

Understanding Patient Safety

The Patient Safety Handbook Patient Safety Global patient safety action plan 2021-2030 Patient Safety Global patient safety report 2024 Principles of Risk Management and Patient Safety Patient Safety, Law Policy and Practice Patient Safety in Developing Countries Engaging patients for patient safety Patient Safety Culture Patient Safety Patient Safety Patient Safety EBOOK: Patient Safety: Research into Practice Patient Safety - Cultural Perspectives Error Reduction in Health Care Patient Safety and Healthcare Improvement at a Glance Advances in Patient Safety Oxford Professional Practice: Handbook of Patient Safety Barbara J. Youngberg Heather Gluyas World Health Organization Claire Cox World Health Organization Barbara Youngberg John Tingle Yaser Al-Worafi World Health Organization Patrick Waterson Charles Vincent Lorri Zipperer Abha Agrawal B.S. Dhillon Kieran Walshe Marita Danielsson Patrice L. Spath Sukhmeet Panesar Kerm Henriksen Peter Lachman

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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

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 activities scenarios and reflective exercises this book enables you to translate current research on patient safety in to everyday good practice by increasing understanding of the key concepts and helping you to develop strategies to minimise the risk of patient harm it focusses on human factors to support understanding of the relationship between human behaviour and fallibility and the design of systems and processes environments tools tasks and technology to improve patient safety it also reflects the who patient safety curriculum patient safety is an essential text for all healthcare professionals

patient safety is fundamental to the provision of health care in all settings however avoidable adverse events errors and risks associated with health care remain major challenges for patient safety globally the seventy second world health

assembly in 2019 adopted resolution wha72/6 on global action on patient safety and mandated for development of a global patient safety action plan this global action plan was adopted by seventy fourth world health assembly in 2021 with a vision of a world in which no one is harmed in health care and every patient receives safe and respectful care every time everywhere the purpose of the action plan is to provide strategic direction for all stakeholders for eliminating avoidable harm in health care and improving patient safety in different practice domains through policy actions on safety and quality of health services as well as for implementation of recommendations at the point of care the action plan provides a framework for countries to develop their respective national action plans on patient safety as well to align existing strategic instruments for improving patient safety in all clinical and health related programmes

there are few resources and books for professionals within the patient safety sector that use case studies to model the practical application of theories of patient safety incident investigation exploring these theories this text brings together contributors from a variety of academic and healthcare professions alongside those with lived experience to help you understand some of the emerging theories of safety science and their practical application the nhs's approach to incident reporting in investigations the patient safety incident response framework psirf has given rise to new found opportunities and freedom of investigation and incident management this book aims to explore emerging safety sciences by leading experts and the practical application of them in differing clinical and organisational contexts written by people who work in patient safety and with chapters on subjects such as system engineering initiative for patient safety seips accimaps and human factors this book is for everyone with an interest in how the landscape of patient safety is changing and how to apply good practice for the reduction of avoidable harm

the first ever report on patient safety the global patient safety report 2024 offers a comprehensive overview of patient safety implementation worldwide aligned with the global patient safety action plan 2021-2030 this report explores policies strategies and initiatives shaping safety in health care from analyses of country actions to in depth summaries of burden of unsafe care it provides crucial insights for policy makers health care leaders researchers and patient safety advocates explore how nations address challenges learn from case studies and feature stories and gain deeper understanding in priority areas for action this report serves as a vital resource for fostering global collaboration and advancing patient safety in health care the contents of this report encompass an analysis that compiles and describes actions taken by countries including the summary of these actions across different who regions and income levels based on member state survey an in depth summary presenting evidence on the overall burden of unsafe health care practices viewed broadly as well as within specific population groups clinical domains and according to major sources of harm case studies showcasing how different countries are learning and developing patient safety solutions within their unique contexts along with feature stories highlighting key global initiatives and interventions in patient safety comparative analyses offering deeper insights into crucial areas such as patient safety policies legal frameworks patient involvement educational initiatives reporting and learning systems and the involvement of various stakeholders

health sciences professions

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

understanding the various aspects of patient safety education practice and research in developing countries is vital in preparing a plan to overcome the challenges of improving patient safety this unique volume discusses patient safety in developing countries and the achievements and challenges faced in those places when trying to improve patient safety education and practice this book includes a compilation of over 100 case studies surrounding patient safety in all aspects of health care both real and simulated scenarios are provided to help medical students and professionals apply their knowledge to solve the cases and prepare for real practice features describes the achievements and challenges of patient safety in developing countries includes real and simulated case studies and key answers on patient safety issues prepares medical students and practitioners for real life situations diverse audience including those in medication to safety testing patient education dispensing changes and the design of health systems aids medical students and practitioners to improve their skills to solve cases

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

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 wiley com go vincent patientsafety essentials

patient safety perspectives on evidence information and knowledge transfer provides background on the patient safety movement systems safety human error and other key philosophies that support change and innovation in the reduction of medical error the book draws from multidisciplinary areas within the acute care environment to share models that support the proactive changes necessary to provide safe care delivery the publication discusses how the tenets of safety

described in the beginning of the book can be actively applied in the field to make evidence information and knowledge eik sharing processes reliable effective and safe this is a wide ranging and important book that is designed to raise awareness of the latent risks for patient safety that are present in the eik identification acquisition and distribution processes structures and systems of many healthcare institutions across the world the expert contributors offer systemic evidence based improvement processes assessment concepts and innovative activities to identify these risks to minimize their potential to adversely impact care these ideas are presented to create opportunities for the field to design and use strategies that enable meaningful implementation and management of eik their thoughts will enable healthcare staff to see eik as a tangible element contributing toward sustainable patient safety improvements

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

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 book

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 doveys anez 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

background shared values norms and beliefs of relevance for safety in health care can be described in terms of patient safety culture this concept overlaps with patient safety climate but culture represents the deeprooted values norms and beliefs whereas climate refers to attitudes and more superficial manifestations of culture there may be numerous subcultures within an organization including different professional cultures in recent years increased attention has been paid to patient safety culture in sweden and the patient safety culture climate in health care is regularly measured based on the assumption that patient safety culture climate can influence various patient safety outcomes aim the overall aim of the

thesis is to contribute to an improved understanding of patient safety culture and subcultures in swedish health care design and methods the thesis is based on four studies applying different methods study 1 was a survey that included 23 781 respondents data were analysed with quantitative methods with primarily descriptive results studies 2 and 3 were qualitative studies involving interviews with a total of 28 registered nurses 24 nurse assistants and 28 physicians interview data were analysed using content analysis study 4 evaluated an intervention intended to influence patient safety culture and included data from a questionnaire with both fixed and open ended questions which was answered by 200 respondents results a key result from study 1 was that professional groups differed in terms of their views and statements about patient safety culture climate registered nurses and nurse assistants in study 2 were found to have partially overlapping norms values and beliefs concerning patient safety which were identified at individual interpersonal and organizational level study 3 found four categories of values and norms among physicians of potential relevance for patient safety predominantly positive perceptions were found in study 4 concerning the walk rounds intervention among frontline staff members local managers and top level managers who participated in the intervention however there were also reflections on disadvantages and some suggestions for improvement conclusions according to the results of the patient safety culture climate questionnaire perceptions about safety culture climate dimensions contribute more to the rating of overall patient safety than background characteristics e g profession and years of experience there are differences in the patient safety culture between registered nurses and nurse assistants which imply that efforts for improved patient safety must be tailored to their respective values norms and beliefs several aspects of physicians professional culture may have relevance for patient safety expectations of being infallible reduce their willingness to talk about errors they make thus limiting opportunities for learning from errors walk rounds are perceived to contribute to increased learning concerning patient safety and could potentially have a positive influence on patient safety culture

error reduction in health care a systems approach to improving patient safety 2nd edition completely revised and updated this book offers a step by step guide for implementing the institute of medicine guidelines to reduce the frequency of errors in health care services and mitigate the impact of those errors that do occur it explores the fundamental concepts and tools of error reduction and shows how to design an effective error reduction initiative the book pinpoints how to reduce and eliminate medical mistakes that threaten the health and safety of patients and teaches how to identify the root cause of medical errors implement strategies for improvement and monitor the effectiveness of these new approaches

patient safety and healthcare improvement at a glance isa timely and thorough overview of healthcare quality writtenspecifically for students and junior doctors and healthcareprofessionals it bridges the gap between the practical and thetheoretical to ensure the safety and wellbeing of patients featuring essential step by step guides to interpreting andmanaging risk quality improvement within clinical specialties andpractice development this highly visual textbook offers the bestpreparation for the increased emphasis on patient safety andquality driven focus in today s healthcare environment healthcare improvement and safety at a glance maps out and follows the world health organizationpatient safety curriculum draws upon the quality improvement work of theinstitute for healthcare improvement this practical guide covering a vital topic of increasingimportance in healthcare provides the first genuine introductionto patient safety and quality improvement grounded in clinicalpractice

v 1 research findings v 2 concepts and methodology v 3 implementation issues v 4 programs tools and products

every day doctors are faced with the challenge of keeping the people they treat safe and free from harm patient safety is a relatively new field of study but the field is expanding and there is now better understanding of what is needed to measure and achieve safety for patients the handbook of patient safety will empower doctors nurses and other professionals to be able to develop safe clinical processes that allow proactive management and minimisation of risk so that people are not harmed when they receive clinical care it gives the rationale for patient safety the theories behind the science of patient safety and then the practical methods that frontline staff can use on a daily basis to decrease harm pocket

sized and practical this handbook is the ideal guide to support frontline staff and trainees as well as all allied professionals in the name of patient safety it reflects the world health organization s patient safety curriculum and is written by international experts in their field who have specialist interests and direct expertise in dealing with patient safety issues this book will demystify what is often seen as a complex topic helping doctors understand the methods needed to provide safe care

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