Understanding Patient Safety

The Patient Safety HandbookPatient SafetyPatient Safety CulturePatient SafetyPatient SafetyPatient SafetyA Socio-cultural Perspective on Patient SafetyPatient SafetyEBOOK: Patient Safety: Research into PracticeError Reduction in Health CarePatient Safety and Healthcare Improvement at a GlancePatient SafetyAdvances in Patient SafetyOxford Professional Practice: Handbook of Patient SafetyYour Patient Safety Survival GuidePatient Safety - Cultural PerspectivesTo Do No HarmGlobal Patient SafetyHealth IT and Patient SafetyPatient Safety, Law Policy and Practice Barbara J. Youngberg Heather Gluyas Patrick Waterson Lorri Zipperer Charles Vincent Abha Agrawal Dr Emma Rowley B.S. Dhillon Kieran Walshe Patrice L. Spath Sukhmeet Panesar Jacqueline Fowler Byers Kerm Henriksen Peter Lachman Gretchen LeFever Watson Marita Danielsson Julianne M. Morath, RN, MS John Tingle Institute of Medicine John Tingle
The Patient Safety Handbook Patient Safety Patient Safety Culture Patient Safety Patient Safety Patient Safety A Socio-cultural Perspective on Patient Safety Patient Safety EBOOK: Patient Safety: Research into Practice Error Reduction in Health Care Patient Safety and Healthcare Improvement at a Glance Patient Safety Advances in Patient Safety Oxford Professional Practice: Handbook of Patient Safety Your Patient Safety Survival Guide Patient Safety - Cultural Perspectives To Do No Harm Global Patient Safety Health IT and Patient Safety Patient Safety, Law Policy and Practice *Barbara J. Youngberg Heather Gluyas Patrick Waterson Lorri Zipperer Charles Vincent Abha Agrawal Dr Emma Rowley B.S. Dhillon Kieran Walshe Patrice L. Spath Sukhmeet Panesar Jacqueline Fowler Byers Kerm Henriksen Peter Lachman Gretchen LeFever Watson Marita Danielsson Julianne M. Morath, RN, MS John Tingle Institute of Medicine John Tingle*

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

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 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

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

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

this edited volume of original chapters 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 the book draws upon a range of theoretical and empirical approaches from across the social sciences to investigate and question the patient safety movement each chapter takes as its focus and question a particular aspect of the patient safety reforms from its policy context and theoretical foundations to its practical application and manifestation in clinical practice whilst also considering the wider implications for the organization and delivery of health care services accordingly the chapters each draw upon a distinct theoretical or methodological approach to critically explore specific dimensions of the patient safety agenda taken as a whole the collection advances a strong coherent argument that is much needed to counter some of the uncritical assumptions that need to be described and analyzed if patient safety is indeed to be achieved

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 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

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

this book provides readers with both a foundation of theoretical knowledge regarding patient safety as well as evidence based strategies for preventing errors in various clinical settings the authorsí goal is to help clinicians and administrators gain the skills and knowledge they need to develop safe patient practices in their organizations key topics include an overview of evidence based best practices for patient safety clear explanation of important patient safety policies and legislation innovative uses of technology such as computerized provider order entry barcoding medications and computerized clinical decision support systems the importance of an informed patient in preventing medical errors how to communicate with the public and the patient about errors if they occur special patient safety concerns for children the elderly and the mentally ill

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

each year one out of every four hospital patients in the united states will be harmed by the care they receive over 400 000 will die as a result dr gretchen lefever watson s definitive guide empowers patients to be patient safety advocates it takes a village to combat preventable errors and omissions that cause millions of deaths and sickness in our nation s hospitals and care facilities although most of these deaths are due to human and system errors not faulty medical decisions or diagnoses this annual death toll as well as the millions of additional incidents of survivable patient harm could be cut in half through consistent use of simple and nearly cost free safety behaviors in your patient safety survival guide gretchen lefever watson delivers a patient centered blueprint on how to transform the patient safety movement so that millions of unnecessary illnesses and deaths in hospitals outpatient facilities and nursing homes can be avoided she provides key safety habits that people must learn to recognize so they can be sure hospital personnel use them during every patient encounter she also explains how addressing the most common safety problems will set the stage for tackling a wide range of issues including healthcare s role in the overuse of opiate painkillers and its related heroin epidemic watson s call for a more sensible societal response to medical and human error in hospitals promotes a timely and full disclosure of all mistakes an approach that has been proven to accelerate the emotional recovery of everyone affected by patient safety events while also reducing the financial burden on hospitals providers and patients readers will learn how to change behavior to catch medical errors before they result in illness or death prevent the spread of dangerous infections in hospitals and other care facilities leverage the power of basic safety hygiene habits eliminate mistakes during surgery and other invasive procedures avoid medication errors and the overuse of opiates raise awareness and inspire civic action in their communities

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

with this important resource health care leaders from the board room to the point of care can learn how to apply the science of safe and best practices from industry to healthcare by changing leadership practices models of service delivery and methods of communication

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

iom s 1999 landmark study to err is human estimated that between 44 000 and 98 000 lives are lost every year due to medical errors this call to action has led to a number of efforts to reduce errors and provide safe and effective health care information technology it has been identified as a way to enhance the safety and effectiveness of care in an effort to catalyze its implementation the u s government has invested billions of dollars toward the development and meaningful use of effective health it designed and properly applied health it can be a positive transformative force for delivering safe health care particularly with computerized prescribing and medication safety however if it is designed and applied inappropriately health it can add an additional layer of complexity to the already complex delivery of health care poorly designed it can introduce risks that may lead to unsafe conditions serious injury or even death poor human computer interactions could result in wrong dosing decisions and wrong diagnoses safe implementation of health it is a complex dynamic process that requires a shared responsibility between vendors and health care organizations health it and patient safety makes recommendations for developing a framework for patient safety and health it this book focuses on finding ways to mitigate the risks of health it assisted care and identifies areas of concern so that the nation is in a better position to realize the potential benefits of health it health it and patient safety is both comprehensive and specific in terms of recommended options and opportunities for public and private interventions that may improve the safety of care that incorporates the use of health it this book will be of interest to the health it industry the federal government healthcare providers and other users of health it and patient advocacy groups

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

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