FIP and PATIENT SAFETY

GLOSSARY OF TERMS

Adverse event
An incident in which harm resulted to a person receiving health care.
Source: Australian Council for Safety and Quality in Healthcare.
http://www.safetyandquality.org/definition/smsequential.htm (accessed: 01/06)

Adverse drug reaction
Adverse effect produced by the use of a medication in the recommended manner. These effects range from "nuisance effects" (e.g., dry mouth with anticholinergic medications) to severe reactions, such as anaphylaxis to penicillin.
Source: Patient Safety Net Glossary. Available at: http://psnet.ahrq.gov/glossary.aspx

Clinical decision support system (CDSS)
Any system designed to improve clinical decision making related to diagnostic or therapeutic processes of care.
Source: Patient Safety Net Glossary. Available at: http://psnet.ahrq.gov/glossary.aspx

Counterfeit medications
Counterfeit medicines are any brand (or generic) medicines and active pharmaceutical ingredients (APIs) that are deliberately and fraudulently mislabelled by unauthorised parties with respect to source, and/or composition and/or therapeutic quality. Counterfeit products include products without active ingredients, or with the wrong active ingredients, or with insufficient or active ingredients, or with fake packaging.
Source: EFPIA position paper. http;//www.efpia.org/4_pos/legal/counterfeit2005.pdf.

Drug-related problem
A drug-related problem is an event or circumstance involving drug therapy that actually or potentially interferes with desired health outcomes.
Source: PCNE Classification for drug related problems V 5.00, revised 06.08.03

Medication error
A medication error is: “any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing; order communication; product labelling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use.”
Source: National Coordinating Council for Medication Errors Reporting and Prevention NCC MERP Taxonomy of Medication Errors. 1998 http://www.nccmerp.org/pdf/taxo2001-07-31.pdf
Medication safety
a) improvement of packaging and labelling of medicines as well as the proprietary and non- proprietary naming, in cooperation with European regulators and the industry;
b) safer selection and procurement of medicines, including a medication errors risk assessment of medicines during formulary and purchasing decisions ;
c) safer storage of medicines in clinical areas in hospitals and community where high risks medicines stock should be restricted ;
d) safer prescribing of medicines, helped by the availability of complete patient records, electronic prescribing,

decision support and clinical pharmacy services ;
e) safer medicines preparation, by minimizing the preparation in clinical areas and supplying ready-to-use medicines;
f) safer dispensing of medicines, enhancing the ability to intercept medication errors, and reducing dispensing errors by the use of automated dispensing systems;
g) safer administration of medicines, helped by the clear and legible label of medicines up to the point of care, bar-coding, minimising the storage of high risk medicines and the use of standardised procedures;
h) safer monitoring of medicines supported by regular medication reviews and the proactive detection of adverse drug events ;
i) independent, updated and accessible information on medicines must be available to health care providers and patients, and considered with patient information when prescribing, dispensing, and administering medication;
j) and patient education for a safer medicines' use, considering patients as active partners in their care;
k) safer communication about medicines for individual patients between health care providers.
Source: COMMITTEE OF EXPERTS ON PHARMACEUTICAL QUESTIONS. Protocol of the EXPERT GROUP ON "SAFE MEDICATION PRACTICES", 3rd meeting. Strasbourg, 9 - 10 November 2004.

Medication history
A medication profile is a chronological list of medicines prescribed for (Rx) and purchased by (OTC) an individual patient.

Medication profile
A medication profile is a list of medicines prescribed for (Rx) and purchased by (OTC) an individual patient usually displayed over a period of 6 months.

Patient safety
Freedom from accidental or preventable injuries produced by medical care
Source: Patient Safety Net Glossary. Available at: http://psnet.ahrq.gov/glossary.aspx

Quality of health care
The extent to which a health care service or product produces a desired outcome.
Source: Australian Council for Safety and Quality in Healthcare,
http://www.safetyandquality.org/definition/smsequential.htm (01/06)
Source: Patient Safety Net Glossary. Available at: http://psnet.ahrq.gov/glossary.aspx

Risk Management
The culture, processes and structures that are directed towards effective management of risk.
Source: Australian Council for Safety and Quality in Healthcare.
http://www.safetyandquality.org/definition/smsequential.htm 01/06

Safety culture
Safety culture and culture of safety are frequently encountered terms referring to a commitment to safety that permeates all levels of an organisation, from frontline personnel to executive management. More specifically, "safety culture" calls up a number of features identified in studies of high reliability organisations, organisations outside of health care with exemplary performance with respect to safety.(1,2) These features include:
· acknowledgment of the high-risk, error-prone nature of an organisation's activities
· a blame-free environment where individuals are able to report errors or close calls without fear of reprimand or punishment
· an expectation of collaboration across ranks to seek solutions to vulnerabilities
· a willingness on the part of the organisation to direct resources for addressing safety concerns (3)
1. Roberts KH. Managing high reliability organizations. Calif Manage Rev. 1990;32:101-113.
2. Weick KE. Organizational culture as a source of high reliability. Calif Manage Rev. 1987;29:112-127.
3. Pizzi L, Goldfarb N, Nash D. Promoting a culture of safety. In: Shojania KG, Duncan BW, McDonald KM, Wachter RM, eds. Making Health Care Safer: A Critical Analysis of Patient Safety Practices. Evidence Report/Technology

Assessment No. 43 from the Agency for Healthcare Research and Quality: AHRQ Publication No. 01-E058; 2001. [Available at: http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat1.section.61719]

Standard
Agreed attributes and processes designed to ensure that a product, service or method will perform consistently at a designated level.
Source: Australian Council for Safety and Quality in Healthcare, http://www.safetyandquality.org/definition/smsequential.htm 01/06

Standard of Care
What the average, prudent clinician would be expected to do under certain circumstances. The standard of care may vary by community (e.g., due to resource constraints). When the term is used in the clinical setting, the standard of care is generally felt not to vary by specialty or level of training. In other words, the standard of care for a condition may well be defined in terms of the standard expected of a specialist, in which case a generalist (or trainee) would be expected to deliver the same care or make a timely referral to the appropriate specialist (or supervisor, in the case of a trainee). Standard of care is also a term of art in malpractice law, and its definition varies from jurisdiction to jurisdiction. When used in this legal sense, often the standard of care is specific to a given specialty; it is often defined as the care expected of a reasonable practitioner with similar training practicing in the same location under the same circumstances.
Source: Patient Safety Net Glossary. Available at: http://psnet.ahrq.gov/glossary.aspx

System failure
A fault, breakdown or dysfunction within an organisation's operational methods, processes or infrastructure.
Source: Australian Council for Safety and Quality in Healthcare, http://www.safetyandquality.org/definition/smsequential.htm (01/06)