regions. Challenges involve identifying the drivers of variation and implementing standardisation where appropriate.

Closed-Loop Feedback – related terms: feedback mechanism, continuous improvement. A process where information about performance or incidents is communicated back to the responsible parties, resulting in corrective action and re-assessment. Example: After a medication error, the pharmacy provides a summary of corrective steps to the prescribing team. Challenges include timely communication and ensuring feedback leads to change.

Commitment to Quality – related terms: quality culture, continuous improvement. The expressed and demonstrated dedication of an organisation's leadership and staff to achieve and sustain high standards of care. Example: A hospital's public quality charter outlining patient-centred goals. Challenges include maintaining commitment amid competing priorities.

Compliance – related terms: regulatory adherence, standards conformity. Conforming to laws, regulations, accreditation standards, and internal policies. Example: Meeting Joint Commission International (JCI) standards for infection control. Challenges involve staying current with evolving regulations and demonstrating compliance through documentation.

Continuous Quality Improvement (CQI) – related terms: Plan-Do-Study-Act (PDSA), Lean. An ongoing, systematic approach to enhance processes and outcomes by iterative testing and learning. Example: Using PDSA cycles to reduce waiting times in an outpatient clinic. Challenges include sustaining momentum and integrating CQI into everyday workflow.

Culture of Safety – related terms: just culture, psychological safety. An organisational environment where staff feel safe to report errors, discuss concerns, and participate in improvement without fear of retribution. Example: Regular safety huddles that encourage open dialogue. Challenges include overcoming historic blame-oriented mindsets and aligning leadership behaviours.

Data Integrity – related terms: data quality, information governance. The accuracy, completeness, and reliability of data used for quality measurement and risk assessment. Example: Validating EHR data before calculating readmission rates. Challenges involve ensuring consistent data entry practices and managing large datasets.

Data Governance – related terms: information governance, data stewardship. The framework for managing data assets, ensuring they are used responsibly, securely, and in compliance with regulations. Example: A data governance committee overseeing patient safety dashboards. Challenges include balancing data accessibility with privacy protections.

Decision Support System (DSS) – related terms: clinical decision support (CDS), e-health tools.

Computer-based applications that provide clinicians with knowledge and patient-specific information to enhance decision-making. Example: An alert for potential drug-drug interaction at the point of prescribing. Challenges include alert fatigue and integration with existing workflows.

Defect – related terms: error, non-conformance. Any deviation from a desired standard, process, or outcome that may lead to compromised quality or safety. Example: A missed step in a surgical safety checklist. Challenges involve detecting low-frequency defects and distinguishing them from acceptable variations.

Deliberate Practice – related terms: reflective practice, skill acquisition. Structured, repetitive practice of clinical tasks with focused feedback to improve performance. Example: Simulation-based rehearsal of emergency airway management (used here only as a conceptual reference). Challenges include securing expert feedback and allocating time for practice.

Designated Safety Officer – related terms: patient safety officer, risk manager. An individual tasked with coordinating safety initiatives, monitoring incident reports, and leading improvement projects. Example: A senior nurse appointed to oversee medication safety across the hospital. Challenges include authority limits and workload balance.

Diagnostic Error – related terms: misdiagnosis, delayed diagnosis. Failure to (a) establish an accurate and timely explanation of the patient's health problem or (b) communicate that explanation to the patient. Example: Missing a myocardial infarction on initial presentation. Challenges involve complex clinical presentations and cognitive biases.

Documented Policy – related terms: standard operating procedure (SOP), guideline. A written statement that outlines required actions, responsibilities, and processes to achieve compliance with standards. Example: A policy detailing hand hygiene protocol. Challenges include keeping policies current and ensuring staff awareness.

Duty of Care – related terms: legal responsibility, standard of care. The legal and ethical obligation of healthcare providers to adhere to a standard of reasonable care while performing any acts that could foreseeably harm patients. Example: Failing to monitor a patient's vital signs post-operatively may breach duty of care. Challenges include defining the appropriate standard in complex cases.

E

Effective Communication – related terms: SBAR, closed-loop communication. The clear, concise, and purposeful exchange of information among healthcare team members to ensure patient safety. Example: Using the SBAR format during handover to convey critical information. Challenges include language barriers and hierarchical dynamics.

Electronic Health Record (EHR) – related terms: digital health record, clinical information system. A digital version of a patient's paper chart that provides real-time, patient-centred information accessible across care settings. Example: Documenting medication orders directly in the EHR. Challenges involve interoperability, user-interface design, and data security.

Emergency Preparedness – related terms: disaster management, crisis response. Planning and capability development to respond effectively to sudden, large-scale events that threaten health services. Example: Establishing triage protocols for a mass-casualty incident. Challenges include resource allocation and regular training refreshers.

Enabling Factors – related terms: facilitators, supportive environment. Elements that promote successful implementation of quality and safety initiatives, such as leadership support, adequate staffing, and access to data. Example: A dedicated quality improvement dashboard that provides real-time metrics. Challenges involve sustaining these factors over time.

Evidence-Based Practice (EBP) – related terms: clinical evidence, best practice. The conscientious use of current best evidence in making decisions about patient care. Example: Applying the latest guideline for anticoagulation in atrial fibrillation. Challenges include translating research into practice and keeping up with rapid evidence growth.

Evaluation Metrics – related terms: outcome measures, process indicators. Quantitative or qualitative data used to assess the effectiveness of an intervention or program. Example: Measuring reduction in catheter-associated urinary tract infections after a hygiene bundle. Challenges include selecting metrics that are sensitive, specific, and aligned with goals.

Event Reporting System – related terms: incident reporting, risk reporting. A structured platform that allows staff to record safety incidents, near misses, and adverse events. Example: An online portal where nurses log medication errors anonymously. Challenges involve encouraging reporting, ensuring anonymity, and preventing data overload.

Executive Sponsor – related terms: senior champion, leadership advocate. A senior executive who provides strategic support, resources, and authority for quality improvement initiatives. Example: A chief medical officer championing a sepsis reduction program. Challenges include competing executive priorities and maintaining visible engagement.

External Accreditation – related terms: JCI, ISO 9001. Formal assessment by an independent body that verifies compliance with predefined quality and safety standards. Example: A hospital receiving JCI accreditation after a comprehensive survey. Challenges include the cost of preparation and sustaining standards after accreditation.

F

Failure Mode and Effects Analysis (FMEA) – related terms: prospective risk assessment, process mapping. A systematic, proactive methodology for identifying potential failure points in a process, assessing their impact, and prioritising actions to mitigate risk. Example: Applying FMEA to the medication dispensing workflow. Challenges include the time-intensive nature of the analysis and need for multidisciplinary input.

Feedback Loop – related terms: closed-loop communication, continuous improvement. The cycle through which information about performance is returned to those who can act on it, fostering learning and change. Example: Publishing monthly safety metrics to frontline staff and inviting suggestions. Challenges include

ensuring feedback is actionable and not overwhelming.

Financial Risk – related terms: budgetary risk, cost containment. The potential for financial loss due to inefficiencies, penalties, or adverse events. Example: Increased costs from hospital-acquired infections leading to reimbursement penalties. Challenges involve quantifying indirect costs and linking financial risk to clinical processes.

Fire Safety – related terms: environmental safety, facility risk. Measures and protocols designed to prevent, detect, and respond to fire hazards within healthcare settings. Example: Regular fire drills and maintenance of sprinkler systems. Challenges include maintaining compliance while ensuring patient care continuity during drills.

Forensic Review – related terms: legal investigation, root cause analysis. A detailed examination of an incident for legal, regulatory, or disciplinary purposes. Example: A forensic review of a death attributed to medication error. Challenges include balancing thoroughness with timeliness and protecting patient confidentiality.

Framework for Quality Improvement – related terms: model for improvement, Lean Six Sigma. Structured approaches that guide organisations in planning, executing, and sustaining improvement work. Example: Using the Institute for Healthcare Improvement's (IHI) Model for Improvement (Aim-Study-Change). Challenges include selecting the appropriate framework for the problem context.

G

Gap Analysis – related terms: needs assessment, performance gap. The process of comparing current performance against desired standards to identify areas for improvement. Example: Comparing actual hand hygiene compliance (70 %) with the target (95 %). Challenges include accurate measurement of current state and prioritising gaps.

Governance Structure – related terms: board committees, clinical governance committee. The arrangement of roles, responsibilities, and reporting lines that oversee quality, safety, and risk activities. Example: A Clinical Governance Committee that reviews audit results quarterly. Challenges involve ensuring clear authority and avoiding duplication of effort.

Grand Rounds – related terms: clinical education, case review. Formal presentations of clinical cases or topics used to disseminate knowledge and discuss quality or safety issues. Example: A grand round focusing on lessons learned from a recent surgical complication. Challenges include translating discussion into concrete practice changes.

H

Hazard Identification – related terms: risk identification, threat analysis. The systematic process of detecting sources of potential harm within a healthcare system. Example: Recognizing that a particular infusion pump model has a known alarm failure. Challenges include capturing latent hazards that are not immediately apparent.

Healthcare Associated Infection (HAI) – related terms: nosocomial infection, infection control. Infections acquired by patients during the course of receiving treatment for other conditions. Example: A central line-associated bloodstream infection. Challenges involve multi-disciplinary coordination and adherence to prevention bundles.

Health Information Privacy – related terms: HIPAA, data confidentiality. Legal and ethical obligations to protect patient information from unauthorized access. Example: Encrypting all EHR transmissions. Challenges include balancing data sharing for quality improvement with privacy regulations.

Human Factors Engineering – related terms: ergonomics, system design. The study of how humans interact with elements of a system, aiming to design processes and tools that reduce error. Example: Redesigning medication labeling to minimise look-alike errors. Challenges include integrating human-factors expertise into existing clinical workflows.

Improvement Cycle – related terms: PDSA cycle, continuous improvement. A repetitive loop of planning, implementing, studying results, and acting on findings to refine processes. Example: Three successive cycles to reduce discharge delays. Challenges include documenting each cycle and ensuring learnings are disseminated.

Incident – related terms: event, adverse event, near miss. Any occurrence that deviates from normal operations, potentially affecting patient safety. Example: A patient fall in a hallway. Challenges involve consistent classification and timely reporting.

Incident Management System – related terms: risk reporting platform, event tracking. Software or procedural framework used to capture, analyse, and follow up on safety incidents. Example: A web-based system that assigns corrective actions to responsible staff. Challenges include user adoption and data validation.

Indicator Dashboard – related terms: performance dashboard, visual analytics. A visual tool displaying key quality and safety metrics for quick interpretation by stakeholders. Example: A real-time dashboard showing hand hygiene compliance rates by unit. Challenges involve data latency and avoiding information overload.

Infection Control Committee – related terms: IPC team, surveillance team. A multidisciplinary group responsible for developing policies, monitoring infection rates, and implementing preventative measures. Example: Reviewing quarterly HAI data and updating cleaning protocols. Challenges include ensuring representation from all relevant disciplines.

Information Governance – related terms: data governance, privacy compliance. The overall management of information assets to ensure they are used responsibly, securely, and in line with legal requirements. Example: A policy dictating who may access patient safety data. Challenges include aligning governance with rapid technological change.

Innovation in Quality – related terms: creative improvement, novel solutions. Introduction of new ideas, methods, or technologies that enhance quality or safety. Example: Using predictive analytics to identify patients at high risk of readmission. Challenges involve evaluating effectiveness and scaling successful

innovations.

Institutional Review Board (IRB) – related terms: ethics committee, research oversight. A committee that reviews and monitors research involving human participants to protect their rights and welfare. Example: IRB approval required before a study collecting patient safety data. Challenges include balancing research needs with patient protection.

J

Just Culture – related terms: blame-free environment, accountability. An organisational philosophy that encourages reporting of errors while distinguishing between human error, at-risk behaviour, and reckless behaviour, assigning appropriate responses. Example: A system where nurses reporting a medication error receive support and a systematic review rather than punitive action. Challenges include consistent application across all staff levels.

K

Key Performance Indicator (KPI) – related terms: clinical indicator, metric. A quantifiable measure used to evaluate the success of an organization in achieving critical objectives. Example: Average length of stay for elective hip replacement. Challenges include selecting KPIs that truly reflect quality rather than merely activity.

Knowledge Management – related terms: learning organization, best-practice repository. The systematic process of capturing, distributing, and effectively using knowledge and information within an organisation. Example: An online library of case studies on successful safety interventions. Challenges involve keeping content current and encouraging staff contribution.

L

Lean Methodology – related terms: process improvement, value stream mapping. A set of principles focused on eliminating waste and enhancing value in processes. Example: Streamlining patient registration to reduce wait times. Challenges include cultural resistance to change and sustaining gains.

Learning Health System – related terms: continuous learning, data-driven improvement. A system that continuously and systematically integrates data and experience to improve health care delivery. Example: Using real-time outcome data to refine treatment pathways. Challenges include data interoperability and ensuring rapid feedback loops.

Leadership Walk-Rounds – related terms: executive presence, safety rounds. Regular, informal visits by senior leaders to clinical areas to discuss safety, quality, and staff concerns. Example: A chief nursing officer meeting unit staff to hear about medication safety issues. Challenges include ensuring authenticity and acting on feedback.

Learning Organisation – related terms: knowledge management, continuous improvement. An entity that facilitates the learning of its members and continuously transforms itself. Example: An institution that systematically reviews lessons from each incident and updates policies accordingly. Challenges involve

embedding learning into daily routines.

Legal Liability – related terms: malpractice, negligence. The responsibility for actions or omissions that cause harm and may result in legal action. Example: A surgeon sued for a preventable surgical error. Challenges include navigating complex legal standards and protecting the organisation while maintaining transparency.

Linkage of Quality and Safety – related terms: integrated governance, risk-benefit balance. The concept that quality improvement and patient safety are interdependent and should be addressed together. Example: Improving medication reconciliation (quality) reduces adverse drug events (safety). Challenges include siloed departments and differing measurement frameworks.

M

Malpractice Insurance – related terms: professional liability, risk transfer. Coverage that protects healthcare providers against claims of negligence. Example: A physician's policy that pays for legal defence and settlements. Challenges include rising premiums linked to incident rates.

Management of Change (MoC) – related terms: change control, transition planning. Structured approach to ensure that changes to processes, technology, or organisation are introduced safely and effectively. Example: Implementing a new EHR module with risk assessment and staff training. Challenges include under-estimating impact on workflow and resistance to change.

Medication Safety – related terms: pharmacy safety, drug-related harm. Strategies and practices designed to prevent medication errors throughout the medication-use process. Example: Barcode scanning at the bedside. Challenges include technology integration and maintaining vigilance in high-stress environments.

Metric Alignment – related terms: strategic mapping, balanced scorecard. Ensuring that performance measures support overarching organisational goals. Example: Aligning readmission reduction metrics with the hospital's value-based care strategy. Challenges include avoiding metric proliferation and ensuring clarity of purpose.

Monitoring and Evaluation (M&E) – related terms: performance monitoring, impact assessment. Ongoing systematic collection and analysis of data to assess the effectiveness of interventions. Example: Quarterly review of pressure-ulcer rates after a new bedding protocol. Challenges involve timely data collection and attributing outcomes to specific actions.

Near Miss – related terms: close call, precursor event. An event that could have resulted in harm but did not, either by chance or timely intervention. Example: A medication dose entered incorrectly but caught before administration. Challenges include encouraging reporting of events that did not cause harm.

Non-Conformity – related terms: defect, non-compliance. Failure to meet a specified requirement, standard, or expectation. Example: A surgical checklist not completed as required. Challenges involve detection, documentation, and corrective action.

Organisational Culture – related terms: culture of safety, climate. The shared values, beliefs, and behaviours that shape how work is performed. Example: A culture that celebrates reporting of safety concerns.

Challenges include changing entrenched attitudes and aligning culture with strategic objectives.

Outcome Measure – related terms: clinical outcome, patient-centred metric. A metric that reflects the result of care on patient health status. Example: 30-Day mortality after myocardial infarction. Challenges include risk adjustment and ensuring measures are patient-relevant.

Patient-Centred Care – related terms: person-focused care, shared decision-making. Care that respects and responds to individual patient preferences, needs, and values. Example: Involving patients in choosing between treatment options. Challenges involve time constraints and ensuring equitable engagement.

Patient Safety Culture Survey – related terms: SAQ, HSOPSC. A structured questionnaire used to assess staff perceptions of safety culture within an organisation. Example: Administering the Safety Attitudes Questionnaire annually. Challenges include response bias and translating survey results into action.

Performance Improvement Plan (PIP) – related terms: corrective action plan, development plan. A formal document outlining steps to address identified performance gaps. Example: A PIP for a department with high infection rates. Challenges include setting realistic targets and monitoring progress.

Process Mapping – related terms: flowchart, value stream map. Visual representation of the steps in a clinical or administrative process to identify inefficiencies and risks. Example: Mapping the discharge process to locate bottlenecks. Challenges involve capturing all variations and keeping maps up-to-date.

Quality Assurance (QA) – related terms: quality control, compliance monitoring. Systematic activities designed to ensure that services meet established standards. Example: Routine audits of surgical instrument sterilisation. Challenges include avoiding a checkbox mentality and linking QA to improvement.

Quality Improvement (QI) – related terms: CQI, process improvement. The systematic, data-driven approach to enhance the effectiveness, efficiency, and safety of healthcare delivery. Example: Implementing a hand-off protocol to reduce communication errors. Challenges involve sustaining gains and engaging all staff levels.

Quality Management System (QMS) – related terms: ISO 9001, organizational framework. A coordinated set of policies, processes, and procedures required for planning and execution of core business activities to meet quality objectives. Example: A hospital's QMS that integrates audit, training, and corrective actions. Challenges include integration with clinical workflows and maintaining documentation.

R

Root Cause Analysis (RCA) – related terms: causal analysis, systemic investigation. A structured method for identifying underlying factors that contribute to an adverse event. Example: An RCA revealing that a confusing medication label contributed to a dosing error. Challenges include avoiding superficial analysis and ensuring multidisciplinary participation.

Risk Assessment – related terms: hazard analysis, probability-impact matrix. The process of identifying, analysing, and evaluating risks to determine their significance and prioritize mitigation. Example: Assessing the risk of patient falls on a geriatric ward. Challenges involve quantifying low-frequency, high-impact

events.

Risk Management Plan – related terms: mitigation strategy, risk register. A documented approach outlining identified risks, their potential impact, and actions to control or eliminate them. Example: A plan that includes staff training, equipment upgrades, and monitoring to address identified medication-error risks. Challenges include keeping the plan current and ensuring accountability.

Risk Register – related terms: risk log, risk matrix. A centralized repository that records identified risks, their assessment, owners, and mitigation actions. Example: A spreadsheet listing all active safety risks with status updates. Challenges involve maintaining accuracy and preventing it from becoming a static document.

Safety Huddle – related terms: briefing, team communication. Short, focused meetings where staff discuss current safety concerns, high-risk patients, and immediate priorities. Example: A daily morning huddle reviewing patients at risk of falls. Challenges include time pressure and ensuring participation from all relevant disciplines.

Safety Netting – related terms: follow-up plan, patient safety. Providing patients with information on what to do if symptoms worsen or do not improve, ensuring continuity of care. Example: Giving discharge instructions that include red-flag signs for infection. Challenges involve clear communication and ensuring patient understanding.

Safety Culture Assessment – related terms: culture survey, climate evaluation. Systematic evaluation of staff attitudes, behaviours, and perceptions regarding safety. Example: Using the Hospital Survey on Patient Safety Culture (HSOPSC) to identify areas for improvement. Challenges include survey fatigue and translating findings into concrete actions.

Safety Indicator – related terms: clinical indicator, performance metric. A specific measure that reflects the safety performance of an organisation. Example: Rate of medication-related adverse events per 1,000 admissions. Challenges include ensuring indicators are sensitive enough to detect change.

Safety Incident – related terms: adverse event, near miss. Any event that could or did result in harm to a patient, staff member, or the organisation. Example: A patient slipping in the bathroom. Challenges involve consistent classification and timely investigation.

Safety Management System (SMS) – related terms: risk management system, quality system. Integrated framework that combines policies, procedures, and tools to manage safety risks. Example: An SMS that includes reporting, analysis, and corrective action workflows. Challenges include ensuring system usability and staff engagement.

Scope of Practice – related terms: professional boundaries, competency. The defined range of activities that a healthcare professional is educated, competent, and authorized to perform. Example: A physiotherapist providing gait assessment but not prescribing medication. Challenges involve clarity across multidisciplinary teams and avoiding role confusion.

Standard Operating Procedure (SOP) – related terms: policy, process guide. Detailed, written instructions to

achieve uniformity of performance for a specific task. Example: SOP for sterile technique during central line insertion. Challenges include keeping SOPs current and ensuring staff adherence.

Strategic Alignment – related terms: goal mapping, organizational objectives. Ensuring that quality and safety initiatives support the broader mission and strategic plan of the organisation. Example: Aligning a sepsis reduction program with the hospital's goal of becoming a high-reliability organisation. Challenges involve competing priorities and resource allocation.

Supervision – related terms: clinical oversight, mentor. Ongoing guidance and monitoring of staff performance to ensure safe and effective care delivery. Example: A senior nurse supervising junior staff during medication administration. Challenges include balancing autonomy with safety oversight.

T

Targeted Intervention – related terms: focused improvement, high-risk strategy. A specific action designed to address a particular identified problem or risk. Example: Implementing a fall-prevention kit for patients identified as high risk. Challenges include ensuring the intervention reaches the intended population.

TeamSTEPPS – related terms: team training, communication framework. A evidence-based set of tools aimed at improving teamwork and communication in healthcare. Example: Using the "check-back" technique during medication administration. Challenges involve sustaining training effects and adapting tools to diverse settings.

Technology Assessment – related terms: health IT evaluation, digital tool appraisal. Systematic evaluation of new technologies for safety, efficacy, and impact on workflow. Example: Assessing a new infusion pump for alarm reliability. Challenges include rapid technology turnover and ensuring user involvement.

Therapeutic Risk Management – related terms: treatment safety, clinical monitoring. Strategies to minimise risks associated with therapeutic interventions. Example: Regular INR monitoring for patients on warfarin. Challenges involve patient adherence and coordinating multidisciplinary monitoring.

Training Needs Analysis (TNA) – related terms: competency gap assessment, learning plan. Process of identifying the knowledge and skill gaps that need to be addressed to improve performance. Example: TNA revealing a need for staff education on new infection-control protocols. Challenges include aligning training with operational demands.

Transparency – related terms: open reporting, accountability. The practice of openly sharing information about performance, incidents, and improvement actions. Example: Publishing hospital-wide infection rates on an intranet site. Challenges involve protecting confidentiality while fostering openness.

Turnover Rate – related terms: staff retention, workforce stability. The proportion of staff who leave an organisation within a given period, influencing continuity of care and safety. Example: High nursing turnover correlating with increased medication errors. Challenges include addressing underlying causes such as workload and morale.

U

Unintended Consequence – related terms: adverse effect, risk spill-over. An outcome that was not anticipated or desired when a change or intervention was implemented. Example: A new electronic order set reducing prescribing errors but increasing alert fatigue. Challenges involve monitoring for secondary effects and adjusting interventions.

Utilisation Review – related terms: resource use audit, clinical appropriateness. Systematic assessment of the appropriateness, necessity, and efficiency of healthcare services. Example: Reviewing imaging orders for compliance with evidence-based criteria. Challenges include balancing cost containment with patient-centred care.