5.12: V Glossary

**At-risk behavior:** According to the Just Culture model, an error that occurs when a behavioral choice is made that increases risk where risk is not recognized or is mistakenly believed to be justified.

**Chemical restraint:** A drug used to manage a patient’s behavior, restrict the patient’s freedom of movement, or impair the patient’s ability to appropriately interact with their surroundings that is not a standard treatment or dosage for the patient’s condition.

**Culture of safety:** The behaviors, beliefs, and values within and across all levels of an organization as they relate to safety and clinical excellence, with a focus on people.

**Handoff reports:** A transfer and acceptance of patient care responsibility achieved through effective communication. It is a real-time process of passing patient specific information from one caregiver to another, or from one team of caregivers to another, for the purpose of ensuring the continuity and safety of the patient’s care.

**Healthy environment:** A place of physical, mental, and social well-being supporting optimal health and safety.

**Human factors:** A science that focuses on the interrelationships between humans, the tools and equipment they use in the workplace, and the environment in which they work.

**Intimate Partner Violence (IPV):** Physical or sexual violence, stalking, and psychological or coercive aggression by current or former intimate partners.

**ISBARR:** A mnemonic for the components of health care team member communication that stands for Introduction, Situation, Background, Assessment, Request/Recommendations, and Repeat back.

**Just Culture:** A quality of an institutional culture of safety where people feel safe raising questions and concerns and
reporting safety events in an environment that emphasizes a nonpunitive response to errors and near misses, but clear lines are drawn between human error, at-risk, and reckless behaviors.

**Learning Culture**: A quality of an institutional culture of safety where people regularly collect information and learn from errors and successes. Data is openly shared and evidence-based practices are used to improve work processes and patient outcomes.

**National Patient Safety Goals**: Annual patient safety goals and recommendations tailored for seven different types of health care agencies based on patient safety data from experts and stakeholders.

**Near misses**: An unplanned event that did not result in a patient injury or illness but had the potential to.

**Never events**: Adverse events that are clearly identifiable, measurable, serious (resulting in death or significant disability), and preventable.

**Reckless behavior**: According to the Just Culture model, an error that occurs when an action is taken with conscious disregard for a substantial and unjustifiable risk.

**Reporting Culture**: A quality of an institutional culture of safety where people realize errors are inevitable and are encouraged to speak up for patient safety by reporting errors and near misses.

**Restrain**: A device, method, or process that is used for the specific purpose of restricting a patient’s freedom of movement without the permission of the person.

**Root cause analysis**: A structured method used to analyze serious adverse events to identify underlying problems that increase the likelihood of errors, while avoiding the trap of focusing on mistakes by individuals.

**Scheduled hourly rounds**: Scheduled hourly visits to each patient’s room to integrate fall prevention activities with the rest of a patient’s care.

**Seclusion**: The confinement of a patient in a locked room from which they cannot exit on their own. It is generally used as a method of discipline, convenience, or coercion.

**Sentinel event**: An unexpected occurrence involving death or serious physiological or psychological injury or the risk thereof.

**Simple human error**: According to the Just Culture model, this is an error that occurs when an individual inadvertently does something other than what should have been done. Most errors are the result of human error due to poor processes, programs, education, environmental issues, or situations. These are managed by correcting the cause, looking at the process, and fixing the deviation.

**Substance abuse**: A maladaptive pattern of continued use of alcohol or a drug despite it causing persistent social, occupational, psychological, or physical problems that can be physically hazardous.

**Universal fall precautions**: A set of interventions to reduce the risk of falls for all patients and focus on keeping the environment safe and comfortable.