Quality Improvement Glossary

There is a wide variety and range of terminology and language used to describe quality, improvement and the science of improvement - methodologies and techniques. This can make it difficult for the learner to understand and target their specific development needs and this glossary of terms, whilst by no means extensive, is intended to clarify some of the commonly used terms.

**Accreditation:** Certification by a recognized body of the facilities, capability, objectivity, competence and integrity of an agency, service or operational group or individual to provide the specific service or operation needed. The term has multiple meanings depending on the sector. Accreditation for healthcare organizations involves an authoritative body surveying and verifying compliance with recognized criteria, similar to certification in other sectors.

**Action Plan:** The plan that identifies the strategies that an organization intends to implement to reduce the risk of similar events occurring in the future. The plan should address responsibility for implementation, oversight, pilot testing as appropriate, time lines, and strategies for measuring the effectiveness of the action.

**Adding Value:** Adding something that the customer wants that was not there before.

**Adverse Event:** Harm to structure or function of the body.

**Aim:** The goal intended to be attained.

**Baseline measurement:** Used to determine the process parameters prior to any improvement effort; the basis against which change is measured.

**Benchmarking:** A technique in which a company measures its performance against that of best in class companies, determines how those companies achieved their performance levels and uses the information to improve its own performance.

**Best practice:** A superior method or innovative practice that contributes to the improved performance of an organization, usually recognized as best by other peer organizations.

**Cause and Effect diagrams (Ishikawa/Fishbone):** A technique to organize and display various theories about what may be the root cause of a problem designed to encourage innovative thinking (but not solutions, only possible causes).

**Checklists:** Designed to improve the safety of care, for example surgical checklists, by ensuring adherence to proven standards of care; improves compliance with standards and decreases complications.

**Continuous improvement (CI):** The ongoing improvement of products, services or processes through incremental and breakthrough improvements.
Continuous Improvement Process: The ongoing enhancement of work processes; activities devoted to maintaining and improving work process performance through small and gradual improvements as well as radical innovations.

Continuous quality improvement (CQI): A philosophy for analyzing capabilities and processes and improving them repeatedly to achieve improvement.

Culture change: A major shift in the attitudes, norms, sentiments, beliefs, values, operating principles and behavior of an organization.

Failure Mode Event Analysis (FMEA): An analytical method that highlights probable failures and the severity of their consequences.

Feedback: Information about the result of an event in the past will influence an occurrence of the same event in the present or future.

Five Whys: A question-asking method used to explore the cause/effect relationships underlying a particular problem. Ultimately, the goal of applying the 5 Whys method is to determine a root cause of a defect or problem.

Flow charts: A type of diagram that represents an algorithm or process showing the steps as boxes of various kinds and their order by connecting these with arrows - can give a step-by-step solution to a given problem.

Gap analysis: The comparison of a current condition to the desired state.

Goal: A broad statement describing a desired future condition or achievement without being specific about how much and when.

High Reliability Organization: An organization that has succeeded in avoiding catastrophes where normal accidents can be expected due to risk factors and complexity.

Human Factors: The scientific discipline concerned with the understanding of interactions among humans and other elements of a system, and the profession that applies theory, principles, data and methods to design in order to optimize human well-being and overall system performance.

Indicators: Established measures to determine how well an organization is meeting operational and performance expectations.

Leadership: The process of social influence in which one person can enlist the aid and support of others in the accomplishment of a common task.

Lean: A management philosophy centered on preserving value with less work, by reducing waste to improve overall customer satisfaction. Lean principles are: Specify value, Identify the value stream, Make the process and value flow, Develop pull systems, Pursue perfection.

Learning organization: An organization which places a high priority on enabling individual learning. Learning and sharing of new knowledge is typically encouraged among all employees, on the assumption that active participation will result in the development of a more responsive workforce.

Measures: Output measures - quality, delivery, lead time; resource measures - cost and inventory levels, stock turns; flexibility measures - customer satisfaction, reduction in back / late orders, ability to accommodate new services.
**Medication error:** A preventable adverse effect of care, whether or not it is evident or harmful to the patient. This might include an inaccurate or incomplete diagnosis or treatment of a disease, injury, infection or other ailment.

**Model for Improvement:** An approach to process improvement that helps teams accelerate the adoption of proven and effective changes. A framework for improvement that involves asking three key questions - What are we trying to accomplish? How will we know that a change is an improvement? What changes can we make that will result in an improvement?

**N:** The number of units in a population.

**n:** The number of units in a sample.

**Person Centeredness:** A focus on respect; choice; empowerment; involvement of patients, care givers and staff in health policy; access and support; information.

**Patient Safety:** Freedom, for a patient, from unnecessary harm or potential harm associated with healthcare.

**Plan-Do-Study-Act (PDSA) Cycle:** Another name for a cycle designed to test a change. The PDSA cycle includes four phases: Plan, Do, Study and Act. PDSA Cycles are small scale, reflective tests used to try out ideas for improvement.

**Process Mapping:** Activities involved in defining exactly what an organization or part of an organization does, who is responsible, to what standard a process should be completed and how success can be determined.

**Quality:** Refers to the inherent or distinctive characteristics of properties of an object, process or other thing which may set apart a person or thing from other persons or things, or may denote some degree of achievement or excellence. In terms of quality improvement in healthcare, quality is about learning what you are doing and doing it better.

**Quality assurance/quality control (QA/QC):** One definition of quality assurance is: all the planned and systematic activities implemented within the quality system that can be demonstrated to provide confidence that a product or service will fulfill requirements for quality. One definition for quality control is: the operational techniques and activities used to fulfill requirements for quality.

**Quality management (QM):** The application of a quality management system in managing a process to achieve maximum quality at the lowest overall cost to the organization while continuing to improve the process.

**Random sampling:** A sampling technique in which sample units are selected so all combinations of n units under consideration have an equal chance of being selected as the sample.

**Reliability:** The ability of a person or system to perform and maintain its functions in routine circumstances, as well as hostile or unexpected circumstances. Reliability theory describes the probability of a system completing its expected function during an interval of time.

**Risk assessment:** An assessment of the probability that an incident will occur and the consequences.
Root Cause Analysis: A class of problem solving methods aimed at identifying the root causes of a problem or events predicated on the belief that problems are best solved by attempting to address, correct or eliminate root causes, as opposed to merely addressing the immediately obvious symptoms. By identifying measures at root cause, it is more probable that problem will not occur again.

Safety culture: A term often used to describe the way in which safety is managed in the workplace, and often reflects “the attitudes, beliefs, perceptions and values that employees share in relation to safety”.

Six Sigma: Seeks to improve the quality of process outputs by identifying and removing the causes of defects (errors) and minimizing variability using statistical methods and following a defined sequence of steps (DMAIC: Define, Measure, Analyze, Improve, Control) and has quantifiable targets.

Spread: The intentional and methodical expansion of the number and type of people, units, or organizations using the improvements.

Teamwork: Work performed by a team towards a common goal; advocated by agreed activities and behaviors as a means of assuring quality and safety in the delivery of services.

Test: A small-scale trial of a new approach or a new process. A test is designed to learn if the change results in improvement, and to fine-tune the change to fit the organization and patients. Tests are carried out using one or more PDSA Cycles

Variation: A departure from a former or normal condition or action or amount or from a standard or type and the amount by which this occurs.

Waste: The identification of which steps in a process add value and which do not. Seven categories of resource are commonly wasted - overproduction; unnecessary transportation; inventory; motion; defects; over-processing; and waiting.

Work flow analysis: A technique for gathering information about the possible set of values calculated at various points in a work flow process. A process’s flow graph is used to determine those parts of a process to which a particular value assigned to a variable might propagate. The information gathered is often used by managers when optimizing a process.

Quality-related Acronyms
1. EBM: Evidence Based Medicine
2. CPG: Clinical Practice Guideline
3. SR: Systematic Review
4. PCPI: Physician Consortium for Performance Improvement
5. NQF: National Quality Forum
6. AQA: AQA Alliance
7. AHRQ: Agency for Healthcare Research Quality
8. CMSS: Council for Medical Specialty Societies
9. PQRS: Physician Quality Reporting System
10. NPRM: Notice of Proposed Rule Making
11. CMS: Centers for Medicare and Medicaid
12. NQS: National Quality Strategy
13. MOC: Maintenance of Certification
14. PIP: Performance In Practice
15. NeuroPI: AAN MOC Program
16. NPP: National Priorities Partnership
17. PMAG: Performance Measurement Advisory Group
18. NINDS: National Institute of Neurological Disorders & Stroke
19. MAP: Measures Application Partnership
20. NPI: National Provider Identifier
21. QPS: Quality Positioning System
22. IOM: Institute of Medicine