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Undergraduate Certificate in Healthcare Risk Management

## Patient Safety in Healthcare

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Patient Safety in Healthcare is a critical aspect of healthcare delivery that focuses on preventing harm to patients resulting from medical errors or adverse events. It encompasses a wide range of strategies, processes, and tools aimed at ensuring that patients receive safe and effective care. In this course, we will explore key terms and vocabulary related to Patient Safety in Healthcare to help you develop a comprehensive understanding of this important topic.

1. **Patient Safety**: Patient safety refers to the absence of preventable harm to patients during the process of healthcare delivery and reduction of risk of unnecessary harm associated with healthcare.
2. **Adverse Event**: An adverse event is an injury resulting from medical intervention rather than the underlying condition of the patient. Adverse events may be preventable or non-preventable.
3. **Medical Error**: A medical error is a preventable adverse event that results from a failure to follow the correct process or procedure, such as a mistake in diagnosis, treatment, or medication.
4. **Near Miss**: A near miss is an event that could have resulted in harm to a patient but did not, either by chance or through timely intervention.
5. **Root Cause Analysis (RCA)**: Root cause analysis is a structured method used to analyze serious adverse events to identify underlying causes and develop strategies to prevent similar events in the future.
6. **Failure Mode and Effects Analysis (FMEA)**: FMEA is a systematic approach used to identify and prevent potential failures in processes, products, or services by analyzing their effects and likelihood of occurrence.
7. **Six Sigma**: Six Sigma is a data-driven methodology for process improvement that aims to reduce defects and variation in processes to improve patient safety and outcomes.
8. **High Reliability Organization (HRO)**: An HRO is an organization that operates in a complex and high-risk environment, such as healthcare, and has a strong commitment to safety, resilience, and continuous improvement.
9. **Patient-Centered Care**: Patient-centered care is an approach to healthcare that respects and responds to the preferences, needs, and values of patients, ensuring that they are actively involved in their care decisions.
10. **TeamSTEPPS**: TeamSTEPPS is a teamwork system developed by the Agency for Healthcare Research and Quality (AHRQ) to improve communication and teamwork among healthcare professionals and enhance patient safety.
11. **Just Culture**: Just culture is a culture within healthcare organizations that promotes accountability, transparency, and fairness in addressing medical errors and adverse events, focusing on system

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improvement rather than blame.

12. **Safety Culture**: Safety culture refers to the shared values, beliefs, and behaviors within an organization that prioritize safety as a core value and promote a proactive approach to identifying and mitigating risks.
13. **Human Factors**: Human factors refer to the study of how humans interact with systems, equipment, and processes in the healthcare environment, with a focus on designing systems that are safe, efficient, and user-friendly.
14. **Standard Operating Procedure (SOP)**: An SOP is a set of step-by-step instructions that outline the processes and procedures for carrying out specific tasks in a standardized manner to ensure consistency and quality of care.
15. **Clinical Practice Guidelines**: Clinical practice guidelines are evidence-based recommendations developed by healthcare experts to guide healthcare professionals in making informed decisions about the care and treatment of patients.
16. **Incident Reporting**: Incident reporting is the process of documenting and reporting adverse events, near misses, and other safety incidents within healthcare organizations to facilitate learning, analysis, and improvement.
17. **Patient Safety Indicators (PSIs)**: PSIs are a set of measures developed by the Agency for Healthcare Research and Quality (AHRQ) to identify potential safety issues in hospitals and assess the quality of patient care.
18. **Health Information Technology (HIT)**: HIT refers to the use of technology, such as electronic health records (EHRs) and clinical decision support systems, to improve the safety, quality, and efficiency of healthcare delivery.
19. **Medication Reconciliation**: Medication reconciliation is the process of comparing a patient's current medication regimen with any new medications prescribed to identify and resolve discrepancies and prevent medication errors.
20. **Handoff Communication**: Handoff communication is the transfer of information about a patient's care, treatment, and condition from one healthcare provider to another during shift changes or transitions in care to ensure continuity and safety.
21. **Never Events**: Never events are serious preventable medical errors that should never occur, such as wrong-site surgery or patient falls, and are used as indicators of healthcare quality and safety.
22. **Cultural Competency**: Cultural competency is the ability of healthcare providers to deliver care that is respectful, sensitive, and responsive to the cultural and linguistic needs of diverse patient populations.
23. **Patient Engagement**: Patient engagement refers to the active involvement of patients in their care, treatment decisions, and health management to improve outcomes, satisfaction, and safety.

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24. **Value-Based Care**: Value-based care is a healthcare delivery model that focuses on improving patient outcomes and experiences while reducing costs through the provision of high-quality, efficient, and coordinated care.
25. **Lean Thinking**: Lean thinking is a management philosophy that aims to eliminate waste, improve efficiency, and enhance quality by continuously identifying and eliminating non-value-added processes in healthcare.
26. **Triple Aim**: The Triple Aim is a framework developed by the Institute for Healthcare Improvement (IHI) that aims to improve population health, enhance patient experience, and reduce healthcare costs simultaneously.
27. **Patient Safety Culture Survey**: A patient safety culture survey is a tool used to assess the attitudes, beliefs, and behaviors of healthcare staff towards patient safety within an organization to identify strengths, weaknesses, and areas for improvement.
28. **Healthcare-associated Infections (HAIs)**: HAIs are infections that patients acquire during the course of receiving healthcare treatment in a hospital or other healthcare facility, leading to additional morbidity, mortality, and costs.
29. **National Patient Safety Goals**: The National Patient Safety Goals are a set of standards established by The Joint Commission to promote specific improvements in patient safety and quality of care across healthcare organizations.
30. **Informed Consent**: Informed consent is the process by which healthcare providers explain the risks, benefits, and alternatives of a proposed treatment or procedure to patients, allowing them to make voluntary and informed decisions about their care.

In conclusion, understanding these key terms and vocabulary related to Patient Safety in Healthcare is essential for healthcare professionals to effectively identify, prevent, and address patient safety issues in clinical practice. By integrating these concepts into daily practice and organizational culture, healthcare organizations can create a safer and more reliable healthcare system for patients and providers alike.