ALTARUM
HEALTHCARE VALUE HUB

Glossary: Medical Harm

Medical harm—largely preventable events caused by human error in healthcare facilities—is a top 5 cause of death in the United States,[1] despite various strategies to address patient safety concerns. This mini-glossary lists terms that may be encountered in policy discussions related to reducing the frequency of medical harm. For additional detail, please see our Taxonomy of Medical Harm.

Term	Acronym	Definition
Adverse Event	AE	Unintended physical injury resulting from or contributed to by medical care (or lack thereof) that: (1) creates a need for additional monitoring, treatment or hospitalization or (2) results in death. Includes never events. See *Never Events.*
Catheter-Associated Urinary Tract Infection	CAUTI	A type of healthcare-associated infection that is commonly acquired through a urinary catheter in hospital settings. As prevention is possible, CAUTIs are an indicator of the frequency of medical harm events. See *Healthcare-Associated Infection*.
Central Line-Associated Bloodstream Infection	CLABSI	A bloodstream infection acquired through a central line catheter. As prevention is possible, CLABSIs are an indicator of the frequency of medical harm events. See *Healthcare-Associated Infection*.
Diagnostic Error		An error or delay in diagnosis, a failure to employ indicated tests, use of outdated tests/therapies or failure to act on the results of monitoring or testing.
Healthcare-Associated Infection	HAI	An infection that is not associated with the reason for which a person went to the hospital or sought care. HAIs—also known as a *hospital*-acquired infection—are a type of hospital-acquired condition. See *Catheter-Associated Urinary Tract Infection* and *Central Line-Associated Bloodstream Infection.*
Hospital-Acquired Condition	HAC	A condition which occurs in the hospital, causes injury to patients and could reasonably have been prevented through the application of evidence-based guidelines. HACs include healthcare-associated infections, adverse drug events and injuries or falls that occur in hospitals, among others. HACs are defined by the Centers for Medicare & Medicaid Services (CMS) and is used by public and private payers in hospital reimbursement. Also known as healthcare-associated condition.
Mandatory Reporting		The practice of requiring healthcare providers to disclose medical harm-related events to a payer or patient safety authority. See *Medical Harm Reporting* and *Public Reporting*.

Term	Acronym	Definition
Medical Error		An act of commission (doing something wrong) or omission (failing to do something right) leading to an undesirable health outcome or significant potential for an undesirable health outcome in a clinical setting.
Medical Harm		Unintended physical injury resulting from healthcare, including never events, hospital-acquired conditions, healthcare-acquired infections, medication errors and diagnostic errors.
Medical Harm Reporting		The disclosure of patient safety events by the clinical personnel associated with the event. See *Mandatory Reporting* and *Public Reporting*.
Medication Error		Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare professional, patient or consumer.
Methicillin-Resistant Staphylococcus Aureus	MRSA	The cause of a staph infection that is resistant to some antibiotics. The spread of MRSA in healthcare settings can be prevented through certain protocols; therefore, it is used as an indicator of the frequency of medical harm events. See *Healthcare-Associated Infection*.
National Healthcare Safety Network	NHSN	The Centers for Disease Control's (CDC) tracking system for healthcare-associated infections that provides healthcare facilities and state and federal governments with data that can be used to identify problems and measure prevention efforts. See *Healthcare-Associated Infections*.
Never Events		Largely preventable adverse events that are identifiable, measurable and serious, resulting in significant disability or death. Many insurers no longer pay for the additional costs associated with never events. See *Serious Reportable Events*.
Near Miss		Any event that could have had adverse consequences, but did not, and was indistinguishable from an adverse event in all but the outcome. See *Adverse Event*.
Potentially Avoidable Complication	PAC	Any medical event that negatively impacts a patient and is potentially controllable by the physician or hospital that manages the patient. As defined by Altarum, PACs include hospital-acquired conditions, patient safety indicators identified by the U.S. Agency for Healthcare Research and Quality (AHRQ), avoidable readmissions, healthcare-acquired infections, medication errors and more, to the extent that this type of harm can be identified by claims data.
Patient Safety Indicators	PSI	A set of 26 indicators developed by the U.S. Agency for Healthcare Research and Quality (AHRQ) to provide information on safety-related adverse events occurring in hospitals following operations, procedures and childbirth.
Patient Safety Organization	PSO	An entity to which healthcare providers and facilities report patient safety data. PSOs can create patient safety recommendations and enforce or encourage these standards. PSO patient safety data can be confidential or publicly-accessible.

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Patient Safety and Quality Improvement Act	PSQIA	Enacted by Congress in 2005, PSQIA encourages provider-driven activities that include collecting, analyzing and reporting patient safety data to reduce medical harm events.
Public Reporting		The practice of making patient safety reports available to the public. See *Medical Harm Reporting* and *Mandatory Reporting.*
Serious Reportable Event	SRE	29 types of "Never Events" grouped into 7 categories, including surgical or procedural events, product or device events, patient protection events, environmental events, radiologic events and criminal events. See *Never Events*.
Standardized Infection Ratio	SIR	A summary statistic that monitors progress towards the prevention of healthcare-acquired infections (HAIs) over time and serves as an indicator of the frequency of medical harm events. An SIR over 1 indicates that there was an increase in the number of HAIs compared to the national baseline, an SIR of 1 indicates that there were as many HAIs as the national baseline and an SIR lower than 1 indicates a decrease in the number of HAIs compared to the national baseline. See *Healthcare-Associated Infection.*
Surgical Site Infections	SSI	An infection that occurs in an area of the body on which a surgery took place. As prevention is possible, SSIs are used as an indicator of the frequency of medical harm events. See *Healthcare-Associated Infection*.

Notes

1. Sipherd, Ray, "The Third-Leading Cause of Death in U.S. Most Doctors Don't Want You to Know About," *CNBC Modern Medicine* (Feb. 22, 2018).
2. Centers for Disease Control and Prevention, *Catheter-Associated Urinary Tract Infections (CAUTI)* (accessed on Sept. 8, 2020).
3. Centers for Disease Control and Prevention, *Central Line-Associated Bloodstream Infections: Resources for Patients and Healthcare Providers* (accessed on Sept. 8, 2020).
4. Agency for Healthcare Research and Quality, *AHRQ Tools to Reduce Hospital-Acquired Conditions* (accessed on Sept. 8, 2020).
5. Patient Safety Network, *Reporting Patient Safety Events* (accessed on Sept. 8, 2020).
6. Centers for Disease Control and Prevention, *Methicillin-Resistant Staphylococcus aureus (MRSA): Healthcare Settings* (accessed on Sept. 8, 2020).
7. Centers for Disease Control and Prevention, *National Healthcare Safety Network (NHSN)* (accessed on Sept. 8, 2020).
8. Agency for Healthcare Research and Quality, *Never Events* (accessed on Sept. 8, 2020).
9. Kelly, Charles, and Samantha Gross, "Do hospitals Have an Adequate Patient Safety System?," *MedCity News* (May 30, 2020).
10. Agency for Healthcare Research and Quality, *Never Events* (accessed on Sept. 8, 2020).
11. Centers for Disease Control and Prevention, *Healthcare-Associated Infections: FAQs About HAI Progress Report* (accessed on Sept. 8, 2020).
12. Centers for Disease Control and Prevention, *Healthcare-Associated Infections: FAQs About HAI Progress Report* (accessed on Sept. 8, 2020).