

Table 1. Definitions of the 24 terms of the vocabulary.

NO	TERM	DEFINITION
DETECTION OF RISK		
1	Patient Safety	The continuous identification, analysis and management of patient-related risks and incidents in order to make patient care safer and minimising harm to patients. Safety emerges from interaction of the components of the system. Improving safety depends on learning how safety emerges from such interactions.
2	Adverse Event	An unintended and undesired occurrence in the healthcare process because of the performance or lack of it of a healthcare provider and/or the healthcare system. <i>Please note: In this vocabulary adverse events are considered as preventable (Please see Diagram 1) although realising, that the clinical distinction between preventable and non preventable events is rather academic.</i>
3	Actual Event	An adverse event, which causes harm.
4	Near Miss (sub-event)	An adverse event, with the capacity to cause harm but which does not have adverse consequences, because of for instance timely and appropriate identification and correction of potential consequences for the patient.
5	Complication	An unintended and undesired outcome which develops as a consequence of intervention of an already present illness. It may be non preventable under the given circumstances. <i>Please note the related definition of term number 12; “Adverse Outcome”.</i>
6	Sentinel Event	Sentinel reflects the seriousness of the injury and the likelihood that investigation of an event will reveal serious problems in current policies or procedures. Such occurrences signal the need for immediate investigation and response.
7	Critical Incident	Occurrences, which are significant or pivotal, in either a desirable or an undesirable way. Significant or pivotal means that there was significant potential for harm (or actual harm), but also that the event has the potential to reveal important hazards in the organisation. In other words, these incidents, whether near misses or events in which significant harm occurred, provide valuable opportunities to learn about individual and organisational factors that can be remedied to prevent similar incidents in the future.
8	Complaint	Each expression of resentment or discontent with the practice, operation or conduct of a healthcare provider made by a potential user or a user of the health care services or someone acting on their behalf.
9	Reporting System	A system which is designed to contain reports on adverse events. On the basis of reports analysis and communication of known causes and risk situations is possible. The system can contain reports on human and technical errors as well as organisational circumstances, which affects the occurrence of adverse events in the health care process. Reporting systems include input from all stakeholders – providers and service users.
10	Professional Standard	The standard of performance in particular circumstances taking into account recent insights and evidence-based norms and a standard of practice to be expected of a comparable experienced and qualified prudent practitioner in equal circumstances. <i>Please note the related definition of term number 24; “Negligence”.</i>

Table 1. Definitions of the 24 terms of the vocabulary (cont.)

NO	TERM	DEFINITION
ANALYSIS OF RISK		
11	Harm	Negative consequence experienced by a patient leading to; death, a permanent or temporary impairment of physical, mental or social function or a more intense or prolonged treatment.
12	Adverse Outcome	An unintended and undesired occurrence in the healthcare process, which causes harm to the patient. <i>Please note related definition of term number 5; “Complication”</i>
13	Risk	The probability or chance that something undesirable will happen. A measure of the probability and severity of potential harm.
14	Calculated Risk	A deliberately and consciously taken risk in which the benefits of a treatment are deemed to offset/countervail the possible burden of serious harm.
15	Barrier	Protect people and structures from adverse events.
16	Situational Awareness	Refers to the degree to which one’s perception of a situation matches reality.
RESULTING ACTIONS		
17	Risk Management	Identifying, assessing, analysing, understanding, and acting on risk issues in order to reach an optimal balance of risk, benefits and costs.
18	Error Management	An approach to manage the aftermath of an error with the goal of reducing future errors, avoiding negative consequences and dealing quickly with consequences once they occur.
19	Action Plan	An Action Plan can be the result of analysis of adverse events. The Action Plan addresses system and process deficiencies; improvement strategies are developed and implemented.
20	Culture of Safety	An integrated pattern of individual and organisational behaviour, based upon shared beliefs and values that continuously seeks to minimise patient harm, which may result from the processes of care delivery.
21	Human Factor	Refers to the study of human abilities, behaviours and characteristics as they affect the design and suggested intended operation of equipment, systems, and jobs. The field concerns itself with considerations of the strengths and weaknesses of human behaviour, physical and mental abilities and how these affect the systems design.
FAILURE MODE		
22	Error	Preventable event leading to an adverse outcome being either an act of commission (doing something wrong) or omission (failing to do the right thing) that leads to an undesirable outcome or having significant potential for such an outcome.
23	Situational Factor	The factor in a process, which activates an error in the system.
24	Negligence	Care provided failed to meet the standard of care reasonably expected of a reasonably prudent and careful practitioner qualified to care for the patient in question. <i>Please note the related definition of term number 10; “Professional standard”</i>

