DEFINITIONS

Below is a list of terms used in the self-assessment that have specific meanings. Where used these terms are capitalised. If using the online database, scroll over the word to see its definition.

Definition Descriptions	
AT-RISK BEHAVIOUR	A BEHAVIOURAL CHOICE that increases risk where risk is not recognized or is mistakenly believed to be justified. Examples of common AT-RISK BEHAVIOURS include: bypassing a duplicate therapy alert during order entry without due consideration; technology work-around; removing more than one patient's medications from an automated dispensing cabinet prior to administration; written orders or documentation that include ERROR-PRONE ABBREVIATIONS.
BEHAVIOURAL CHOICES	Refers to intentional acts that are undertaken by the free exercise of one's judgment. Unlike HUMAN ERROR, which is unintentional behaviour, BEHAVIOURAL CHOICE represents the purposeful behaviour we intentionally employ while engaging in our day-to-day activities.
CLINICAL INFORMATION SYSTEM	Refers to any computer system into which medication information is entered and accessed by PRACTITIONERS. This includes systems into which pharmacy staff enter or validate medication orders and prescribers order entry systems into which medical staff enter medication orders.
CLINICAL PHARMACY SERVICE	A team of pharmacists that provide services aimed at minimising the inherent risks associated with the use of medicines, increasing patient safety at all steps in the medicines management pathway and optimising health outcomes. These activities include: medication reconciliation; assessment of current medication management; clinical review, therapeutic drug monitoring and adverse drug reaction management; contributing to the Medication Management Plan; providing medicines information; facilitating continuity of medication management on discharge or transfer; participating in interdisciplinary ward rounds and meetings; training and education; participating in research; quality improvement activities and peer review. (*SHPA Standards of Practice for Clinical Pharmacy Services* http://jppr.shpa.org.au/Current-issue/JPPR-2013/JPPR-June-2013/N)
CLOSE CALLS	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.
COACH	A supportive discussion among staff (peer-to-peer or manager-to-workers) intended to: 1) help staff see the risks associated with their BEHAVIOURAL CHOICES that were not seen or were misread as being insignificant or justifiable, 2) learn the incentives that encourage these AT-RISK BEHAVIOURS, and 3) help staff make safer BEHAVIOURAL CHOICES in the future.
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.
DRUG AND THERAPEUTICS COMMITTEE	A multidisciplinary committee with a commitment to the overall governance of the medicines management system in their health service organisation to ensure the judicious, appropriate, safe, effective and cost-effective use of medicines. For additional information on DRUG AND THERAPEUTICS COMMITTEES and their role in medicines governance please refer to CATAG's *Achieving Effective Medicines Governance: Guiding Principles for the Roles and Responsibilities of Drug and Therapeutics Committees in Australian Public Hospitals* (www.catag.org.au/resources).

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Definition Descriptions	
ERROR-PRONE ABBREVIATIONS	Certain medical abbreviations, symbols, and dose designations that are considered dangerous and have often contributed to serious medication errors. The Australian Commission on Safety and Quality in Health Care published the *Recommendations for Terminology, Abbreviations and Symbols used in the Prescribing and Administration of Medicines* which contains a list of error-prone abbreviations that should be avoided.
FAILURE MODE AND EFFECTS ANALYSIS	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).
HIGH RISK MEDICINES/ HIGH RISK IV SOLUTIONS/ HIGH RISK INFUSIONS	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 RISK MEDICINES include heparin, warfarin, insulin, chemotherapy, concentrated electrolytes, opioids, neuromuscular blocking agents, antithrombotic agents, and adrenergic agonists. (ISMP provides a list of high-alert medicines at: www.ismp.org/Tools/highalertmedications.pdf and the Australian Commission on Safety and Quality in Health Care has a webpage dedicated to HIGH RISK MEDICINES http://www.safetyandquality.gov.au/our-work/medication-safety/medication-alerts/).
HUMAN ERRORS	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 BEHAVIOURAL CHOICE.
HUMAN FACTORS	The study of the interrelationships between humans, the tools they use, and the environment in which they work.
INDEPENDENT DOUBLE CHECK	A procedure in which two individuals, preferably two registered 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 the results. This would involve for example, checking the accuracy of the dose/kg and the weight being used in the calculation. In the case of receiving a telephone order an INDEPENDENT DOUBLE CHECK means that the order must be read back to the prescriber (in figures and words –e.g. 50mg: fifty milligrams, five 0 mg). As a further check, the prescriber should repeat the order to a second person.
INTERFACE	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 behaviour choices of patients, visitors, and staff, and for responding to staff behaviours in a fair and just manner. In turn, staff are accountable for the quality of their BEHAVIOURAL CHOICES (HUMAN ERROR is not a BEHAVIOURAL CHOICE) and for reporting their errors and system vulnerabilities.

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Definition Descriptions	
MACHINE-READABLE CODING	An encoded identifying mark or electronic tag (e.g. bar code) representing data that can be read with a computerised reading device, such as a scanner or imager.
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 DEVICES	Equipment such as infusion pumps, implantable pumps, syringes, pen devices that contain medication (e.g., adrenaline, insulin), tubing, patient-controlled analgesia pumps, automated compounding devices, robotics, and other related devices that are used for medication preparation, dispensing, and administration.
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 and rhythm, retain protective reflexes, and remain responsive to verbal commands and physical stimulation.
NEAR MISSES	Refer to definition for CLOSE CALLS.
PATIENT-SPECIFIC DOSE/MEDICATION	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).
PHARMACEUTICAL REVIEW	PHARMACEUTICAL REVIEW is a minimum standard of systematic appraisal of all aspects of patients' medication management within an institution conducted or supervised by a qualified and suitably trained health professional (ideally a pharmacist) acting as part of a multidisciplinary team. It includes objective review of medication prescribing, dispensing, distribution, administration, monitoring of outcomes and documentation of medication related information in order to optimise Quality Use of Medicines.
PRACTITIONER	A registered healthcare professional who is authorised within the hospital to prescribe, dispense, or administer medications (such as a doctor, nurse or pharmacist).
PRESCRIBER ORDER ENTRY SYSTEM	A computerised system into which prescribers can directly enter medication orders. Also known as "e-prescribing".
RECKLESS BEHAVIOURS	A BEHAVIOURAL CHOICE to consciously disregard a substantial and unjustifiable risk. The person engaging in RECKLESS BEHAVIOUR: 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 behaviour, and 6) is unable to justify his/her behaviour 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	A retrospective process for identifying the most basic or causal factor(s) that underlies the occurrence or possible occurrence of an adverse event. The hospital governing body or executive should regularly monitor safety and quality data, as well as take action to improve the safety and quality of patient care (refer to Criterion 1.2 from the ACSQHC *National Safety and Quality Health Service Standards*). The governing body or executive should endeavour to put the findings of ROOT CAUSE ANALYSIS into action.

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Definition Descriptions	
SMART PUMP TECHNOLOGY/ SMART INFUSION PUMP	An infusion pump with computer software that is 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.
STANDARD ORDER SET	A pre-populated order for multiple medications for a particular treatment regime against which the prescriber may include additional particulars, such as dosage calculations. Includes digital forms created in an electronic medication management system and hard copy forms, including those that combine a medication chart format with non-handwritten hard copy orders or prescriptions.
STAT	In the context of medication administration "stat" is used as an abbreviation to mean "give as a single dose immediately". The expected time of administration should be specified whenever a stat dose is prescribed.
SYSTEM DESIGN	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	TALL-MAN LETTERING is a method for differentiating between drug names that look similar and may be confused. It involves the use of lower and upper case letters to help make medication names more easily distinguishable (e.g. fluoxetine and fluVOXAMine). The Australian Commission on Safety and Quality in Health Care has compiled a *National Tall Man Lettering List* comprising of look-alike, sound-alike names predicted to pose the greatest risk. The national list is available from http://www.safetyandquality.gov.au/our-work/medication-safety/safer-naming-labelling-and-packaging-of-medicines/national-tall-man-lettering/.
UNIT-DOSE	UNIT-DOSE is a system of packaging whereby each dosage unit is separately packed in a protectively sealed unit and labelled with the name of the medicine, strength, dose contained within the pack, batch number and expiry date. The presentation should minimise or eliminate the preparation required for the medicine to be administered. UNIT-DOSE packaging should be consistent with requirements of the Society of Hospitals Pharmacists of *Australia Drug Design and Presentation Guidelines*. The advantage of a unit dose system is that each dosage unit is identifiable up to the point of administration. Dosage integrity minimises wastage as unused doses may be reissued. (For more information, refer to the Society of Hospital Pharmacists of Australia *Standards of Practice for the Distribution of Medicines in Australian Hospitals*. June 2006. J Pharm Pract Res 2006; 36(2): 143-9).
UNIT-OF-USE	This distribution system is based on dispensing individual patient supplies for a short period in a presentation that minimises or eliminates the preparation required for the medicine to be administered. Medicines are usually dispensed in UNIT-DOSE packs or in individually labelled containers. The amount of medicine dispensed should be determined by hospital policy; three to seven days is commonly used in acute care facilities. For more information refer to the Society of Hospital Pharmacists of Australia *Standards of Practice for the Distribution of Medicines in Australian Hospitals*. June 2006, J Pharm Pract Res 2006; 36(2): 143-9).