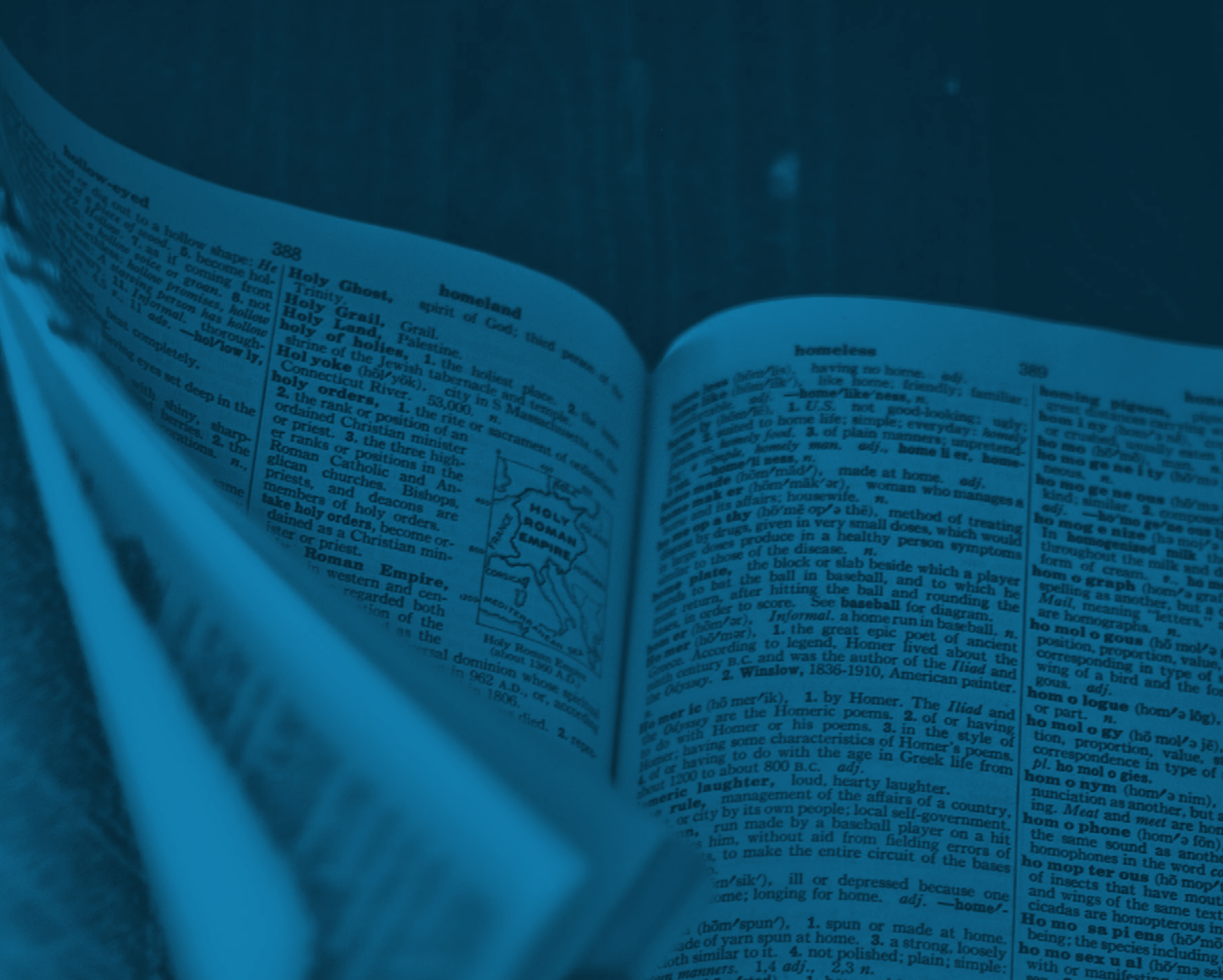

COST ACTION CA19113 - ERNST CONSORTIUM

Terms' Glossary

ERNST
The European Researchers' Network Working on Second Victims

cost
EUROPEAN COOPERATION IN SCIENCE & TECHNOLOGY

Funded by the European Union

Terms' definitions

In this glossary we present a set of terms belonging to the professional field of medicine that concern our field of research and which are fundamental elements to be able to name, define situations and actions and to be able to understanding between each other.

- Active Failures -

Unsafe acts committed by those working at the sharp end of a system, which are usually short-lived and often unpredictable. (Reason, 2000)

- Adverse Event -

An incident which resulted in harm to a patient. (WHO, 2009) Unintended physical injury resulting from or contributed to by medical care that requires additional monitoring, treatment or hospitalization, or that results in death. (IHI, 2009)

- Error -

Failure to carry out a planned action as intended or application of an incorrect plan. (WHO, 2009)

- First Victim -

A patient who experiences an adverse event, and also their close relatives.

- Harm -

Impairment of structure or function of the body and/or any deleterious effect arising there from. Harm includes disease, injury, suffering, disability and death. (WHO, 2009)

- Human Factors -

Study of the interrelationships between humans, the tools, equipment and methods they use, and the environments in which they live and work. (WHO, 2009)

- Incident -

Any deviation from usual medical care that causes an injury to the patient or poses a risk of harm. Includes errors, preventable adverse events, and hazards. (WHO, 2009)

- Just Culture -

An environment which seeks to balance the need to learn from mistakes and the need to take disciplinary action. (WHO, 2009)

- Latent Conditions -

The inevitable "resident pathogens" within a system. They arise from decisions made by designers, builders, procedure writers, and top-level management. Latent conditions can lie dormant before combining with other factors or active failures to breach a system's safety defences. Unlike many active failures, can be identified and removed before they cause an adverse event. (Reason, 2000)

- Medical Error -

An adverse event or near miss that is preventable with the current state of medical knowledge. (WHO, 2009)

- Near Miss -

An unplanned event that had the potential to result in injury, illness or damage – but fortunately it did not. (EU-OSHA)

- Open Disclosure -

The open discussion of adverse events that result in harm to a patient while receiving health care with the patient, their family and carers. The elements of open disclosure are: (1) an apology or expression of regret; (2) a factual explanation of what happened; (3) an opportunity for the patient, their family, and carers to relate their experience; (4) a discussion of the potential consequences of the adverse events; and (5) an explanation of the steps being taken to manage the adverse event and prevent recurrence. (Australian Commission on Safety and Quality in Health Care, 2013)

- Patient Safety -

Patient safety is a framework of organized activities that creates cultures, processes, procedures, behaviours, technologies and environments in health care that consistently and sustainably lower risks, reduce the occurrence of avoidable harm, make error less likely and reduce impact of harm when it does occur. (WHO, 2020)

- Peer Support -

Peer Support is “emotional first aid” for healthcare providers who are involved in unanticipated adverse patient events, medical errors, or other stressful situations encountered through patient care.

- Preventable -

Accepted by the community as avoidable in the particular set of circumstances. (WHO, 2009)

- Psychological safety -

Feeling able to show and employ one’s self without fear of negative consequences to self--image, status, or career. (Kahn, 1990) A shared belief that the team is safe for interpersonal risk-taking. (Edmondson, 1999) When employees feel safe voicing concerns and reporting problems and can trust their supervisor. (MacCurtain et al., 2018)

- 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. (WHO, 2009)

- Risk -

The probability of danger, loss or injury within the health-care system. (WHO, 2009)

- Root Cause Analysis -

Systematic iterative process whereby the factors that contribute to an incident are identified by reconstructuring the sequence of events and repeatedly asking “why” until the underlying root causes (contributing factors or hazards) have been elucidated. (WHO, 2009)

- Safe Care -

Safe care involves making evidence-based clinical decisions to maximize the health outcomes of an individual and to minimize the potential for harm. (WHO, 2009)

- Safety Culture -

The safety culture of an organization is the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the characteristics of the organization's health and safety management. Organizations with a positive safety culture are characterized by communications based on mutual trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of preventive measures. (WHO, 2021)

- Second Victim -

Any health care worker, directly or indirectly involved in an unanticipated adverse patient event, unintentional healthcare error, or patient injury and who becomes victimized in the sense that they are also negatively impacted. (Vanhaech et al., 2022)

- Sentinel Event -

An unexpected occurrence involving death or serious physical or psychological injury to patients, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. (WHO, 2020)

- Speaking Up -

Speaking up can be defined as assertive communication of quality and patient safety concerns by a team member through information, questions, or opinions in situations where clinical rules are neglected, forgotten or even unknown by a healthcare professional (HCP) in order to avoid patient harm. (Schwappach 2019)

- Systems Approach -

Using prompt, intensive investigation followed by multidisciplinary systems analysis… to [uncover] both proximal and systemic causes of errors… It is based on the concept that although individuals make errors, characteristics of the systems within which they work can make errors more likely and also more difficult to detect and correct. Further, it takes the position that while individuals must be responsible for the quality of their work, more errors will be eliminated by focusing on systems than on individuals. It substitutes inquiry for blame and focuses on circumstances rather than on character. (WHO, 2009)

- Third Victim -

The healthcare organisations who could suffer loss of reputation, depending on how the situation is handled by the institutional leaders. (Denham, 2007)

- Violation -

Deliberate deviation from an operating procedure, standard or rule. (WHO, 2009)

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References

Australian Commission on Safety and Quality in Health Care (2013), Australian Open Disclosure Framework. ACSQHC, Sydney.

Denham, C. R. (2007). TRUST: The 5 rights of the second victim. Journal of Patient Safety, 3(2), 107–119. https://doi.org/10.1097/01.jps.0000236917.02321.fd

Edmondson, A. (1999). Psychological safety and learning behavior in work teams. Administrative Science Quarterly, 44, 350–383. https://doi.org/10.2307/2666999

EU-OSHA. Near misses - OSHwiki | European Agency for Safety and Health at Work. Retrieved April 3, 2023, from https://oshwiki.osha.europa.eu/en/themes/near-misses

MacCurtain, S., Murphy, C., O'Sullivan, M., MacMahon, J., & Turner, T. (2018). To stand back or step in? Exploring the responses of employees who observe workplace bullying. Nursing Inquiry, 25, e12207. https://doi.org/10.1111/nin.12207

Griffin F, Resar R. IHI Global Trigger Tool for measuring adverse events. Second Edi. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2009.

Kahn, W. A. (1990). Psychological conditions of personal engagement and disengagement at work. Academy of Management Journal, 33, 692– 724. https://doi.org/10.2307/256287

Reason, J. (2000). Human error: models and management. BMJ, 320, 768–770.

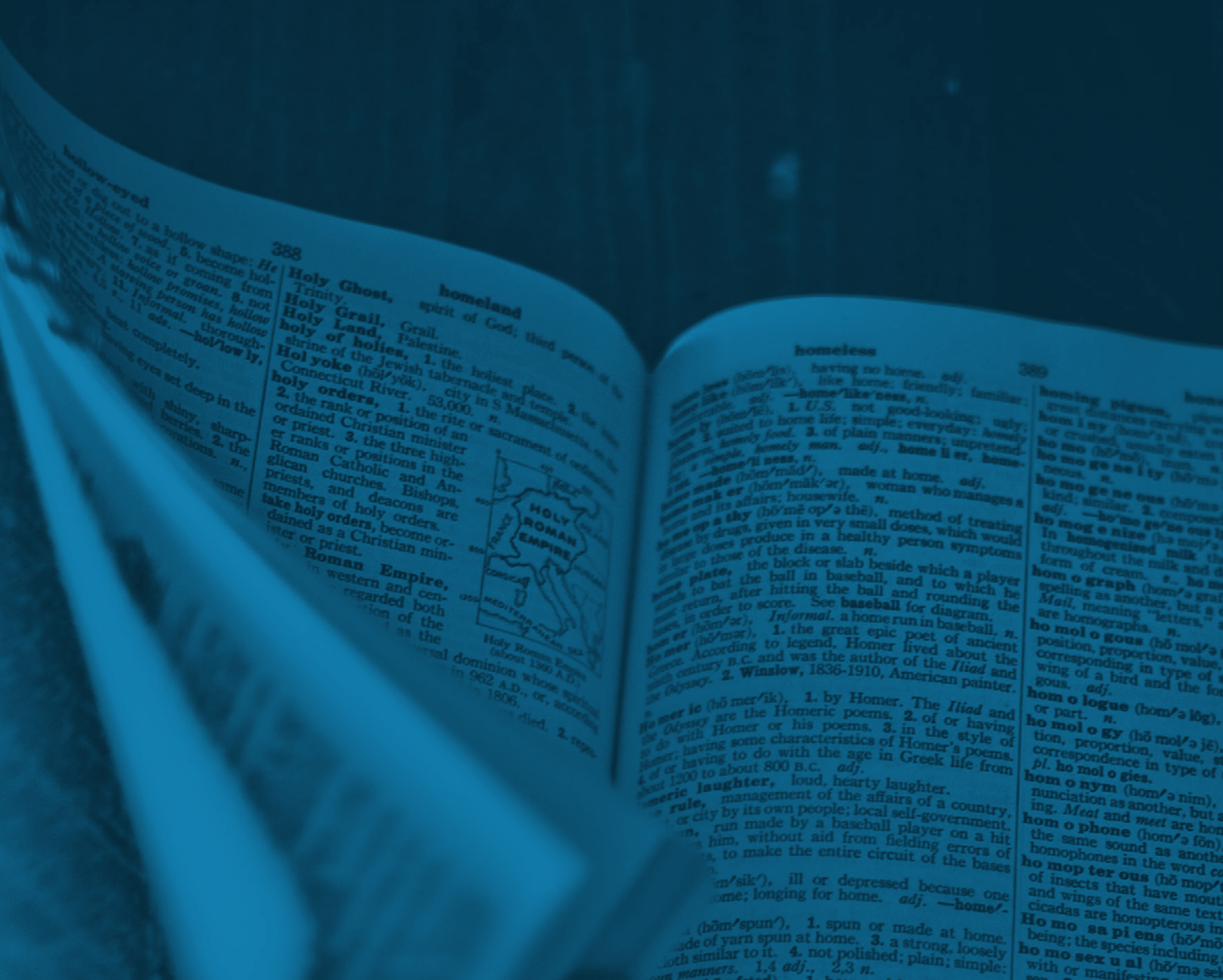
Schwappach D, Sendlhofer G, Kamolz LP, Köle W, Brunner G. Speaking up culture of medical students within an academic teaching hospital: Need of faculty working in patient safety. PLoS One. 2019;14(9):1–13.

Vanhaecht, K., Seys, D., Russotto, S., Strametz, R., Mira, J., Sigurgeirsdóttir, S., Wu, A. W., Pölluste, K., Popovici, D. G., Sfetcu, R., Kurt, S., & Panella, M. (2022). An Evidence and Consensus-Based Definition of Second Victim: A Strategic Topic in Healthcare Quality, Patient Safety, Person-Centeredness and Human Resource Management. International Journal of Environmental Research and Public Health, 19(24), 1–10. https://doi.org/10.3390/ijerph192416869

World Health Organization. Global Patient Safety Action Plan 2021-2030 Towards eliminating avoidable harm in health care. Geneva: World Health Organization; 2021.

World Health Organization. (2009). The conceptual framework for the international classification for patient safety - final technical report. World Health Organization. https://doi.org/10.1109/AERO.2013.649689

World Health Organization. (2020). Patient Safety Incident Reporting and Learning Systems: technical report and guidance. World Health Organization



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