Safety and Quality Glossary of Terms
Definitions

Hospital and Health Board members may be exposed to the safety and quality terms set out in the Glossary during their terms of appointment on the board.

A Glossary of terms from the Queensland Health Clinical Governance Framework

Word/Term	Meaning
Clinical Governance	An integrated component of corporate governance of health service organisations. It ensures that all healthcare workers and members of governing bodies, such as boards – are accountable to patients and the community for delivering safe, effective and high-quality services. Clinical governance systems provide confidence to the community and the healthcare organisation, as well as a commitment to continuously improve services.
Community of Practice	A group of people with shared interests and passions using collective critical enquiry and reflection to build a shared identity and enable continuous learning and improvement.
Consumer	A person who has used, or may potentially use, health services, or is a carer for a patient using health services.
Continuous/Quality Improvement	The combined efforts of the workforce and others – including consumers, patients and their families, researchers, planners and educators – to make changes that will lead to better patient outcomes (health), better system performance (care) and better professional development. Quality improvement activities may be undertaken in sequence, intermittently or continually.
Cultural Safety	Consumers are culturally safe when healthcare providers have considered power relations, cultural differences, and patients' rights. Essential features of cultural safety are: • An understanding of one's culture • An acknowledgement of difference, and requirement that healthcare providers are actively mindful and respectful of difference(s) • Staff are well-informed around cultural practices and have knowledge of the impact of inherent bias and racial discrimination • Informed by the theory of power relations • An appreciation of the historical context of colonisation, the practices of racism at individual and institutional levels, and their impact on Aboriginal and Torres Strait Islander people's living and wellbeing, both in the present and past • That its presence or absence is determined by the experience of the recipient of care and not defined by the healthcare provider.
Custodianship	The process of (safe)guarding, protecting and/or maintaining in relation to a person, property or records/information.
Determinants of Health (social)	The social determinants of health are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems.
Health Equity	The absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically.
Health Service Directive	Health Service Directives are issued by the Director General of the Department of Health to Hospital and Health Services (HHSs) and focused on specific requirements or outcomes to be achieved by HHSs.
Leadership	Having a vision of what can be achieved, and then communicating this to others and evolving strategies for realising the vision. Leaders motivate people and can negotiate for resources and other supports to achieve goals.
Legislative Compliance	Legislative compliance refers to the efforts that organisations undertake to ensure awareness of and compliance with relevant laws, policies and regulations.
Open Disclosure	An open discussion with a patient and/or family/carer about an incident that resulted in harm to the patient while receiving health care. The criteria of open disclosure are an expression of regret, and a factual explanation of what happened, the potential consequences, and the steps taken to manage the event and prevent recurrence.
Person-centred Care	An approach to the planning, delivery and evaluation of health care that is founded on mutually beneficial partnerships among healthcare providers and patients. Person-centred care is respectful of, and responsive to, the preferences, needs and values of patients and consumers. Key dimensions of person-centred care include respect, emotional support, physical comfort, information and communication, continuity and transition, care coordination, involvement of carers and family, and access to care. Also known as patient-centred care or consumer-centred care.
Policy	A set of principles that reflect the organisation's mission and direction.
Review	A review involves a comprehensive and factual assessment of a reported patient safety concern, through respectful collaboration with key stakeholders and collection of relevant data. Information is analysed and recommendations made to enable improvements to patient safety.
Risk Management	The design and implementation of a program to identify and avoid or minimise risks to patients, employees, volunteers, visitors and the organisation.
Safety Culture	As a component of organisational culture, safety culture refers to shared values, attitudes, perceptions, competencies and patterns of behaviour that determine the commitment to, the style and the proficiency of an organisation's patient safety management. Positive patient safety cultures have strong leadership that drives and prioritises safety as well as: • Shared perceptions, developed over time, of the importance of safety • Constructive communication and the ability for healthcare workers to speak up, and for leaders to promote and model openness and transparency • Mutual trust • A workforce that is engaged and aware that things can go wrong and that mistakes occur • Ability to recognise, respond to, give feedback about, and learn from, adverse advents and near misses.
Strategy	A healthcare strategy is a plan that guides the actions and goals of a healthcare organisation or system over a specific period of time. It can help improve the quality, efficiency, and effectiveness of healthcare services, as well as address the challenges and opportunities in the changing healthcare environment.

A glossary of key terms used within Patient safety | Health service directive | Queensland Health

Term	Definition/Explanation/Details
Clinical Incident	Any event or circumstance which has actually or could potentially lead to unintended and/or unnecessary mental or physical harm to a patient.
Flag	A point on the VLAD, identifying a predetermined level of variation has been reached i.e. more (or less) patients have experienced an outcome than expected over a period of time.
Patient safety issue	An event or circumstance that has led to patient harm or could potentially lead to patient harm.
Hospital standardised mortality ratio	The hospital standardised mortality ratio compares the observed number of deaths in a hospital with the expected number of deaths based on jurisdictional (state or national) data, using a logistic regression model that adjusts for factors that affect the risk for in-hospital death such as age, principal diagnoses, co-morbidities, length of hospital stay and route of admission.
Lower level 3 flag	A level 3 flag indicates a hospital's result is highly statistically significantly different from the State average.
Patient Safety and Quality	The Patient Safety and Quality, Clinical Excellence Queensland, Department of Health
Severity assessment code 1 (SAC1)	Death or likely permanent harm which is not reasonably expected as an outcome of healthcare.
Variable Life Adjusted Display also referred to as VLAD	A statistical methodology used to monitor patient outcomes to assist in identifying possible areas of concern or strength for safety and quality of care. It is to be interpreted and viewed with the intention to understand causation and to determine whether corrective action is necessary.
VLAD review response	Feedback from a Hospital and Health Service detailing what was considered in the review, review findings and actions.

A glossary of terms from the Variable life adjusted display and other national patient safety indicators guideline | Health service directive guideline | Queensland Health

Term	Definition / explanation / details
Variable Life Adjusted Display	A statistical methodology used to monitor patient outcomes to assist in identifying possible areas of concern or strength for safety and quality of care. It is to be interpreted and viewed with the intention to understand causation and to determine whether corrective action is necessary.
VLAD Clinical Monitoring System	An electronic information system that disseminates VLAD graphs, notification reports and captures HHS reviews/responses to VLAD flags. https://psp.bnc.health.qld.gov.au/cas/main/login.aspx
Flag	A point on the VLAD, identifying a predetermined level of variation has been reached i.e. more (or less) patients have experienced an outcome than expected over a period of time.
Lower level 3 flag	A level 3 flag indicates a hospital's result is highly statistically significantly different from the State average.
Notification report	A list of new and previous flags that have occurred within a hospital requiring a VLAD response to be submitted
Response	Feedback from a hospital detailing what was considered in the review, review findings and actions
Systems Team	The Team within PSQ responsible for production of the VLAD graphs, maintenance of VLAD CM and the first stage review of VLAD responses.
National Patient Safety Indicators	National safety and quality indicators, managed by Australian Commission on Safety and Quality in Healthcare. https://www.safetyandquality.gov.au/publications-and-resources/resource-library/national-core-hospital-based-outcome-indicator-specification

A Glossary of terms from the Patient safety notification system | Health service directive guideline | Queensland Health

Term	Definition / explanation / details
Patient safety notification	The term patient safety notification is a generic term used in this Guideline to refer to a range of different types of patient safety notifications that include patient safety alerts, patient safety notices, patient safety communiqués,
Patient safety alert	Aims to quickly disseminate information to HHSs regarding a safety matter requiring immediate mandatory attention and urgent action. It specifies mandatory action to be undertaken by HHSs, assigns responsibility for action and feedback as well as timeframes in which the action should occur.
Patient safety notice	Aims to inform HHSs regarding potential quality and safety issues requiring semi-urgent risk assessment at the local level to determine appropriate action with regards to incidents. The patient safety notice will specify that HHSs must undertake a risk assessment. It also recommends action to be taken.
Patient safety advisory	Aims to inform HHSs regarding potential quality and safety issues of lower urgency and lower risk, requiring risk assessment at the local level to determine appropriate action. The patient safety advisory will suggest HHSs undertake a risk assessment. It also recommends action to be taken.
Patient safety communiqué	A patient safety communique aims to disseminate quality and safety information to HHSs to ensure lessons learned from local, statewide, national and international sources are shared across Queensland Health in a pro-active manner.
Patient safety risk	An event or circumstance that has led to or could potentially lead to patient harm.
Risk	The potential for an event to have an impact on individuals and/or organisations. It is measured in terms of likelihood and consequence.
Statewide patient safety issues/risks	A locally identified patient safety issue/risk that may also apply to other HHS and may result in patient harm; for example; equipment failure or product fault potentially resulting in death.

A Glossary of terms from the Best practice guide to clinical incident management (health.qld.gov.au)

Term	Description
Clinical Incident	An event or circumstance that resulted, or could have resulted in unintended and/or unnecessary harm to a patient or consumer; or a complaint, loss or damage. An incident may also be a near miss.
Just Culture	A just culture is a culture is an environment that seeks to balance the need to learn from mistakes and the need to take disciplinary action.
Near Miss	An event or situation that could have resulted in an accident, injury or illness, but did not, either by chance or through timely intervention
Patient	A person who is a recipient of healthcare. Synonyms for patient include 'consumer' and 'client'.
Patient Safety	Actions undertaken by individuals and organisations to protect health care recipients from being harmed by the effects of health care services.
Patient Safety Entity	An entity, specified within the Hospital and Health Boards Act 2011, whose responsibilities include the planning, implementation, management and evaluation of patient safety initiatives and programs for a health service
Preventable Event	An event that could have been anticipated and prepared for, but that occurs because of an error or other system failure.
Quality Improvement	Quality improvement is the framework used to systematically improve care. Quality improvements seeks to standardize processes and structure to reduce variation, achieve predictable results, and improve outcomes for patients, healthcare systems, and organisations
Restorative Just Culture	Restorative just culture aims to repair trust and relationships damaged after an incident. It allows all parties to discuss how they have been affected, and collaboratively decide what should be done to repair harm.
Risk Assessment	An assessment that examines a process in detail, including sequencing of events; assesses actual and potential risk, failure, or points of vulnerability; and, through a logical process, prioritizes areas for improvement based on the actual or potential patient care impact (criticality).
Root Cause Analysis (RCA)	A systematic process of investigating a critical incident or an adverse outcome to determine the multiple, underlying contributing factors. The analysis focuses on identifying the latent conditions that underlie variation in performance and, if applicable, developing recommendations for improvements to decrease the likelihood of a similar incident in the future.
Safety I	Safety I takes accidents as the focus point and tries to prevent harm occurring
Safety II	Safety II emphasis is on ensuring that as much as possible goes right, expanding beyond the area of incident prevention to promoting a real safety management approach over a simple risk assessment.
Severity Assessment Code (SAC)	Queensland Health SAC applies four SAC categories to capture the severity and duration of harm that results from an incident. • SAC1 death or likely permanent harm which is not reasonably expected as an outcome of healthcare • SAC2 temporary harm which is not reasonably expected as an outcome of healthcare • SAC3 minimal harm which is not reasonably expected as an outcome of healthcare • SAC4 no harm or near miss
Surveillance	Routine collection and review of data to examine the extent of a disease, to follow trends, and to detect changes in disease occurrence.
Systems Analysis	An analysis of the resources (personnel, facilities, equipment, materials, funds, and other elements), organization, administration, procedures, and policies needed to carry out a given task. The analysis typically addresses alternatives in each category, and their relative efficiency and effectiveness.
System Failure	The common categories [of systems failure] include failures of design (process design, task design, and equipment design) and failures of organization and environment (presence of psychological precursors such as conditions of the workplace, schedules, etc.; inadequate team building; and training failures).
System Improvement	The result or outcome of the culture, processes, and structures that are directed toward the prevention of system failure and improvement of safety and quality.
Underlying Cause	The systems or process cause that allow for the proximate cause of an event to occur. Underlying causes may involve special-cause variation, common-cause variation, or both.

A glossary of terms taken from the Australian Commission on Safety and Quality in Health Care.

Term	Definition / explanation / details
Accreditation	Accreditation is an evaluation process that involves assessment by qualified external peer reviewers to assess a health service organisation's compliance with safety and quality standards.
Accrediting Agencies	The Commission approves accrediting agencies to assess health services to the NSQHS Standards, MPS Module, and/or the National Clinical Trials Governance Framework under the Australian Health Service Safety and Quality Accreditation Scheme. Approved accrediting agencies contact details | Australian Commission on Safety and Quality in Health Care
The National Safety and Quality Health Service (NSQHS) Standards	Developed by the Australian Commission on Safety and Quality in Health Care in collaboration with the Australian Government, states and territories, the private sector, clinical experts, patients and carers. They provide a quality assurance mechanism that tests whether relevant systems are in place to ensure that expected standards of safety and quality are met. The eight NSQHS Standards are: • Clinical governance • Partnering with consumers • Preventing and controlling healthcare-associated infections • Medication safety • Comprehensive care • Communicating for safety • Blood management • Recognising and responding to acute deterioration
Australian Health Service Safety and Quality	Under the National Health Reform Act 2011, the Australian Commission on Safety and Quality in Health Care (the Commission) is responsible for the formulation of standards relating to health care safety and quality matters. This

Accreditation Scheme (AHSSQA)	includes formulating and coordinating the AHSSQA Scheme, which provides for the national coordination of accreditation processes.
Attestation Statement	Attesting to compliance is a formal process. It involves the chair of a governing body or proprietor of a health service organisation confirming the governing body fully complied with actions in the NSQHS Standards and the National Clinical Trials Governance Framework, or parts thereof, relating to the responsibilities of governing bodies generally for Governance, Leadership and Culture. It is mandatory for all hospitals and day procedure services to submit an annual attestation statement.
Action rated 'not-met'	Part or all the requirements of the action were not met; improvements were required.
Action rated 'met with recommendation"	The requirements of an action were largely met across the organisation, with the exception of a minor part of the action in a specific service.
Mandatory Reassessment	Organisations that have a number of actions not met are required to undertake a further assessment within six months of the assessment being finalised. The criteria are: • The number of actions rated not met and met with recommendations combined, equals or is greater than 16 per cent of all assessed actions • The number of actions, from the Clinical Governance Standard that are rated not met, equals or is greater than eight.

Queensland Government