Definition of Key Terms

Adverse Event	An injury caused by medical management rather than the patient's underlying condition. A preventable adverse event is an adverse event attributable to an error or system failure (IOM 1998, 28).
Close Call or 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 (QuIC 2000).
Crew Resource Management Training	Considers human performance limiters (such as fatigue and stress) and the nature of human error, and it defines behaviors that are countermeasures to error, such as leadership, briefings, monitoring and cross-checking, decision making, and review and modification of plans (Helmreich 2000, 783).
Error	Failure of a planned action to be completed as intended or use of a wrong plan to achieve an aim (IOM 1999, 28; Reason 1990, 9).
Failure Modes and Effects Analysis	A systematic, proactive method for evaluating a process to identify where and how it might fail and to assess the relative impact of different failures in order to identify the parts of the process that most need change (IHI 2005a).
High Reliability Organization	Highly complex, technology-intensive organizations that must operate, as far as humanly possible, according to a failure-free standard (Reason 1997, 213).
Human Factors	The study of the interrelationships among humans, the tools they use, and the environment in which they live and work (IOM 1999, 63).
Patient Safety	Freedom from accidental injury or, more broadly, avoiding injuries to patients from the care that is intended to help them (IOM 1999, 58; 2001, 5).
Root Cause Analysis	A structured process for identifying the causal or contributing factors underlying adverse events or close calls (AHRQ 2005).
Situational Awareness	Refers to the degree to which one's perception of a situation matches reality, including awareness of fatigue and stress among team members (including oneself) environmental threats to safety, appropriate immediate goals, and the deteriorating status of the crisis or patient (AHRQ 2005).
System	A set of interdependent elements interacting to achieve a common aim. These elements may be both human and nonhuman (equipment, technologies, etc.) (IOM 1999, 52)