Advanced Skill Certificate in Quality Assurance and Improvement in Health and Social Care

Patient Safety And Harm Free Care

Adverse Event – an incident that results in harm to a patient, ranging from minor injury to death. Related terms: incident, near miss. Example: a medication error causing an allergic reaction. Practical application includes tracking through incident reporting systems to identify patterns. Challenges involve under-reporting due to fear of blame.

Alarm Fatigue – desensitisation of staff to safety alarms caused by excessive or non-critical alerts. Related terms: clinical alarm, alert overload. Example: nurses ignoring bedside monitor alarms after frequent false positives. Reducing unnecessary alarms and setting appropriate thresholds are key strategies. Overcoming cultural reliance on alarms can be difficult.

Audit – systematic review of processes or outcomes against established standards. Related terms: clinical audit, quality audit. Example: reviewing surgical site infection rates against national benchmarks. Audits drive improvement by highlighting gaps. Maintaining staff engagement and data accuracy are common obstacles.

Barrier Analysis – examination of obstacles that prevent safe practice. Related terms: root cause analysis, systems thinking. Example: identifying lack of equipment availability as a barrier to hand hygiene. Applying barrier analysis helps design realistic interventions. Challenges include distinguishing between perceived and actual barriers.

Best Practice – interventions proven through research to achieve optimal outcomes. Related terms: evidence-based practice, clinical guideline. Example: using chlorhexidine for skin antisepsis before catheter insertion. Implementing best practice requires training and monitoring. Resistance to change may impede adoption.

Blame Culture – environment where individuals are held personally responsible for system failures. Related terms: just culture, safety culture. Example: punitive response to medication errors discourages reporting. Shifting to a non-punitive approach encourages transparency. Overcoming entrenched attitudes is a major challenge.

Case Review – detailed examination of a specific patient incident to understand causes and outcomes. Related terms: mortality review, morbidity review. Example: multidisciplinary review of a postoperative hemorrhage. Findings inform policy updates. Ensuring objective analysis can be difficult.

Clinical Governance – framework through which organisations are accountable for continuously improving service quality. Related terms: quality assurance, risk management. Example: integrating patient safety metrics into board meetings. Supports systematic improvement. Aligning governance with frontline practice may be complex.

Clinical Indicator – measurable element of care that reflects quality or safety. Related terms: performance

metric, key performance indicator. Example: proportion of patients receiving prophylactic antibiotics within one hour of incision. Indicators guide benchmarking. Selecting relevant, actionable indicators is essential.

Clinical Pathway – evidence-based, multidisciplinary plan outlining optimal steps for a specific condition. Related terms: care pathway, protocol. Example: fast-track recovery pathway for hip replacement. Improves consistency and reduces variation. Customising pathways to local context can be challenging.

Communication Failure – breakdown in information exchange that jeopardises patient safety. Related terms: handover error, information loss. Example: missing critical lab result during shift change. Implementing structured handover tools mitigates risk. Cultural barriers to open communication persist.

Compliance – degree to which practices adhere to standards, policies, or regulations. Related terms: adherence, conformity. Example: audit of hand hygiene compliance showing 85 % adherence. Monitoring compliance drives accountability. Achieving high compliance often requires sustained education.

Continuous Improvement – ongoing effort to enhance processes, outcomes, and safety. Related terms: quality improvement, Kaizen. Example: Plan-Do-Study-Act cycles to reduce catheter-associated infections. Encourages incremental change. Maintaining momentum over time can be demanding.

Culture of Safety – shared values, beliefs, and behaviours that promote safe care. Related terms: just culture, safety climate. Example: staff feeling comfortable reporting near misses. Cultivating safety culture involves leadership commitment. Measuring cultural change reliably is a known difficulty.

Data Integrity – accuracy, completeness, and reliability of information used for safety analysis. Related terms: data quality, information governance. Example: ensuring electronic medication records reflect actual administration. High data integrity supports valid conclusions. Data entry errors and system incompatibilities threaten integrity.

Defensive Medicine – practice of ordering unnecessary tests or procedures to avoid liability. Related terms: over-testing, risk aversion. Example: ordering CT scans for low-risk headache. Increases cost and potential harm. Balancing patient safety with prudent resource use is a challenge.

Diagnostic Error – failure to correctly or timely identify a patient's condition. Related terms: misdiagnosis, delayed diagnosis. Example: missing sepsis in an elderly patient presenting with atypical symptoms. Implementing decision support tools can reduce errors. Cognitive biases often underlie diagnostic mistakes.

Discharge Planning – coordinated process ensuring safe transition from hospital to home or other settings. Related terms: care transition, continuity of care. Example: arranging community nursing support for a patient with a new wound. Effective planning reduces readmissions. Communication gaps between settings are frequent obstacles.

Do-Not-Resuscitate (DNR) Order – directive indicating that cardiopulmonary resuscitation should not be performed. Related terms: advanced directive, end-of-life care. Example: documenting patient wishes after a thorough discussion. Clear DNR policies prevent unwanted interventions. Misunderstanding of DNR scope can cause conflict.

Drug-Related Problem (DRP) – any event involving medication that interferes with desired health outcomes. Related terms: adverse drug reaction, medication error. Example: a patient experiencing renal toxicity from an inappropriate dose. Pharmacist-led medication reviews help resolve DRPs. Complex regimens increase DRP risk.

Education and Training – systematic programmes to develop competencies in safety practices. Related terms: learning, competency development. Example: simulation-based training for rapid response. Ongoing education sustains skill levels. Time constraints and staff turnover hinder consistent training.

Emergency Department (ED) Overcrowding – situation where patient demand exceeds capacity, compromising safety. Related terms: access block, boarding. Example: prolonged wait times leading to delayed antibiotics for sepsis. Strategies include fast-track pathways and resource reallocation. Systemic pressures often limit effectiveness.

Equipment Failure – malfunction of medical devices that can cause patient harm. Related terms: device safety, maintenance. Example: infusion pump delivering incorrect dose due to software glitch. Robust maintenance schedules and reporting mechanisms reduce risk. Budget constraints may delay repairs.

Evidence-Based Practice (EBP) – integration of best research evidence with clinical expertise and patient values. Related terms: research utilisation, guideline implementation. Example: using low-dose aspirin for secondary prevention of cardiovascular events. EBP improves outcomes and standardises care. Translating evidence into practice can be slow.

Fall Prevention – systematic approach to reduce patient falls and related injuries. Related terms: risk assessment, mobility safety. Example: installing bed alarms and conducting gait assessments. Multifactorial interventions are most effective. Staff adherence to protocols varies.

Feedback Loop – process where information about performance is returned to the source for adjustment. Related terms: performance feedback, continuous learning. Example: providing clinicians with infection rate dashboards. Timely feedback encourages corrective action. Delayed feedback diminishes impact.

Fire Safety – measures to prevent, detect, and respond to fire hazards in healthcare settings. Related terms: evacuation plan, risk assessment. Example: regular fire drills and maintaining clear exit routes. Fire safety protects both patients and staff. Balancing infection control with fire-safety requirements can be tricky.

FMEA (Failure Modes and Effects Analysis) – proactive method to identify potential failures in a process and assess their impact. Related terms: prospective risk assessment, reliability engineering. Example: analysing medication administration steps to spot omission risks. FMEA guides preventive redesign. Requires multidisciplinary participation and time.

Hand Hygiene – practice of cleaning hands to remove pathogens and prevent transmission. Related terms: infection control, WHO “Five Moments”. Example: using alcohol-based hand rub before patient contact. Hand hygiene is a cornerstone of patient safety. Compliance often falls short despite education.

Harm-Free Care – delivery of health services without causing injury, infection, or other adverse outcomes.

Related terms: patient safety, zero-harm. Example: implementing a bundle to prevent ventilator-associated pneumonia. The goal is to eliminate preventable harm. Achieving zero harm is aspirational and requires system-wide commitment.

Health Information Exchange (HIE) – electronic sharing of health data across organisations to improve care continuity. Related terms: interoperability, data sharing. Example: accessing a patient's medication list from a different hospital. HIE supports safer prescribing. Privacy concerns and technical standards pose challenges.

High-Reliability Organisation (HRO) – entity that operates in complex, high-risk environments with a low incidence of errors. Related terms: resilience, safety culture. Example: a trauma centre that consistently avoids catastrophic failures. HRO principles include preoccupation with failure and deference to expertise. Embedding these principles requires deep cultural change.

Incident Reporting – systematic capture of events that could or did result in patient harm. Related terms: adverse event reporting, safety reporting system. Example: using an online portal to log a medication error. Reporting provides data for trend analysis. Under-reporting remains a major barrier.

Infection Control – set of practices to prevent spread of infectious agents. Related terms: sterilisation, isolation precautions. Example: using contact precautions for patients with MRSA. Effective infection control reduces HAIs. Compliance with protocols varies across units.

Interdisciplinary Team (IDT) – group of professionals from diverse disciplines collaborating on patient care. Related terms: multidisciplinary team, team-based care. Example: nurses, physicians, pharmacists, and social workers planning discharge. IDTs improve communication and safety. Scheduling and role clarity can be problematic.

International Patient Safety Goals (IPSG) – set of objectives by the Joint Commission International to improve safety worldwide. Related terms: global standards, accreditation. Example: goal to identify patients correctly before procedures. Adoption of IPSG promotes uniform safety priorities. Local adaptation may be needed.

JCAHO (Joint Commission on Accreditation of Healthcare Organizations) – US body that accredits and certifies health-care organisations, setting safety standards. Related terms: accreditation, sentinel event. Example: compliance with National Patient Safety Goals. Accreditation drives systematic safety improvements. Maintaining compliance requires continuous effort.

Kaizen – Japanese term meaning "continuous improvement," applied to small, incremental changes. Related terms: lean, quality improvement. Example: daily huddles to identify workflow bottlenecks. Kaizen fosters staff ownership of safety. Sustaining momentum may be difficult without leadership support.

Knowledge Management – processes for creating, sharing, using, and retaining knowledge within an organisation. Related terms: learning organisation, best practice repository. Example: an online library of safety protocols. Effective knowledge management accelerates improvement. Information overload can hinder usefulness.

Learning Health System – system that continuously and systematically integrates data and experience to improve care. Related terms: real-world evidence, feedback loop. Example: using electronic health record data to refine sepsis pathways. Enables rapid cycle improvement. Requires robust data analytics capability.

Leadership Walkrounds – senior leaders regularly visit clinical areas to discuss safety concerns with staff. Related terms: executive presence, safety climate. Example: a director meeting nurses on a ward to discuss medication safety. Walkrounds build trust and surface hidden issues. Time constraints limit frequency.

Lean Methodology – approach focused on eliminating waste and improving flow. Related terms: value stream mapping, Kaizen. Example: streamlining medication dispensing to reduce waiting time. Lean tools support safety by simplifying processes. Misapplication can lead to staff fatigue.

Learning Curve – representation of how proficiency improves with practice over time. Related terms: skill acquisition, competency development. Example: nurses mastering a new infusion pump after several uses. Understanding the learning curve informs training schedules. Accelerated adoption may increase error risk.

Medication Reconciliation – process of creating an accurate list of a patient's medications and comparing it across transitions. Related terms: medication review, discharge planning. Example: verifying home drugs against hospital orders at admission. Reduces drug-related problems. Incomplete histories often impede reconciliation.

Micro-learning – short, focused educational modules targeting specific safety topics. Related terms: e-learning, just-in-time training. Example: a 5-minute video on proper needle disposal. Increases knowledge retention. Limited depth may require supplemental training.

Near Miss – event that could have caused harm but did not, either by chance or timely intervention. Related terms: close call, sentinel event. Example: a syringe left uncapped but caught before use. Near-miss reporting uncovers system weaknesses. Fear of repercussions often suppresses reporting.

Non-Compliance – failure to follow established policies or standards. Related terms: deviation, breach. Example: staff bypassing hand-washing protocols. Identifying non-compliance triggers corrective actions. Persistent non-compliance may indicate deeper cultural issues.

Observation Study – research method involving direct monitoring of practices to assess safety behaviours. Related terms: audit, ethnography. Example: observing hand-hygiene adherence during ward rounds. Provides real-time insight into practice gaps. Observer effect can alter behaviour.

Open Disclosure – transparent communication with patients and families about incidents that have caused harm. Related terms: apology, patient communication. Example: informing a patient about a surgical site infection caused by a breach in sterility. Builds trust and may reduce litigation. Requires skilled communication training.

Organisational Learning – collective process by which an institution gains knowledge from experience and applies it to improve. Related terms: knowledge management, continuous improvement. Example: using lessons from a medication error to redesign the prescribing workflow. Learning loops close gaps.

Institutional inertia can impede progress.

Patient-Centred Care – approach that respects and responds to individual patient preferences, needs, and values. Related terms: shared decision-making, person-focused care. Example: involving the patient in selecting an anticoagulant based on lifestyle. Enhances safety by aligning treatment with patient context. Requires effective communication skills.

Patient Safety Indicator (PSI) – metric derived from administrative data to identify potentially preventable complications. Related terms: quality metric, benchmark. Example: rate of postoperative pulmonary embolism. PSIs help compare performance across institutions. Coding inaccuracies can distort results.

Patient Safety Culture Survey – questionnaire used to assess staff perceptions of safety climate. Related terms: safety climate, organisational assessment. Example: the AHRQ Hospital Survey on Patient Safety Culture. Results guide targeted interventions. Low response rates may limit validity.

Patient Safety Incident – any event or circumstance that could have resulted, or did result, in unnecessary harm to a patient. Related terms: adverse event, near miss. Example: a mis-labelled specimen leading to an incorrect diagnosis. Incident analysis uncovers root causes. Timely reporting is critical.

Patient Safety Officer (PSO) – designated individual responsible for overseeing safety initiatives and reporting. Related terms: clinical risk manager, quality director. Example: PSO leading a root-cause analysis team after a sentinel event. PSOs coordinate cross-departmental safety efforts. Role clarity and authority affect effectiveness.

Patient Safety Net – framework of policies and programmes ensuring vulnerable populations receive safe care. Related terms: equity, access to care. Example: community outreach to reduce medication errors among the elderly. Addresses disparities that affect safety. Funding and resource allocation are persistent challenges.

Patient-Reported Outcome Measures (PROMs) – tools that capture patients' views on health status and treatment impact. Related terms: patient experience, quality of life. Example: using PROMs to assess pain after joint replacement. PROMs inform safety by highlighting unanticipated adverse effects. Data collection burden can limit uptake.

Performance Dashboard – visual display of key safety metrics for rapid monitoring. Related terms: scorecard, KPI. Example: a real-time chart showing hand-hygiene compliance rates. Dashboards promote accountability and quick response. Over-reliance on numbers may overlook qualitative issues.

Plan-Do-Study-Act (PDSA) Cycle – iterative method for testing changes on a small scale before wider implementation. Related terms: quality improvement, rapid cycle testing. Example: testing a new checklist for central line insertion on one ward. Allows learning from failures. Poorly defined measures can limit learning.

Practice Variation – differences in care delivery that are not explained by patient needs or preferences. Related terms: clinical variation, unwarranted variation. Example: differing rates of imaging for low-back pain

across hospitals. Identifying variation highlights opportunities for standardisation. Resistance may arise from perceived loss of autonomy.

Process Mapping – visual representation of steps in a workflow to identify inefficiencies. Related terms: flowchart, value stream mapping. Example: mapping the medication ordering process to locate duplication. Helps target improvement interventions. Complex processes may produce overwhelming diagrams.

Quality Assurance (QA) – systematic activities to ensure that services meet defined standards. Related terms: quality control, quality improvement. Example: routine audit of surgical checklist completion. QA maintains baseline performance. It may be perceived as punitive if not balanced with improvement focus.

Quality Improvement (QI) – coordinated activities aimed at enhancing the effectiveness and safety of care. Related terms: continuous improvement, PDSA. Example: reducing central line-associated bloodstream infections through a bundled approach. QI fosters a proactive safety mindset. Sustaining gains after the project ends is often challenging.

Root Cause Analysis (RCA) – systematic investigation to determine underlying reasons for an adverse event. Related terms: causal analysis, systems thinking. Example: RCA of a fall reveals inadequate lighting and staff fatigue. RCA informs corrective actions that target system flaws. Time-intensive nature can delay remediation.

Safety Briefing – short, focused meeting before a shift to discuss safety priorities. Related terms: huddle, safety huddle. Example: reviewing medication safety alerts at the start of the day. Briefings align staff on immediate risks. Inconsistent attendance reduces effectiveness.

Safety Culture – shared values, attitudes, and behaviours that shape an organisation's approach to safety. Related terms: just culture, safety climate. Example: staff feeling empowered to stop a procedure if they perceive danger. Strong safety culture reduces errors. Measuring culture accurately requires validated tools.

Safety Indicator – specific measure that signals performance in a safety domain. Related terms: metric, KPI. Example: rate of falls per 1,000 patient days. Indicators guide monitoring and benchmarking. Selecting meaningful indicators avoids data overload.

Safety Netting – practice of providing patients with information on what to do if symptoms worsen after discharge. Related terms: post-discharge advice, follow-up. Example: giving a patient a written plan for recognizing infection signs after surgery. Enhances early detection of complications. Documentation and consistency can be problematic.

Safety Officer – individual tasked with overseeing risk management and safety initiatives within a department. Related terms: clinical risk manager, PSO. Example: a safety officer coordinating a medication safety committee. Provides focal point for safety concerns. Role overlap may cause confusion.

Safety Reporting System – electronic platform for logging incidents, near misses, and hazards. Related terms: incident reporting, adverse event database. Example: a web-based portal where staff submit medication errors. Facilitates data aggregation for trend analysis. User-friendliness influences reporting

rates.

Safety Training – educational activities designed to improve competence in safe practices. Related terms: simulation, competency assessment. Example: a workshop on proper use of restraints. Training updates knowledge and skills. Retention declines without reinforcement.

Safety-Critical Equipment – devices whose failure could directly cause patient harm. Related terms: medical device, high-risk equipment. Example: ventilators, infusion pumps. Rigorous maintenance and calibration are mandatory. Budget limitations may affect service contracts.

Sentinel Event – unexpected occurrence involving death or serious physical or psychological injury. Related terms: critical incident, catastrophic event. Example: surgery on the wrong site. Mandatory reporting triggers immediate investigation. High emotional impact can affect staff morale.

Simulation-Based Learning – use of realistic scenarios to develop skills and decision-making in a safe environment. Related terms: clinical simulation, skills lab. Example: mock code drills to practice resuscitation. Enhances preparedness and teamwork. Resource-intensive setup may limit frequency.

Standardised Protocol – written, evidence-based instructions that guide specific clinical actions. Related terms: clinical pathway, guideline. Example: a protocol for sepsis identification and management. Reduces variation and errors. Rigid protocols may not fit every clinical nuance.

Systemic Risk – hazards embedded in organisational structures, processes, or culture that increase likelihood of harm. Related terms: latent error, system failure. Example: fragmented communication channels across departments. Addressing systemic risk requires organisational change. Identification can be complex.

TeamSTEPPS – evidence-based framework for improving teamwork and communication in healthcare. Related terms: crew resource management, interdisciplinary collaboration. Example: using the SBAR (Situation, Background, Assessment, Recommendation) technique during handovers. Enhances shared mental models. Training uptake varies across units.

Therapeutic Inertia – failure to initiate or intensify therapy when indicated, potentially leading to adverse outcomes. Related terms: clinical inertia, under-treatment. Example: not escalating antihypertensive therapy despite uncontrolled blood pressure. Recognising inertia prompts guideline-driven action. Provider complacency can sustain inertia.

Time-Out Procedure – mandatory pause before invasive procedures to verify patient identity, procedure, and site. Related terms: pre-procedure checklist, surgical pause. Example: surgical team confirming the correct limb for amputation. Time-out reduces wrong-site surgery. Compliance may slip under time pressure.

Training Needs Assessment – systematic evaluation of staff competencies to identify gaps in knowledge or skills. Related terms: skill audit, learning gap analysis. Example: surveying nurses on their confidence in using electronic medication administration records. Informs targeted education programmes. Survey fatigue can

affect response quality.

Transparency – openness in sharing information about safety performance, incidents, and improvement actions. Related terms: open disclosure, accountability. Example: publishing quarterly safety dashboards for all staff. Promotes trust and collective responsibility. Balancing transparency with confidentiality is delicate.

Turnaround Time (TAT) – interval between a request and the completion of a service. Related terms: process efficiency, lead time. Example: time from lab test order to result availability. Reducing TAT can prevent delays in diagnosis. Bottlenecks often arise in high-volume settings.

Unintended Consequence – outcome that is not foreseen and may be harmful, arising from an intervention. Related terms: spillover effect, negative externality. Example: implementing a strict hand-off protocol that inadvertently increases documentation burden and errors. Anticipating consequences requires thorough planning. Continuous monitoring can detect emerging issues.

Usability Testing – evaluation of how easily users can interact with a system or device. Related terms: human factors, user-centered design. Example: testing an electronic prescribing interface for navigation errors. Improves safety by reducing user errors. Limited resources may restrict extensive testing.

Vigilance – sustained attention to potential safety threats and emerging risks. Related terms: monitoring, situational awareness. Example: staff remaining alert for signs of patient deterioration. Cultivates proactive risk identification. Fatigue and workload can erode vigilance.

Virtual Care Safety – considerations ensuring patient safety in telehealth and remote monitoring contexts. Related terms: e-health, digital health safety. Example: verifying patient identity before a virtual consultation. Addresses unique risks such as technology failures. Regulatory guidance is still evolving.

Wound Care Bundle – set of evidence-based practices applied together to reduce infection and promote healing. Related terms: care bundle, infection control. Example: using sterile technique, appropriate dressing, and prophylactic antibiotics for surgical wounds. Bundles improve outcomes when adhered to. Compliance monitoring is essential.

Zero-Harm Initiative – strategic effort to eliminate preventable patient harm. Related terms: harm-free care, safety culture. Example: organisation-wide campaign targeting medication errors, falls, and pressure injuries. Ambitious goal that drives system-wide change. Requires sustained leadership commitment and measurement.