Quality and Safety Terminology

1. measurable items that reflect the quality of care provided.

2. an adverse patient acquired condition related to one's hospitalization

3. organization that advances and disseminates scientific knowledge to improve human health

4. national agency that surveys hospitals and certifies compliance with quality standards

5. serious and costly errors in health care delivery that should not occur

6. unexpected occurrence involving patient death or serious injury

7. Framework for taking action to systematically make changes that lead to measurable improvements in health care services.

8. adhering to best known methods & repeating key tasks in the same way until a better way is found.

9. error that could have harmed a patient, but serious harm did not occur as a result of chance.

10. an event results in unintended harm to a patient by an act of commission or omission rather than by the underlying disease of the patient.

11. a type of bar graph that reflects the frequency with which problems occur so that the most commonly occurring problems are readily visible.

12. graph of date in time order that helps identify any changes that occur over time.

13. method of problem solving that helps to identify how and why an event occurred.

14. tool that maps what actually occurs during the process versus what is intended.

A. run chart

B. Hospital-acquired condition

C. quality improvement

D. Joint Commission

E. clinical indicators

F. Sentinel event

G. root cause analysis

H. Never events

I. adverse event

J. pareto chart

K. standardization

L. near miss

M. flowcharts

N. Institute of Medicine (IOM)

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