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Patient Safety Handbook-Barbara J. Youngberg 2012-08-30 Health Sciences & Professions
Patient Safety-Charles Vincent 2011-07-20 When you are ready to implement measures to improve patient safety, this is the book to consult. Charles Vincent, one of the world's pioneers in patient safety, discusses each and every aspect clearly and compellingly. He reviews the evidence of risks and harms to patients, and he provides practical guidance on implementing safer practices in health care. The second edition puts greater emphasis on this practical side. Examples of team based initiatives show how patient safety can be improved by changing practices, both cultural and technological, throughout whole organisations. Not only does this benefit patients; it also impacts positively on health care delivery, with consequent savings in the economy. Patient Safety has been praised as a gateway to understanding the subject. This second edition is more than that – it is a revelation of the pervading influence of health care errors, and a guide to how these can be overcome. "... The beauty of this book is that it describes the complexity of patient safety in a simple coherent way and captures the breadth of issues that encompass this fascinating field. The author provides numerous ways in which the reader can take this subject further with links to the international world of patient safety and evidence based research... One of the most difficult aspects of patient safety is that of implementation of safer practices and sustained change. Charles Vincent, through this book, provides all who read it clear examples to help with these challenges" From a review in Hospital Medicine by Dr Suzette Woodward, Director of Patient Safety. Access 'Essentials of Patient Safety – Free Online Introduction': www.wiley.com/go/vincent/patientsafety/essentials
Advances in Patient Safety-Kerm Henriksen 2005 v. 1. Research findings -- v. 2. Concepts and methodology -- v. 3. Implementation issues -- v. 4. Programs, tools and products.
Researching Patient Safety and Quality in Healthcare-Karina Aase 2016-10-03 Researching Patient Safety and Quality in Health Care: A Nordic Perspective is an anthology based on contributions from leading researchers on quality and safety in healthcare in the Nordic countries together with four internationally renowned patient safety authors. Research on patient safety and quality has been dominated by countries such as the USA, England, Canada, and Australia. This book addresses the current debates in research on patient safety and quality in healthcare from a Nordic perspective. What are the flavours of Nordic research within these topics? What does it add to the international research literature? This book illustrates the unique nature of researching patient safety and quality with the Nordic perspective as well as showcasing representative work. The book presents an overview of the status and evidence of international and Nordic research on quality and safety in healthcare. Four different perspectives are used to present the trends within the research field: a patient perspective, a methodological perspective, a theoretical perspective, and a clinical perspective. The book then presents the status of Nordic research in the field and displays a set of illustrative work and current research topics within the Nordic context, concluding with a discussion of the characteristic features of Nordic research on patient safety and quality in healthcare. The anthology presents an inter-professional perspective and researchers from disciplines such as medical and nursing sciences, humanities, social sciences and engineering. It is written to contribute to the patient safety cause with translational knowledge that will be useful to researchers, policy makers and healthcare managers within Nordic countries and internationally.
Patient Safety-Sidney Dekker 2016-04-19 Increased concern for patient safety has put the issue at the top of the agenda of practitioners, hospitals, and even governments. The risks to patients are many and diverse, and the complexity of the healthcare system that delivers them is huge. Yet the discourse is often oversimplified and underdeveloped. Written from a scientific, human factors perspective, Patient Safety: A Human Factors Approach delineates a method that can enlighten and clarify this discourse as well as put us on a better path to correcting the issues. People often think, understandably, that safety lies mainly in the hands through which care ultimately flows to the patient—those who are closest to the patient, whose decisions can mean the difference between life and death, between health and morbidity. The human factors approach refuses to lay the responsibility for safety and risk solely at the feet of people at the sharp end. That is where we should intervene to make things safer, to tighten practice, to focus attention, to remind people to be careful, to impose rules and guidelines. The book defines an approach that looks relentlessly for sources of safety and risk everywhere in the system—the designs of devices; the teamwork and coordination between different practitioners; their communication across hierarchical and gender boundaries; the cognitive processes of individuals; the organization that surrounds, constrains, and empowers them; the economic and human resources offered; the technology available; the political landscape; and even the culture of the place. The breadth of the human factors approach is itself testimony to the realization that there are no easy answers or silver bullets for resolving the issues in patient safety. A user-friendly introduction to the approach, this book takes the complexity of health care seriously and doesn’t over simplify the problem. It demonstrates what the approach does do, that is offer the substance and guidance to consider the issues in all their nuance and complexity.
Patient Safety Culture-Patrick Waterson 2018-10-09 How safe are hospitals? Why do some hospitals have higher rates of accident and errors involving patients? How can we accurately measure and assess staff attitudes towards safety? How can hospitals and other healthcare environments improve their safety culture and minimize harm to patients? These and other questions have been the focus of research within the area of Patient Safety Culture (PSC) in the last decade. More and more hospitals and healthcare managers are trying to understand the nature of the culture within their organisations and implement strategies for improving patient safety. The main purpose of this book is to provide researchers, healthcare managers and human factors practitioners with details of the latest developments within the theory and application of PSC within healthcare. It brings together contributions from the most prominent researchers and practitioners in the field of PSC and covers the background to work on safety culture (e.g. measuring safety culture in industries such as aviation and the nuclear industry), the dominant theories and concepts within PSC, examples of PSC tools, methods of assessment and their application, and details of the most prominent challenges for the future in the area. Patient Safety Culture: Theory, Methods and Application is essential reading for all of the professional groups involved in patient safety and healthcare quality improvement, filling an important gap in the current market.
Patient Safety-Jacqueline Fowler Byers 2004-06-03 cs.nurse.fund_surg
Improving Patient Safety-Raghav Govindarajan 2019-01-15 Based on the IOM's estimate of 44,000 deaths annually, medical errors rank as the eighth leading cause of death in the U.S. Clearly medical errors are an epidemic that needs to be contained. Despite these numbers, patient safety and medical errors remain an issue for physicians and other clinicians. This book bridges the issues related to patient safety by providing clinically relevant, vignette-based description of the areas where most problems occur. Each vignette highlights a particular issue such as communication, human facturs, E.H.R., etc. and provides tools and strategies for improving quality in these areas and creating a safer environment for patients.
Patient Safety and Quality- 2008 "Nurses play a vital role in improving the safety and quality of patient car -- not only in the hospital or ambulatory treatment facility, but also of community-based care and the care performed by family members. Nurses need know what proven techniques and interventions they can use to enhance patient outcomes. To address this need, the Agency for Healthcare Research and Quality (AHRQ), with additional funding from the Robert Wood Johnson Foundation, has prepared this comprehensive, 1,400-page, handbook for nurses on patient safety and quality -- Patient Safety and Quality: An Evidence-Based Handbook for Nurses. (AHRQ Publication No. 08-0043)."--Online AHRQ blurb, http://www.ahrq.gov/qual/nurseshdbk.
Patient Safety, Law Policy and Practice-John Tingle 2011-03-02 Patient safety is an issue which in recent years has grown to prominence in a number of countries’ political and health service agendas. The World Health Organisation has launched the World Alliance for Patient Safety. Millions of patients, according to the Alliance, endure prolonged ill-health, disability and death caused by unreliable practices, services, and poor health care environments. At any given time 1.4 million people worldwide are suffering from an infection acquired in a health facility. Patient Safety, Law Policy and Practice explores the impact of legal systems on patient safety initiatives. It asks whether legal systems are being used in appropriate ways to support state and local managerial systems in developing patient safety procedures, and what alternative approaches can and should be utilized. The chapters in this collection explore the patient safety managerial structures that exist in countries where there is a developed patient safety infrastructure and culture. The legal structures of these countries are explored and related to major in-country patient safety issues such as consent to treatment protocols and guidelines, complaint handling, adverse incident reporting systems, and civil litigation systems, in order to draw comparisons and conclusions on patient safety.
The Patient Safety Handbook-Barbara J. Youngberg 2004 In the current climate of managed care, tight cost controls, limited resources, and the growing demand for health care services, conditions of errors are ripe. This book offer practical guidance on implementing systems and processes to improve outcomes and advance patient safety.
Foundations in Patient Safety for Health Professionals-Kimberly A. Galt 2009-10-01 To Err is Human, said the 1999 landmark report published by the Institute of Medicine. the report that highlighted tragic numbers of injury and harm, the wide reaching nature of this problem, and areas of need to reverse this growing trend was also a call to action. Today, health care professionals recognize the importance of patient safety education across many disciplines. Based on an interprofessional course designed by faculty in bioethics, business, dentistry, law, medicine, nursing, occupational therapy, pharmacy, physical therapy, and social work, Foundations of Patient Safety for Heal
Patient Safety-Charles Vincent 2011-07-20 When you are ready to implement measures to improve patient safety, this is the book to consult. Charles Vincent, one of the world's pioneers in patient safety, discusses each and every aspect clearly and compellingly. He reviews the evidence of risks and harms to patients, and he provides practical guidance on implementing safer practices in health care. The second edition puts greater emphasis on this practical side. Examples of team based initiatives show how patient safety can be improved by changing practices, both cultural and technological, throughout whole organisations. Not only does this benefit patients; it also impacts positively on health care delivery, with consequent savings in the economy. Patient Safety has been praised as a gateway to understanding the subject. This second edition is more than that – it is a revelation of the pervading influence of health care errors, and a guide to how these can be overcome. "... The beauty of this book is that it describes the complexity of patient safety in a simple coherent way and captures the breadth of issues that encompass this fascinating field. The author provides numerous ways in which the reader can take this subject further with links to the international world of patient safety and evidence based research... One of the most difficult aspects of patient safety is that of implementation of safer practices and sustained change. Charles Vincent, through this book, provides all who read it clear examples to help with these challenges" From a review in Hospital Medicine by Dr Suzette Woodward, Director of Patient Safety. Access 'Essentials of Patient Safety – Free Online Introduction': www.wiley.com/go/vincent/patientsafety/essentials
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Measuring Patient Safety-Stephanie S. Poe 2005 In protecting patients from harm through safety initiatives, nurses can use their expertise and organizational knowledge to reduce directly the risk of injury to patients. Improving patient safety requires nurses to assume leadership roles in measuring and improving the structures, processes, and patient outcomes in the clinical setting. Measuring Patient Safety will enable them to impact patient safety with knowledge and confidence.
Global Patient Safety-John Tingle 2018-08-15 This book explores patient safety themes in developed, developing and transitioning countries. A foundation premise is the concept of ‘reverse innovation’ as mutual learning from the chapters challenges traditional assumptions about the construction and location of knowledge. This edited collection can be seen to facilitate global learning. This book will, hopefully, form a bridge for those countries seeking to enhance their patient safety policies. Contributors to this book challenge many supposed generalisations about human societies, including consideration of how medical care is mediated within those societies and how patient safety is assured or compromised. By introducing major theories from the developing world in the book, readers are encouraged to reflect on their impact on the patient safety and the health quality debate. The development of practical patient safety policies for wider use is also encouraged. The volume presents a ground-breaking perspective by exploring fundamental issues relating to patient safety through different academic disciplines. It develops the possibility of a new patient safety and health quality synthesis and discourse relevant to all concerned with patient safety and health quality in a global context.
Patient Safety-Heather Gluyas 2013-12-04 How can we make health care processes safer and more consistent? How do we improve care outcomes for patients? With a range of coaching tips, scenarios, activities and reflective exercises, this book enables you to translate current research on patient safety in to everyday good practice and develop strategies to minimise the risk of patient harm.
Patient Safety-Abha Agrawal 2013-10-04 Despite the evolution and growing awareness of patient safety, many medical professionals are not a part of this important conversation. Clinicians often believe they are too busy taking care of patients to adopt and implement patient safety initiatives and that acknowledging medical errors is an affront to their skills. Patient Safety provides clinicians with a better understanding of the prevalence, causes and solutions for medical errors; bringing best practice principles to the bedside. Written by experts from a variety of backgrounds, each chapter features an analysis of clinical cases based on the Root Cause Analysis (RCA) methodology, along with case-based discussions on various patient safety topics. The systems and processes outlined in the book are general and broadly applicable to institutions of all sizes and structures. The core ethic of medical professionals is to “do no harm”. Patient Safety is a comprehensive resource for physicians, nurses and students, as well as healthcare leaders and administrators for identifying, solving and preventing medical error.
Quality Work Environments for Nurse and Patient Safety-Linda McGillis Hall 2005 Key areas of concern in nursing work environment, are covered extensively, such as leadership, workload and productivity, all of which are front-page issues in practice, systems, and policy levels.
Patient Safety and Health Care Management-Grant T. Savage 2008-07-25 Contains four sections that include, theoretical perspectives on managing patient safety, top management perspectives on patient safety, health information technology perspectives on patient safety, and organizational behavior and change perspectives on patient safety.
Patient Safety Act-Linda T. Kohn 2011-01 This is a print on demand edition of a hard to find publication. In 1999 preventable medical errors caused as many as 98,000 deaths a year among hospital patients in the U.S. Congress passed the Patient Safety and Quality Improvement Act of 2005 (PSA) to encourage health care providers to voluntarily report info. on medical errors and other events -- patient safety data -- for analysis and to facilitate the development of improvements in patient safety using these data. This report describes progress by HHS and AHRQ to implement the PSA by: (1) creating a list of Patient Safety Org. to collect patient safety data from health care providers to develop improvements in patient safety; and (2) implementing the network of patient safety databases to collect and aggregate patient safety data. Charts and tables.
Patient Safety-B.S. Dhillon 2011-11-08 With unintended harm during hospital care costing billions of dollars to the world economy, not to mention millions of deaths each year, it’s no wonder the issue is equally front and center in the minds of healthcare providers and the public. Although the issue has been tackled in journal articles and conference proceedings, there are very few books on the topic. And none consider how methods and techniques developed in the area of engineering can handle safety and human error-related problems. Until now. Written by an expert with vast know-how in engineering management, design, reliability, safety, and quality, Patient Safety: An Engineering Approach brings together the pertinent information scattered throughout books and journals, eliminating the need to consult many different and diverse sources to find what you need. B.S. Dhillon draws on his real-world experience to demonstrate how to handle patient safety-related problems using engineering techniques and backs this up with references for further reading at the end of each chapter. He sets the stage with introductory chapters on mathematical, patient safety, and human factors concepts essential to understanding materials presented in subsequent chapters. Dhillon’s clear, concise discussion of the topics presents the information in such a way that no previous knowledge is required to understand the contents, yet he does not present it at a merely rudimentary level. He brings a fresh approach and engineering perspective to the issues, giving you a new tool kit for performing patient safety-related analysis, designing better medical systems/devices, and handling patient safety-related problems from an engineering perspective.
Patient Safety-Institute of Medicine 2003-12-20 Americans should be able to count on receiving health care that is safe. To achieve this, a new health care delivery system is needed â€" a system that both prevents errors from occurring, and learns from them when they do occur. The development of such a system requires a commitment by all stakeholders to a culture of safety and to the development of improved information systems for the delivery of health care. This national health information infrastructure is needed to provide immediate access to complete patient information and decision-support tools for clinicians and their patients. In addition, this infrastructure must capture patient safety information as a by-product of care and use this information to design even safer delivery systems. Health data standards are both a critical and time-sensitive building block of the national health information infrastructure. Building on the Institute of Medicine reports To Err Is Human and Crossing the Quality Chasm, Patient Safety puts forward a road map for the development and adoption of key health care data standards to support both information exchange and the reporting and analysis of patient safety data.
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Patient Safety and Hospital Accreditation-Sharon Ann Myers, RN, MSN, MSB, FACHE, FAIHQ, CPHQ, CPHRM 2011-12-20 Improving the culture of safety in our health care institutions is an essential component of preventing or reducing errors as well as improving overall health care quality. This book presents the clinically tested Myer's Patient Safety Model for health care system leaders, middle managers, and administrators to build their patient safety program and to help sustain, renew, or obtain accreditation. The author provides detailed explanations of why medical errors still occur in accredited hospitals, and provides the much needed organization-wide steps to prevent these errors and enhance patient safety for improved outcomes. Current patient safety challenges are discussed with an emphasis on the concept of reliability. The Myers Model is examined in detail, along with current evidence for its three interrelated levels of organizational structure-the leadership (system) level, the unit (microsystem) level, and the individual level. The text includes interviews about key aspects of patient safety with three leaders of major health care accreditation programs in the U.S., Canada, and Australia. Additionally, it provides an overview of reporting systems within the U.S. and covers two essential tools for patient safety-root cause analysis and failure mode and effect analysis. The book links all aspects of patient safety with accreditation standards at the national level, and also discusses efforts to globalize accreditation criteria and procedures. Key Features: Presents a clinically tested model for building a patient safety program and helping to sustain, renew, or obtain accreditation Provides tools for use in ensuring patient safety and accreditation, including root cause analysis and failure mode and effect analysis Discusses how aggregate data inform patient safety documentation and accreditation through integrated perspectives Offers a global view of accreditation and patient safety Includes techniques to improve communication among members of health care teams
Patient Safety in Surgery-Philip F. Stahel 2014-08-20 In general, surgeons strive to achieve excellent results and ideal patient outcomes, however, this noble task is frequently failed. For patients, surgical complications are analogous to “friendly fire” in wartime. Both scenarios imply that harm is unintentionally done by somebody whose aim was to help. Interestingly, adverse events resulting from surgical interventions are more frequently related to system errors and a communication breakdown among providers, rather than to the imminent threat of the surgical blade “gone wrong”. Patient Safety in Surgery aims to increase the safety and quality of care for patients undergoing surgical procedures in all fields of surgery. Patient Safety in Surgery, covers all aspects related to patient safety in surgery, including pertinent issues of interest to surgeons, medical trainees (students, residents, and fellows), nurses, anaesthesiologists, patients, patient families, advocacy groups, and medicolegal experts.
Evaluation of the Patient Safety Improvement Corps-Stephanie Teleki 2006 An evaluation of the first two years of the Agency for Healthcare Research and Quality and Veterans' Affairs' Patient Safety Improvement Corps program for improving health care professionals' patient-safety knowledge and skills. Data were collected through in-person interviews at the final training session, and through telephone follow-up interviews one year later. Overall, participants valued the tools and skills they learned and continue to use.
Patient Safety: Research Into Practice-Walshe, Kieran 2005-11-01 Winner of the Basis of Medicine Award in the BMA Book Medical Book Competition 2006! In many countries, during the last decade there has been a growing public realization that healthcare organisations are often dangerous places to be. Reports published in Australia, Canada, New Zealand, United Kingdom and the USA have served to focus public and policy attention on the safety of patients and to highlight the alarmingly high incidence of errors and adverse events that lead to some kind of harm or injury. This book presents a research-based perspective on patient safety, drawing together the most recent ideas and thinking from researchers on how to research and understand patient safety issues, and how research findings are used to shape policy and practice. The book examines key issues, including: Analysis and measurement of patient safety Approaches to improving patient safety Future policy and practice regarding patient safety The legal dimensions of patient safety Patient Safety is essential reading for researchers, policy makers and practitioners involved in, or interested in, patient safety. The book is also of interest to the growing number of postgraduate students on health policy and health management programmes that focus upon healthcare quality, risk management and patient safety. Contributors: Sally Adams, Tony Avery, Maureen Baker, Paul Beatty, Ruth Boaden, Tanya Claridge, Gary Cook, Caroline Davy, Susan Dovey, Aneez Esmail, Rachel Finn, Martin Fletcher, Sally Giles, John Hickner, Rachel Howard, Amanda Howe, Michael A. Jones, Sue Kirk, Rebecca Lawton, Martin Marshall, Caroline Morris, Dianne Parker, Shirley Pearce, Bob Phillips, Steve Rogers, Richard Thomson, Charles Vincent, Kieran Walshe, Justin Waring, Alison Watkin, Fiona Watts, Liz West, Maria Woloshynowych.
A Socio-cultural Perspective on Patient Safety-Emma Rowley 2011 This edited volume of original essays brings together researchers from around the world who are exploring the facets of health care organization and delivery that are sometimes marginal to mainstream patient safety theories and methodologies but offer important insights into the socio-cultural and organizational context of patient safety. By examining these critical insights or perspectives and drawing upon theories and methodologies often neglected by mainstream safety researchers, this collection shows we can learn more about not only the barriers and drivers to implementing patient safety programmes, but also about the more fundamental issues that shape notions of safety, alternate strategies for enhancing safety, and the wider implications of the safety agenda on the future of health care delivery. In so doing, A Socio-cultural Perspective on Patient Safety challenges the taken-for-granted assumptions around fundamental philosophical and political issues upon which mainstream orthodoxy relies.
Innovating for Patient Safety in Medicine-Rebecca Lawton 2012-07-18 This book helps the next generation of doctors understand how to contribute to making healthcare safer. Patient safety is increasingly important in medical practice today and is becoming a core part of training for medical students and foundation doctors. This book will enable the student or junior doctor to challenge and innovate in practice to improve patient safety and care. It takes a practical approach and explores what patient safety is, why it is important, how to involve patients, the role of education, technology and resources, how to be an innovative practitioner and measuring the impact of patient safety initiatives.
Nursing Pathways for Patient Safety E-book-National Council of State Boards of Nursing 2009-09-25 With a wealth of helpful guidelines and assessment tools, Nursing Pathways for Patient Safety makes it easy to identify the causes of practice breakdowns and to reduce health care errors. It provides expert guidance from the National Council of State Boards of Nursing (NCSBN), plus an overview of the TERCAP® assessment tool. The book systematically examines the causes of practice breakdowns resulting from practice styles, health care environments, teamwork, and structural systems to promote patient safety. An overview of the NCSBN Practice Breakdown Initiative introduces the TERCAP® assessment tool and provides a helpful framework for understanding the scope of problems, along with NCSBN’s approach to addressing them. Coverage of each type of practice breakdown systematically explores errors in areas such as clinical reasoning or judgment, prevention, and intervention. Case Studies provide real-life examples of practice breakdowns and help you learn to identify problems and propose solutions. Chapters on mandatory reporting and implementation of a whole systems approach offer practical information on understanding TERCAP® and implementing a whole systems approach to preventing practice breakdowns.
Assessing Patient Safety Practices and Outcomes in the U.S. Health Care System-Donna Farley 2009 Presents the results of a two-year study that analyzes how patient safety practices are being adopted by U.S. health care providers, examines hospital experiences with a patient safety culture survey, and assesses patient safety outcomes trends. In case studies of four U.S. communities, researchers collected information on the dynamics of local patient safety activities and on adoption of safe practices by hospitals.
Building a Culture of Patient Safety Through Simulation-Kathleen Gallo, PhD, MBA, RN, FAAN 2014-08-29 "This book provides a dynamic and comprehensive interprofessional approach to building a culture of safety by using simulation across clinical and education spheres in healthcare... This is a comprehensive guide and resource for healthcare organizations, educators, and diverse interprofessional healthcare team members to use to improve patient safety efforts to adapt to the ever-changing, complex world of healthcare. Its practical application is pertinent in transforming the education and practice of medicine, nursing, and other health-related fields... Weighted Numerical Score: 99 - 5 Stars!" Patricia West, MS, BSN Michigan State University College of Nursing Doody's Medical Reviews ì[The authors] have brought together a core group of national leaders to produce what I think is a paradigm-busting book that will help to transform education at the graduate level in medicine, nursing, and all related fields. The book speaks expertly about the high fidelity of simulation training, the need for synthetic models, the adult learning theory behind the debriefÖit is a manifesto about where we must go as an interprofessional team, caring for the patient of the future.î From the Foreword, by David B. Nash, MD, MBA Dean, Jefferson School of Population Health Philadelphia, PA This groundbreaking book reflects the accomplishments of an internationally recognized leader of innovation regarding interprofessional clinical learning through simulation. Based on the North Shore-LIJ Health System corporate university experience, the book describes how this organization used simulation to successfully tackle the major interprofessional health issue of our time: patient safety. This health system created a transformative simulation center that involves nurses, doctors, and related health professionals whose work in clinical teams has resulted in measurable improvements in all aspects of clinical decision-making, critical thinking, teamwork, and communication skillsótoward the ultimate goal of improved patient safety. Key Features: Describes in detail a groundbreaking system of achieving patient safety that uses interprofessional clinical learning through simulation Detailed case studies using concrete methods and examples illustrate the application of theory to practice Presents simulations scalable to any size organization and for use by health care professionals in all specialties Includes theoretical foundations and practical applications for teaching and learning Focuses on interprofessional cooperation and learning
Handbook of Human Factors and Ergonomics in Health Care and Patient Safety, Second Edition-Pascale Carayon 2016-04-19 The first edition of Handbook of Human Factors and Ergonomics in Health Care and Patient Safety took the medical and ergonomics communities by storm with in-depth coverage of human factors and ergonomics research, concepts, theories, models, methods, and interventions and how they can be applied in health care. Other books focus on particular human factors and ergonomics issues such as human error or design of medical devices or a specific application such as emergency medicine. This book draws on both areas to provide a compendium of human factors and ergonomics issues relevant to health care and patient safety. The second edition takes a more practical approach with coverage of methods, interventions, and applications and a greater range of domains such as medication safety, surgery, anesthesia, and infection prevention. New topics include: work schedules error recovery telemedicine workflow analysis simulation health information technology development and design patient safety management Reflecting developments and advances in the five years since the first edition, the book explores medical technology and telemedicine and puts a special emphasis on the contributions of human factors and ergonomics to the improvement of patient safety and quality of care. In order to take patient safety to the next level, collaboration between human factors professionals and health care providers must occur. This book brings both groups closer to achieving that goal.
The Handbook of Patient Safety Compliance-Fay A. Rozovsky 2005-03-04 Written for virtually every professional and leader in the healthcare field, as well as students who are preparing for careers inhealth services delivery, this book presents a framework fordeveloping a patient safety program, shows how best to examineevents that do occur, and reveals how to ensure that appropriatecorrective and preventative actions are reviewed for effectiveness.The book covers a comprehensive selection of topics including The link between patient safety and legal and regulatorycompliance The role of accreditation and standard-setting organizations inpatient safety Failure modes and effect analysis Voluntary and regulatory oversight of medical error Evidence-based outcomes and standards of care Creation and preservation of reports, data, and device evidencein medical error situations Claims management when dealing with patient safety events Full disclosure Patient safety in human research Managing confidentiality in the face of litigation Managing patient safety compliance through accountability-basedcredentialing for health care professionals Planning for the future
The Improvement Guide-Gerald J. Langley 2009-06-03 This new edition of this bestselling guide offers an integrated approach to process improvement that delivers quick and substantial results in quality and productivity in diverse settings. The authors explore their Model for Improvement that worked with international improvement efforts at multinational companies as well as in different industries such as healthcare and public agencies. This edition includes new information that shows how to accelerate improvement by spreading changes across multiple sites. The book presents a practical tool kit of ideas, examples, and applications.
Understanding Patient Safety, Third Edition-Robert Wachter 2017-12-01 Now revised and updated—the landmark patient safety primer written by the world’s leading authorities Medical errors are the unfortunate byproduct of an increasingly complex healthcare system. Now more than ever, keeping patients safe takes well-trained caregivers, relevant insights from a range of industries, additional investment—and a groundbreaking text like Understanding Patient Safety. Understanding Patient Safety is “must read” for those seeking to master the clinical, organizational, and systems issues of patient safety. In this bestselling primer, patient safety pioneer Robert Wachter and Kiran Gupta put all the essential tools and principles at your fingertips. Engaging and accessible, the book is filled with high-yield cases, analyses, tables, graphics, along with key points and references—all designed to help you optimize quality and safety. Understanding Patient Safety begins with an introduction to patient safety and medical errors. Its second section surveys specific types of medical errors, including those related to surgery, medications, diagnosis, transition and handoff, and infections. The third section covers proven solutions, from establishing reporting systems, to creating a culture of safety. The third edition reflects pivotal new developments in the field, including major updates in diagnostic errors, information technology and patient safety, ambulatory safety, and clinician burnout. Features: •Coverage of human factors and errors at the person-machine interface •Review of workplace issues, including supporting caregivers after major errors •How to organize an effective safety program •Coordination of patient education and training •Overview of the malpractice system •Discussion of the patient’s role
Implementing Patient Safety-Suzette Woodward 2019-09-11 Over the last two decades across the globe we have seen a multitude of programs, projects and books to help improve the safety of patient care in healthcare. However, the full potential of these has not yet been reached. Most of the current approaches are top down, programmatic and target driven. These look at problems in isolation one harm at a time with simplistic solutions that fail to support a holistic, systematic approach. They are focused on collecting incident data and learning from failure using tools that are not fit for purpose in a complex nonlinear system. Very rarely do the solutions help build the conditions, cultures and behaviours that support a safer system and help the people involved work safely. Healthcare is stuck in a relentlessly negative approach to safety. Those working in patient safety and healthcare are struggling, and books on patient safety to date instruct the reader to continue doing the same things we have been doing for the last 20 years. This book uniquely combines the latest thinking in safety, including creating a balanced approach to learning from what works as a way to understand why it fails, together with the evidence on building a just culture, positive workplaces and working relationships that we now know are so important for safety. It helps people understand how to address issues despite their complexities and improve safety with practical ways to truly understand what day to day healthcare work is actually like, rather than what people imagine it is like. This book builds on the author’s first book Rethinking Patient Safety which exposed what we need to do differently to truly transform our approach to patient safety. It updates the reader further on the concepts explored in the first book but also vitally helps readers understand the ‘how’. Implementing Patient Safety goes beyond the rhetoric and provides the reader with ideas and examples for how the latest thinking can actually be achieved. It is based on the author’s personal experience of leading a national culture change campaign in the National Health Service for five years. The lessons arise from helping hundreds of organisations and people rethink and implement a whole new way of thinking about improving patient safety in healthcare.

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