

Shared meanings: preferred terms and definitions for safety and quality concepts

William B Runciman

An early initiative of the Australian Council for Safety and Quality in Health Care (ACSQHC) was to set up a mechanism for reaching agreement on preferred terms and definitions for safety and quality concepts. The aim was to devise a language with common meanings to facilitate discussion and research.¹ This need had been recognised before the Council was formed,² and a group of international experts had been asked to comment on proposed terms and definitions (see *Acknowledgements*). The group was emailed proposals, along with alternative definitions from the literature, and asked their opinions and preferences, as well as any additional terms which should be considered. Their comments were circulated regularly among the group.

When ACSQHC was formed, I was asked to coordinate a process to advance this "Shared meanings" project. We created a website, listing terms with their preferred and alternative definitions, sources and comments on the definitions.³ Visitors to the site were invited to submit suggestions. In all, 149 terms and their preferred definitions were posted, with a further 296 alternate definitions, and 63 sources of information (eg, there were 16 definitions for "error", 14 for "adverse event", and five for "adverse drug event"). It was decided to choose terms and definitions with meanings as close as possible to those in colloquial use, and not to use terms which are potentially ambiguous (eg, "accident", "complication", "medicament"); 19 terms posted were designated "not for further consideration".

A project group was then formed (see *Acknowledgements*), and a series of meetings held to decide on preferred terms and their definitions. The group decided to avoid long definitions with several "qualifiers", but instead to start with simple, basic definitions, and then to "build" by defining the key terms used in these. It is therefore necessary to read the terms and their definitions in the sequence provided in Box 1; an alphabetically arranged list is given in Box 2.

In October 2004, the World Alliance for Patient Safety was launched under the auspices of the World Health Organization (WHO), and one of its first initiatives was to develop a classifica-

tion for patient safety.⁴ At a meeting in October 2005, the WHO invited me to propose an underlying information model for this classification. The WHO classification group is hosting a web-based Delphi process⁵ to seek submissions from member countries as to which concepts should populate the classification and to propose preferred terms in their various languages. The ACSQHC terms and definitions shown in Box 2 have gained considerable currency (eg, many are used by the National Patient Safety Agency in the United Kingdom), and will be submitted for consideration for this worldwide patient safety classification, which is planned to become a member of the WHO Family of International Classifications.⁶

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Author details

William B Runciman, FANZCA, FJFICM, PhD, Professor, and President, Australian Patient Safety Foundation

Department of Anaesthesia and Intensive Care, Royal Adelaide Hospital, and University of Adelaide, Adelaide, SA.

Correspondence: research@apsf.net.au

1 Sequence in which to read the terms in Box 2

1 Incident	12 Injury	23 Side effect	34 Blame
2 Health care incident	13 Suffering	24 Error	35 Negligence
3 Health	14 Disability	25 Root cause analysis	36 Monitor
4 Health care	15 Adverse event	26 System failure	37 Benchmark
5 Event	16 Near miss	27 System improvement	38 Standard
6 Circumstance	17 Safety	28 Quality	39 Accreditation
7 Agent	18 Hazard	29 Quality of health care	40 Credentialling
8 Harm	19 Outcome	30 Risk	41 Iatrogenic
9 Complaint	20 Health care outcome	31 Risk management	42 Nosocomial
10 Loss	21 Preventable	32 Liability	43 Stakeholder
11 Disease	22 Adverse reaction	33 Accountable	

2 List of preferred terms and definitions devised by the Australian Council for Safety and Quality in Health Care

Introduction

* An asterisk indicates that there are further terms within that definition which are also defined. For example, the term "**incident**" contains the additional terms (in **bold**) "**event**", "**circumstance**", "**harm**", "**complaint**" and "**loss**", which are themselves defined.

The definition for "**harm**", in turn, contains the terms "**disease**", "**injury**", "**suffering**" and "**disability**", each of which is also defined. Alternative definitions, comments and sources of information are available from the author.

Terms and definitions

Accountable Being held responsible.

Accreditation* Being granted recognition for meeting designated **standards** for structure, process and **outcome**.

Adverse event* An **incident** in which **harm** resulted to a person receiving **health care**.

Adverse reaction* An **adverse event** where the correct process was followed for the context in which the event occurred but unexpected and unpreventable **harm** resulted. (For example, an adverse drug reaction will be said to have occurred when the right drug was used for the correct indication in the right dose given by the right route, but the patient suffered unexpected and unpreventable harm. Adverse reactions can also result from some diagnostic tests, therapeutic interventions or devices.)

Agent One who, or that which, acts to produce a change.

Benchmark A criterion against which something is measured.

Blame To hold at fault (implies culpability).

Circumstance* All the factors connected with or influencing an **event**, **agent** or person/s.

Complaint An expression of dissatisfaction with something.

Credentialling* The process of assessing and conferring approval on a person's suitability to provide a defined type of **health care**. (Can be synonymous with clinical privileging.)

Disability* Any type of impairment of body structure or function, activity limitation and/or restriction of participation in society, associated with a past or present **harm**.

Disease A physiological or psychological dysfunction.

Error Unintentionally being wrong in conduct or judgement. Errors may occur by doing the wrong thing (commission) or by failing to do the right thing (omission).

Event Something that happens to or with a person.

Harm* Harm includes **disease**, **injury**, **suffering**, **disability** and death.

Hazard* A **circumstance** or **agent** that can lead to **harm**, damage or **loss**.

Health* A state of complete physical, mental and social wellbeing and not merely the absence of **disease** or infirmity.

Health care* Services provided to individuals or communities to promote, maintain, monitor, or restore **health**. Health care is not limited to medical care and includes self-care.

Health care incident* An **event** or **circumstance** during **health care** which could have, or did, result in unintended or unnecessary **harm** to a person and/or a **complaint**, **loss** or damage.

Health care outcome* The **health** status of an individual, a group of people or a population which is wholly or partially attributable to an action, **agent** or **circumstance**.

Iatrogenic* Arising from or associated with **health care** rather than an underlying **disease** or **injury**.

Incident* An **event** or **circumstance** which could have resulted, or did result, in unintended or unnecessary **harm** to a person and/or a **complaint**, **loss** or damage.

Injury* Damage to tissues caused by an **agent** or **circumstance**.

Liability Responsibility for an action according to the law or in a legal sense.

Loss Any negative consequence, including financial.

Monitor To check, supervise, observe critically, or record the progress of an activity, action or system on a regular basis in order to identify and/or track change.

Near miss* An **incident** that did not cause **harm**.

Negligence (civil or criminal)* An incident causing **harm**, damage or **loss** as the result of doing something wrong or failing to provide a reasonable level of care in a **circumstance** in which one has a duty of care.

Nosocomial Pertaining to or originating in a hospital (synonymous with "hospital-acquired").

Outcome* The status of an individual, a group of people or a population which is wholly or partially attributable to an action, **agent** or **circumstance**.

Preventable* Accepted by the community as potentially avoidable in the particular set of **circumstances**.

Quality (degree of)* The extent to which a service or product produces a desired **outcome** or outcomes.

Quality of health care (degree of)* The extent to which a **health care** service or product produces a desired **outcome** or outcomes.

Risk The chance of something happening that will have a negative impact. It is measured in terms of consequences and likelihood.

Risk management* In **health care**, designing and implementing a program of activities to identify and avoid or minimise **risks** to patients, employees, visitors and the institution; to minimise financial **losses** (including legal **liability**) that might arise consequentially; and to transfer **risk** to others through payment of premiums (insurance).

Root cause analysis* A systematic process whereby the factors which contributed to an **incident** are identified.

Safety* Freedom from **hazard**.

Side effect* An effect, other than that intended, produced by an **agent** (see also "**adverse reaction**").

Stakeholder Those people and organisations who may affect, be affected by, or perceive themselves to be affected by, a decision or activity.

Standard Agreed attributes and processes designed to ensure that a product, service or method will perform consistently at a designated level.

Suffering* Experiencing anything subjectively unpleasant. This may include pain, malaise, nausea, vomiting, **loss**, depression, agitation, alarm, fear or grief.

System failure A fault, breakdown or dysfunction within an organisation's operational methods, processes or infrastructure.

System improvement* The result or **outcome** of the culture, processes and structures that are directed towards the prevention of **system failure** and the improvement in **safety** and **quality**. ♦

References

- 1 Australian Council for Safety and Quality in Health Care. First national report on patient safety. Canberra: ACSQHC, 2001: 8.
- 2 Runciman WB, Moller J. Iatrogenic injury in Australia. Adelaide: Australian Patient Safety Foundation, 2001: 9.
- 3 Australian Council for Safety and Quality in Health Care. Shared meanings. Available at: <http://www.safetyandquality.org/definition/sminroduction.htm#explain%2020lists> (accessed Nov 2005).
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- 5 Adler M, Ziglio E, editors. Gazing into the oracle: the Delphi method and its application to social policy and public health. Bristol: Jessica Kingsley Publishers, 1996.
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