**Key Definitions** *(For purposes of the 2011 ISMP Medication Safety Self Assessment for Hospitals)*

**HIGH-ALERT MEDICATIONS (OR DRUGS)**
Medications that bear a heightened risk of causing significant patient harm when they are used in error. Although mistakes may or may not be more common with these drugs, the consequences of an error are more devastating to patients. Examples of high-alert medications include heparin, warfarin, insulin, chemotherapy, potassium chloride for injection concentrate, opioids, neuromuscular blocking agents, antithrombotic agents, and adrenergic agonists. (A complete list can be found at: [www.ismp.org/Tools/highalertmedications.pdf](http://www.ismp.org/Tools/highalertmedications.pdf).)

**IMPLEMENTED**
Accomplished or achieved in practice, not just in policy: to carry into effect.

**MEDICATION (OR DRUG)**
Medication includes: prescription medications; sample medications; herbal remedies; vitamins; nutraceuticals; over-the-counter drugs; vaccines; diagnostic and contrast agents used on or administered to persons to diagnose, treat, or prevent disease or other abnormal conditions; radioactive medications; respiratory therapy treatments; parenteral nutrition; blood derivatives; intravenous solutions (plain, with electrolytes and/or drugs); and any product designated by the Food and Drug Administration (FDA) as a drug. The definition of medication does not include enteral nutrition solutions (which are considered food products), oxygen, and other medical gases.

**PRACTITIONER**
A licensed healthcare professional who is authorized within the institution to prescribe, dispense, or administer medications, such as a physician, physician assistant, nurse anesthetist, nurse practitioner, nurse, pharmacist, or respiratory therapist.

**UNIT STOCK**
Medications that are not labeled or stored for a specific patient and that are available outside the pharmacy. This would include medications stored in medication rooms, refrigerators, storage cabinets, and automated dispensing cabinets (ADCs), for potential administration to various patients.

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<thead>
<tr>
<th>AT-RISK BEHAVIOR</th>
<th>CLOSE CALL</th>
<th>COACH</th>
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<td>A BEHAVIORAL CHOICE that increases risk where risk is not recognized or is mistakenly believed to be justified. Examples of common AT-RISK BEHAVIORS include: bypassing a duplicate therapy alert during order entry without due consideration; technology work-arounds; removing more than one patient’s medications from an automated dispensing cabinet prior to administration; written orders or documentation that include ERROR-PRONE ABBREVIATIONS.</td>
<td>An error that took place but was captured before reaching the patient. For example, penicillin was ordered for a patient allergic to the drug; however, the pharmacist was alerted to the allergy during computer order entry, the prescriber was called, and the penicillin was not dispensed or administered to the patient. Or the wrong drug was dispensed by pharmacy, and a nurse caught the error before it was administered to the patient.</td>
<td>A supportive discussion among staff (peer-to-peer or manager-to-workers) intended to: 1) help staff see the risks associated with their BEHAVIORAL CHOICES that were not seen or were misread as being insignificant or justifiable, 2) learn the incentives that encourage these AT-RISK BEHAVIORS, and 3) help staff make safer BEHAVIORAL CHOICES in the future.</td>
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The following defined terms are designated throughout the text of the self assessment in **BOLD, SMALL CAPITAL LETTERS**. In the online version of the assessment, these terms are highlighted in blue and are linked to their definition.
**COMPUTER ORDER ENTRY SYSTEM**
Refers to any computer system into which medical orders are entered, including pharmacy computer systems into which pharmacy staff enter or validate medication orders, as well as computerized prescriber order entry (CPOE) systems into which medical staff enter medication orders.

**DEEP SEDATION**
An induced state of sedation characterized by depressed consciousness such that the patient is unable to continuously and independently maintain a patent airway and respiratory rate, and experiences a partial loss of protective reflexes and ability to respond to verbal commands or physical stimulation.

**ERROR-PRONE ABBREVIATIONS**
Certain medical abbreviations, symbols, and dose designations that are considered “dangerous” and have often contributed to serious medication errors. A complete list can be found at: www.ismp.org/Tools/errorproneabbreviations.pdf.

**FAILURE MODE AND EFFECTS ANALYSIS (FMEA)**
A proactive risk assessment method based on the simultaneous analysis of possible failure modes, their consequences, and associated risk factors. Also referred to as Failure Mode Effects and Criticality Analysis (FMECA) and Healthcare Failure Mode and Effects Analysis (HFMEA).

**HUMAN ERROR**
Inadvertently doing other than what should have been done; a mental slip, lapse, or mistake such as miscalculating a dose, forgetting to dilute a medication, or transposing the doses of two antibiotics while prescribing the medications. **HUMAN ERRORS** are unintentional acts, not a behavioral choice.

**HUMAN FACTORS**
The study of the interrelationships between humans, the tools they use, and the environment in which they work and live.

**INDEPENDENT DOUBLE CHECK**
A procedure in which two individuals, preferably two licensed practitioners, separately check each component of the work process. An example would be one person calculating a medication dose for a specific patient and a second individual independently performing the same calculation (not just verifying the calculation) and matching results.

**INTERFACED**
A direct link between two information systems such that the information from one system is immediately available to the user of the second system and integrated into the system in a way that supports clinical decision making (e.g., INTERFACING the laboratory and pharmacy computer systems would immediately provide corresponding laboratory data to the pharmacist while he/she is entering or reviewing a specific medication order). This may or may not include a bi-directional **INTERFACE** of the two systems to allow communication in both directions.

**JUST CULTURE**
Refers to a safety-supportive model of shared accountability where healthcare institutions are accountable for the systems they design, for supporting the safe behavior choices of patients, visitors, and staff, and for responding to staff behaviors in a fair and just manner. In turn, staff are accountable for the quality of their **BEHAVIORAL CHOICES** (HUMAN ERROR is not a behavioral choice) and for reporting their errors and system vulnerabilities.

**LICENSED INDEPENDENT PRACTITIONER**
An individual permitted by law and by the organization to provide care, treatment, and services without direct supervision.

**MAXIMUM DOSE**
The dose of a medication that represents the upper limit that is normally found in the literature and/or manufacturer recommendations. **MAXIMUM DOSES** may vary according to age, weight, or diagnosis.
**MEDICATION DEVICE**
Equipment such as infusion pumps, implantable pumps, syringes, pen devices that contain medication (e.g., EPINEPHrine, insulin), tubing, patient-controlled analgesia pumps, automated compounding devices, robotics, and other related devices that are used for medication preparation, dispensing, and administration.

**MNEMONICS**
A limited number of letters and/or numbers that are used to represent a specific medication (e.g., ASA80 may represent aspirin 80 mg tablets).

**MODERATE SEDATION**
An induced state of sedation characterized by a minimally depressed consciousness such that the patient is able to continuously and independently maintain a patent airway and respiratory rate, retain protective reflexes, and remain responsive to verbal commands and physical stimulation.

**NURSE-CONTROLLED ANALGESIA**
The intermittent dosing of a patient-controlled analgesia pump or device performed by a nurse or other licensed practitioner rather than the patient. This practice should only be performed by nursing protocol when patients are capable of requesting a dose of medication within the prescribed limits, but not capable of performing the function themselves.

**PATIENT-SPECIFIC MEDICATION (OR DOSE)**
A ready-to-administer PATIENT-SPECIFIC DOSE of medication that exactly matches the dose ordered by the prescriber. This may or may not correspond to the manufacturer UNIT-DOSE package. (See UNIT DOSE.)

**PHARMACY AND THERAPEUTICS COMMITTEE**
An interdisciplinary committee that convenes on a scheduled basis, or when necessary, to review the safety, use, efficacy, and monitoring of medications that will be available for use in the hospital. The committee also sets policy and procedures, on behalf of the medical staff and hospital administration, on the safety of the entire medication use process.

**POTENTIAL ADVERSE DRUG EVENTS**
Conditions associated with drug therapy that could lead to patient harm, or an incident related to drug therapy with the potential for harm. An example is a patient who received penicillin despite a known allergy to penicillin, but did not have a reaction. Included in this category are potentially harmful errors that have been intercepted before reaching the patient as well as those that have reached the patient.

**POTENTIAL ADVERSE EVENTS**
Conditions that could lead to patient harm, or an incident related to the medical management of the patient with the potential for harm. An example is a patient who fell in the bathroom but did not sustain an injury. Included in this category are potentially harmful errors that have been intercepted before reaching the patient as well as those that have reached the patient.

**PROACTIVE RISK ASSESSMENT**
The process of identifying and systematically analyzing the risk and hazards embedded in the process and structure of care to prevent adverse events from occurring. Knowing where the risk and hazards are helps to inform the design, planning, and development of appropriate interventions that will eliminate or minimize risk and hazards before patient injuries occur.

**RECKLESS BEHAVIOR**
A behavioral choice to consciously disregard a substantial and unjustifiable risk. The person engaging in reckless behavior: 1) always perceives the risk he/she is taking, 2) understands that the risk is substantial, 3) does not mistakenly believe the risk is justified, 4) behaves intentionally, 5) knows others are not engaging in the same behavior, and 6) is unable to justify his/her behavior through an objective risk-benefit analysis. Examples include: reusing a dropped surgical instrument knowing that the action could result in a serious hospital-acquired infection, and working while under the influence of alcohol.
ROOT CAUSE ANALYSIS (RCA)
A retrospective process for identifying the most basic or causal factor(s) that underlies the occurrence or possible occurrence of an adverse event.

RULE OF 6
A formula, originally designed for pediatric emergencies, in which the amount of drug to add to a set volume of solution and the rate of infusion are calculated using the following guidelines: $6 \times$ weight in kilograms (kg) equals the amount of drug in milligrams (mg) that should be added to 100 mL of solution. The infusion volume in mL per hour then equals the mcg/kg/minute dose ordered. For example, a drug ordered at 10 mcg/kg/minute would equal an infusion rate of 10 mL per hour using the RULE OF 6.

SMART INFUSION PUMP/SMART PUMP TECHNOLOGY
An infusion pump with computer software that is, at a minimum, capable of alerting the user to unsafe dose limits and programming errors if standard concentrations and dose limits have been programmed into the pump’s library.

SYSTEM DESIGN/REDESIGN
Refers to the design/redesign of processes, procedures, equipment, INTERFACES, overall structure, and the environment or conditions under which staff work, for the purpose of satisfying specific requirements, such as patient safety. The design of a system dictates how reliable it is in terms of satisfying specific requirements.

TALL MAN LETTERS
Refers to the use of mixed case letters to help draw attention to the dissimilarities of certain look-alike drug name pairs. A list of look-alike drug names with recommended TALL MAN LETTERS can be found at: www.ismp.org/Tools/tallmanletters.pdf.

UNIT DOSE
A single package that contains one dose of a medication intended for one patient (e.g., a package with one tablet, one single-use vial of parenteral medication, 5 mL container holding one dose of liquid medication). (See PATIENT-SPECIFIC MEDICATION.)

WALKROUNDS™
A formal process in which a core group, including senior executives, conducts weekly visits to different areas of the hospital to ask specific questions about adverse events or CLOSE CALLS and about the factors or systems issues that lead to these events. (Frankel A, Graydon-Baker E, Neppl C, et al. Patient safety leadership WalkRounds™. Jt Comm J Qual Safety. 2003;29:16-26.)