NQF Patient Safety Terms and Definitions

In order to standardize patient safety terminology and their definitions, a review process was initiated at the National Quality Forum (NQF) to collate, review and finalize a standardized set of terms that will be utilized in NQF patient safety programs and products.

The NQF Patient Safety Team, originally consisting of four members—(the Senior Advisor for Patient Safety, a Project Manager, and two Research Analysts, two with clinical backgrounds and two with policy backgrounds)—initially conducted an internal review of all NQF patient safety related terms and corresponding definitions. The original analysis of the Agency for Healthcare Research and Quality's (AHRQ) *Common Formats for Event Reporting to Patient Safety Organizations (*Common Formats*)*, the NQF-endorsed *Patient Safety Event Taxonomy*, and the World Health Organization *International Classification for Patient Safety* (WHO-ICPS) yielded additional terms and definitions, as selected by the Team.

This initial set of terms and definitions was reviewed by the Team, and then expanded to comprise initiatives including: the *Common Data Fields* project, an NQF-lead multi-stakeholder initiative to identify definitions related to measure submissions; NQF safety-related reports; the *Merriam-Webster Online Dictionary*; and multiple publications from The Institute of Medicine (including *To Err is Human* and *Patient Safety: Achieving a New Standard for Healthcare*).

A broader table of patient safety terms and definitions was formed to allow for a comparison among these different primary sources. The Team conducted a comprehensive review of this table, choosing which terms were most appropriate for a patient safety glossary and then selecting a definition for each. When appropriate, the Team merged or created definitions based on personal knowledge and the different terms available. This broader table went through multiple revisions, where terms, sources, and definitions were continuously updated. A final list of definitions was formed, and given final review and approval by NQF's Senior Advisor for Patient Safety. The proposed list was then circulated to all Senior Leadership at NQF for review and comments before the finalized list was posted to the NQF website.

This subjective methodology used by NQF is in line with the process used to develop other taxonomies, including The Joint Commission's (TJC) *Patient Safety Event Taxonomy* (PSET) and AHRQ's *Common Formats*.

For example, AHRQ convened a Patient Safety Working Group, including representatives of all health agencies within the Department of Health and Human Services, to review existing terms for inclusion as definitions within the Common Formats. TJC used an expert advisory taxonomy workgroup, along with input from business groups, healthcare organizations, medical specialty societies, and government health agencies to form the PSET. In both efforts, these expert panels made assessments on data rather than including information based on objective statistical analyses.

The list of NQF Patient Safety Terms and Definitions was completed in December 2009.

TERM	DEFINITION
Accident	An event that involves damage to a defined system that disrupts the ongoing or future output of the system[1]
Active error	An error that occurs at the level of the frontline operator and whose effects are felt almost immediately[2]
Adverse event	An event that results in unintended harm to the patient by an act of commission or omission rather than by the underlying disease or condition of the patient[3]
Adverse	Describes a negative consequence that results in unintended injury or illness, which may or may not have been preventable[4]
Adverse drug event	Any incident in which the use of a medication (drug or biologic) at any dose, a medical device, or a special nutritional product (for example, dietary supplement, infant formula, medical food) may have resulted in an adverse outcome in a patient[5]
Adverse drug reaction	An undesirable response associated with use of a drug that either compromises therapeutic efficacy, enhances toxicity, or both[6]
Associated with	Means it is reasonable to initially assume that the adverse event was due to the referenced course of care; further investigation and/or root cause analysis of the unplanned event may be needed to confirm or refute the presumed relationship[7]
Catheter associated urinary tract infection (CAUTI)	A urinary tract infection (UTI) that occurs in a patient who had an associated indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI[8]
Central line associated bloodstream infections (CLABSI)	Primary bloodstream infections that are associated with the presence of a central line or an umbilical catheter, in neonates, at the time of or before the onset of the infection[9]
Communication	A process by which information is exchanged between individuals through a common system of symbols, signs, or behavior[10]
Comparative effectiveness research	Comparison of the effectiveness of the risks and benefits of two or more health care services or treatments used to treat a specific disease or condition in approximate real-world settings[11]
Composite measure	A combination of two or more individual measures in a single measure that results in a single score[12]
Culture	The integrated pattern of human knowledge, values, belief, and behavior that depends upon the capacity for learning and transmitting knowledge
Disability	A physical or mental impairment that substantially limits one or more of an individual's major life activities[13]
Effective	Providing care processes and achieving outcomes as supported by scientific evidence[14]
Environment	The circumstances, objects, or conditions surrounding an individual[15]
Error	The failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim (commission). This definition also includes failure of an unplanned action that should have been completed (omission).[16]
Event	A discrete, auditable, and clearly defined occurrence[17,18]
Failure to rescue	Death among patients with treatable serious complications [19]
Fall	A sudden, unintended, uncontrolled downward displacement of a patient's body to the ground or other object. This includes situations where a patient falls while being assisted by another person, but excludes falls resulting from a purposeful action or violent blow.[20]

Handover	The accurate, clear, and complete communication about a patient's condition, care, treatment, medications, services, and any recent or expected changes between different caregivers or providers[21]
Harm	Any physical or psychological injury or damage to the health of a person, including both temporary and permanent injury[22]
Healthcare acquired infection	Infections that patients acquire while receiving treatment for medical or surgical conditions. They are associated with a variety of causes, including the use of medical devices, such as catheters and ventilators, complications following a surgical procedure, transmission between patients and healthcare workers, or the result of antibiotic overuse.[23]
Healthcare facility	Any licensed facility that is organized, maintained, and operated for the diagnosis, prevention, treatment, rehabilitation, convalescence, or other care of human illness or injury, physical or mental, including care during and after pregnancy. Healthcare facilities include, but are not limited to, hospitals, nursing homes, rehabilitation centers, medical centers or offices, outpatient dialysis centers, reproductive health centers, independent clinical laboratories, hospices, and ambulatory surgical centers.[24]
Hospital acquired condition	Events that (a) are high cost or high volume or both, (b) result in the assignment of a case to a Diagnosis Related Group (DRG) that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines[25]
Incident	A patient safety event that reached the patient, whether or not the patient was harmed.[26]
Informed consent	A process of communication between a patient and healthcare professional that results in the patient's authorization or agreement to undergo a specific medical intervention[27]
Leadership	A process by which a person sets direction and influences others to accomplish a mission, task, or objective, and directs the organization in a way that makes it more cohesive and coherent[28]
Low-risk pregnancy	A pregnancy occurring in a woman aged 18-39 who has no previous diagnosis of essential hypertension, renal disease, collagen-vascular disease, liver disease, cardiovascular disease, placenta previa, multiple gestation, intrauterine growth, retardation, smoking, pregnancy-induced hypertension, premature rupture of membranes, or other previously documented condition that poses a high risk of poor pregnancy outcome[29]
Mandatory reporting	Legal requirement for physicians and other professionals providing health services to report suspected incidents of abuse and neglect. As mandated reporters, they are generally afforded legal immunity for such reports and most jurisdictions impose a civil or criminal penalty for failure to report.[30]
Medical device	An instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including a component part, or accessory which is recognized in the official National Formulary, or the United States Pharmacopoeia, or any supplement to them, intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals, or intended to affect the structure or any function of the body of man or other animals, and which does not achieve any of its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of any of its primary intended purposes[31]

Medication error	Any error occurring in the medication-use process[32]
Mitigation	An action or circumstance which prevents or moderates the progression of an incident towards harming a patient[33]
Near miss	An event or a situation that did not produce patient harm, but only because of intervening factors, such as patient health or timely intervention[34]
Outcome	In healthcare, an outcome may be measured in a variety of ways, but it tends to reflect the health and well-being of the patient and the associated costs of care[35]
Patient centered	Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions[36]
Patient elopement	Any situation in which an admitted patient (i.e., inpatient) leaves the healthcare facility without staff's knowledge[37]
Patient safety	The prevention and mitigation of harm caused by errors of omission or commission that are associated with healthcare, and involving the establishment of operational systems and processes that minimize the likelihood of errors and maximize the likelihood of intercepting them when they occur[38]
Patient safety events	A process or act of omission or commission that resulted in hazardous health care conditions and/or unintended harm to the patient. An event is identified by a generalized high-level, discrete, auditable term or group of terms.[39]
Patient safety practices	Discrete and clearly recognizable processes or manners of providing care that have an evidence base demonstrating that they reduce the likelihood of harm due to the systems, processes, or environments of care.[40]
Preventable (event)	Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure[41]
Process	The activities that constitute healthcare, usually carried out by professional personnel, but also including other contributions to care, particularly by patients and their families[42]
Quality	The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge[43]
Restraint	Any method of restricting a patient's freedom of movement that: is not a usual and customary part of a medical diagnostic or treatment procedure to which the patient or his or her legal representative has consented; that is not indicated to treat the patient's medical condition or symptoms; or that does not promote the patient's independent functioning[44]
Risk	Possibility of loss or injury[45]
Safe practice	Practices that have been demonstrated to be effective in reducing the occurrence of adverse healthcare events[46]
Safety	The condition of being free from harm or risk, as a result of prevention and mitigation strategies[47]
Sentinel event	An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called "sentinel" because they signal the need for immediate investigation and response.[48]
Serious (event)	Describes an event that results in death or loss of a body part, disability or loss of bodily function lasting more than seven days or still present at the time of

	discharge from an inpatient healthcare facility or, when referring to other than an adverse event, a non-trivial event[49]
Structure	The conditions under which care is provided[50]
Surgery	An invasive operative procedure in which skin or mucous membranes and connective tissue is incised or an instrument is introduced through a natural body orifice[51]
Surgery begins	Surgery begins, regardless of setting, at the point of surgical incision, tissue puncture, or the insertion of an instrument into tissues, cavities, or organs.[52]
Surgery ends	Surgery ends after counts have concluded, the surgical incision has been closed, and/or operative device(s) such as probes have been removed, regardless of setting (e.g., postanesthesia recovery unit, surgical suite, endoscopy unit).[53]
Surgery on the wrong body part	Surgery performed on a body part that is not consistent with the correctly documented informed consent for that patient[54]
Surgery performed on the wrong patient	Surgery performed on a patient that is not consistent with the correctly documented informed consent for that patient
Surgical site infection	An infection that occurs within 30 days of an operative procedure[55]
System factors	Failures of design and failures of organization and environment[56]
Timely	Reducing waits and sometimes harmful delays for both those who receive and those who give care[57]
Unambiguous	An event that is clearly defined and easily identified[58]
Usually preventable (event)	Recognizes that some of these events are not always avoidable, given the complexity of healthcare; therefore, the presence of an event on the list is not an a priori judgment either of a systems failure or of a lack of due care[59]

---

[1] Committee on Quality of Health Care in America, Institute of Medicine, *To Err is Human: Building a Safer Healthcare System*. Washington, DC: National Academies Press; 2000.
[2] Ibid.
[3] Committee on Data Standards for Patient Safety, Institute of Medicine, *Patient Safety: Achieving a New Standard of Care*. Washington, DC: National Academies Press; 2004.
[4] National Quality Forum (NQF), *Serious Reportable Events in Healthcare 2006 Update: A Consensus Report*, Washington, DC: NQF;2009.
[5] The Joint Commission (TJC), *Sentinel Event Glossary of Terms*; 2006. Available at http://www.jointcommission.org/sentinelevents/se_glossary.htm. Last accessed December 2009.
[6] Ibid.
[7] National Quality Forum (NQF), *Serious Reportable Events in Healthcare 2006 Update.*
[8] Centers for Disease Control and Prevention, *The National Healthcare Safety Network (NHSN) Manual: Patient Safety Component Protocol;* 2009. Available at http://www.premierinc.com/safety/topics/guidelines/downloads/NHSN_Manual_PatientSafetyProtocol_CURRENT_b.pdf.
[9] Ibid.
[10] *Merriam-Webster's Online Dictionary*, *Communication*, Available at http://www.merriamwebster.com/dictionary/communication. Last accessed August 2009.
[11] Academy Health. *A First Look at the Volume and Cost of Comparative Effectiveness Research in the United States*. Washington, DC: Academy Health;2009. Available at http://www.academyhealth.org/files/publications/CERMonograph09.pdf.
[12] National Quality Forum (NQF), *Composite Measure Evaluation Framework and National Voluntary Consensus Standards for Mortality and Safety: Composite Measures,* Washington, DC: NQF;2009.
[13] National Quality Forum (NQF), *Serious Reportable Events in Healthcare 2006 Update.*
[14] National Quality Forum (NQF), *Common Data Fields Collaboration*, Washington, DC: NQF;2009

[15] *Merriam-Webster's Online Dictionary*, *Environment*, Available at http://www.merriamwebster.com/dictionary/environment. Last Accessed August 2009.
[16] Committee on Data Standards for Patient Safety, Institute of Medicine,
[17] National Quality Forum (NQF), *Standardizing a Patient Safety Taxonomy.* Washington, DC: NQF;2005.
[18] National Quality Forum (NQF), *Serious Reportable Events in Healthcare 2006 Update.*
[19] Agency for Healthcare Research and Quality (AHRQ). *AHRQ quality indicators. Guide to patient safety indicators [version 3.1].* Rockville (MD): AHRQ Pub;2007 (AHRQ Pub; no. 03-R203).
[20] The Agency for Healthcare Research and Quality (AHRQ), *Common Formats*. Washington, DC: AHRQ;2009 http://www.pso.ahrq.gov/formats/commonfmt.htm. Last Accessed December 2009.
[21] The Joint Commission (TJC), *Patient Safety Essentials for Healthcare*. Chicago: 2005.
[22] World Health Organization. *International Classification for Patient Safety*; Available at http://www.who.int/patientsafety/taxonomy/en/. Last Accessed August 2009.
[23] Department of Health and Human Services, *Action Plan to Prevent Healthcare Acquired Infections*. Available at http://www.hhs.gov/ophs/initiatives/hai/draft-hai-plan-01062009.pdf. Last Accessed August 2009
[24] National Quality Forum (NQF), *Serious Reportable Events in Healthcare 2006 Update.*
[25] Department of Health and Human Services, *Overview of Healthcare Acquired Conditions*, Available at http://www.cms.hhs.gov/hospitalacqcond/. Last accessed August 2009.
[26] The Agency for Healthcare Research and Quality (AHRQ), *Common Formats*.
[27] National Quality Forum (NQF), *Serious Reportable Events in Healthcare 2006 Update.*
[28] Borkowski, N. *Organizational Behavior in Health Care*. Boston: Jones and Bartlett Publishers, Inc.; 2005.
[29] National Quality Forum (NQF), *Serious Reportable Events in Healthcare 2006 Update.*
[30] Council on Scientific Affairs. *AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect.* JAMA. 1985;254(6):796-800.
[31] National Quality Forum (NQF), *Serious Reportable Events in Healthcare 2006 Update.*
[32] Committee on Identifying and Preventing Medication Errors, Institute of Medicine, *Preventing Medication Errors*. Washington, DC: National Academies Press;2006.
[33] World Health Organization. *International Classification for Patient Safety.*
[34] National Quality Forum (NQF), *Serious Reportable Events in Healthcare 2009 Update.*
[35] National Quality Forum (NQF), *Safe Practices for Better Healthcare: 2009 Update.*
[36] Committee on Quality of Health Care in America , Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century.* Washington, DC: National Academies Press; 2001.
[37] National Quality Forum (NQF), *Serious Reportable Events in Healthcare: A Consensus Report*, Washington, DC: NQF; 2002.
[38] Angood, P., Colchamiro, E., Lyzenga, A., and Marinelarena, M. *Meeting of the National Quality Forum Patient Safety Team*. Washington, DC. August 2009. Unpublished.
[39] World Health Organization. *International Classification for Patient Safety.*
[40] National Quality Forum (NQF), *Safe Practices for Better Healthcare: 2009 Update.*
[41] National Quality Forum (NQF), *Serious Reportable Events in Healthcare 2009 Update.*
[42] Donabedian, A. *An Introduction to Quality Assurance in Healthcare*. Oxford University Press; 2002.
[43] Committee on Quality of Health Care in America, Institute of Medicine. *Crossing the Quality Chasm.*
[44] National Quality Forum (NQF), *Serious Reportable Events in Healthcare 2006 Update.*
[45] *Merriam-Webster's Online Dictionary*, *Risk*, Available at http://www.merriamwebster.com/dictionary/risk. Last Accessed August 2009.
[46] National Quality Forum (NQF), *Safe Practices for Better Healthcare: 2009 Update.*
[47] *Merriam-Webster's Online Dictionary*, *Safety*, Available at http://www.merriamwebster.com/dictionary/safety. Last Accessed August 2009.
[48] The Joint Commission (TJC), *Sentinel Event Glossary of Terms*.
[49] National Quality Forum (NQF), *Serious Reportable Events in Healthcare 2006 Update.*
[50] Donabedian, A.
[51] National Quality Forum (NQF), *Serious Reportable Events in Healthcare 2006 Update.*
[52] Ibid.
[53] Ibid.
[54] Ibid.
[55] National Quality Forum (NQF), *National Voluntary Consensus Standards for the Reporting of Healthcare Acquired Infections: A Consensus Report,* Washington, DC: NQF;2009.
[56] National Quality Forum (NQF), *Standardizing a Patient Safety Taxonomy.*
[57] Committee on Quality of Health Care in America, Institute of Medicine. *Crossing the Quality Chasm.*
[58] National Quality Forum (NQF), *Serious Reportable Events in Healthcare 2006 Update.*
[59] Ibid.