
Postgraduate Certificate in Health Innovation and Technology

Healthcare Quality and Safety.

Adverse Event: An event that results in harm to a patient, such as an injury or illness, and is caused by medical management rather than the underlying condition of the patient.

Agency for Healthcare Research and Quality (AHRQ): An agency of the U.S. Department of Health and Human Services that supports research to improve the quality and safety of healthcare.

Appropriateness: The degree to which healthcare services are consistent with current professional knowledge and patient preferences.

Benchmarking: The process of comparing an organization's performance metrics to those of other organizations to identify best practices and areas for improvement.

Centers for Medicare & Medicaid Services (CMS): A federal agency within the U.S. Department of Health and Human Services that administers the nation's major healthcare programs.

Clinical Practice Guidelines: Evidence-based recommendations for healthcare providers to use in making decisions about patient care.

Continuous Quality Improvement (CQI): A systematic approach to improving healthcare quality by identifying areas for improvement, developing interventions, and evaluating outcomes.

Data Collection: The process of gathering information on healthcare processes and outcomes to evaluate performance and make improvements.

Electronic Health Record (EHR): A digital version of a patient's paper chart that contains information about the patient's medical history, diagnoses, medications, treatment plans, immunization dates, allergies, radiology images, and laboratory test results.

Failure Mode and Effects Analysis (FMEA): A proactive method for identifying and addressing potential failures in healthcare processes before they occur.

Health Information Technology (HIT): The use of technology to manage and exchange health information.

Incident Reporting: The process of reporting any event that could have or did harm a patient, staff member, or visitor in a healthcare setting.

Joint Commission: An independent, not-for-profit organization that accredits and certifies healthcare organizations and programs in the United States.

Key Performance Indicators (KPIs): Quantifiable measures that reflect the critical success factors of an organization.

Lean Six Sigma: A methodology that combines Lean manufacturing principles and Six Sigma quality management tools to improve processes and reduce defects.

Medication Reconciliation: The process of creating the most accurate list possible of all medications a patient is taking and comparing that list with the physician's admission, transfer, and/or discharge orders.

National Patient Safety Goals: Goals established by The Joint Commission to help accredited organizations address specific areas of concern in regards to patient safety.

Outcomes Measurement: The process of evaluating the results of healthcare interventions to determine their effectiveness.

Patient Safety Culture: The values, beliefs, and norms that shape the behavior of individuals and groups in healthcare organizations with respect to patient safety.

Quality Improvement (QI): The systematic and continuous actions that lead to measurable improvement in healthcare services and the health status of targeted patient groups.

Root Cause Analysis (RCA): A method of problem-solving used to identify the underlying causes of adverse events in healthcare.

Standard Operating Procedures (SOPs): Step-by-step instructions that describe how to perform a routine operation or activity.

TeamSTEPPS: A teamwork system designed for healthcare professionals that is focused on improving communication and teamwork skills among healthcare professionals.

Value-Based Purchasing (VBP): A payment strategy that rewards healthcare providers with incentive payments for the quality of care they provide to Medicare beneficiaries.