

Whistleblowing And Patient Safety The S Or Free

Patient Safety Handbook Patient Safety Culture Patient Safety Patient Safety Research Handbook on Patient Safety and the Law Textbook of Patient Safety and Clinical Risk Management EBOOK: Patient Safety: Research into Practice Seven Steps to Patient Safety Principles of Risk Management and Patient Safety Global patient safety report 2024 Global patient safety action plan 2021-2030 Oxford Professional Practice: Handbook of Patient Safety Patient Safety - A Psychological Perspective Patient Safety Patient Safety Understanding Patient Safety, Second Edition Making Healthcare Safe A Socio-cultural Perspective on Patient Safety Patient Safety Engaging patients for patient safety Barbara J. Youngberg Patrick Waterson Heather Gluyas Claire Cox John Tingle Liam Donaldson Kieran Walshe National Patient Safety Agency (Great Britain) Barbara J. Youngberg World Health Organization World Health Organization Peter Lachman Hannes Zacher Lorri Zipperer Charles Vincent Robert Wachter Lucian L. Leape Dr Emma Rowley Abha Agrawal World Health Organization

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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 for medical errors are ripe nearly 100 000 people die each year from medical errors and tens of thousands more are injured this comprehensive handbook on patient safety reflects the goals of many in the health care industry to advance the reliability of healthcare systems worldwide with contributions from prominent thought leaders in the field this thoroughly revised second edition of the patient safety handbook looks at all the recent changes in the industry and offers practical guidance on implementing systems and processes to improve outcomes and advance patient safety the book covers the full spectrum of patient safety and risk reduction from the fundamentals of the science of safety through a thorough discussion of operational issues and the application of the principles of research real life case studies from renowned health care organizations and their leadership help the reader understand the practical application of the strategies presented key features offers contributions from prominent thought leaders in both academia and the profession examines the newest scientific advances

in the science of safety includes real life case studies from renowned health care organizations

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

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

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

despite recurring efforts a gap exists across a variety of contexts between the protection of patients safety in theory and in practice this timely research handbook highlights these critical issues and suggests both

legal and policy changes are necessary to better protect patients safety

implementing safety practices in healthcare saves lives and improves the quality of care it is therefore vital to apply good clinical practices such as the who surgical checklist to adopt the most appropriate measures for the prevention of assistance related risks and to identify the potential ones using tools such as reporting learning systems the culture of safety in the care environment and of human factors influencing it should be developed from the beginning of medical studies and in the first years of professional practice in order to have the maximum impact on clinicians and nurses behavior medical errors tend to vary with the level of proficiency and experience and this must be taken into account in adverse events prevention human factors assume a decisive importance in resilient organizations and an understanding of risk control and containment is fundamental for all medical and surgical specialties this open access book offers recommendations and examples of how to improve patient safety by changing practices introducing organizational and technological innovations and creating effective patient centered timely efficient and equitable care systems in order to spread the quality and patient safety culture among the new generation of healthcare professionals and is intended for residents and young professionals in different clinical specialties

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

principles of risk management and patient safety identifies changes in the industry and describes how these changes have influenced the functions of risk management in all aspects of healthcare the book is divided into four sections the first section describes the current state of the healthcare industry and looks at the importance of risk management and the emergence of patient safety it also explores the importance of working with other sectors of the health care industry such as the pharmaceutical and device manufacturers the last three sections focus on the three main components of the risk manager s

responsibility claims management risk financing and proactive loss control the final section touches on solutions for seamless integration between risk management and patient safety functions using an integrative approach principles of risk management and patient safety offers a comprehensive review of the current issues which formulate the basis of a risk management program and provide the knowledge that a risk manager would be expected to have 2011 504 pages

the first ever who 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

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

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

this comprehensive book takes a psychological perspective on patient safety it is based on the most recent theoretical and empirical research evidence from psychology including clinical work and organizational psychology and adjacent social and behavioral sciences such as human factors factors that influence safety related experiences behaviors and outcomes of patients and professionals working in clinical settings such as medical practices and hospitals are reviewed structured and critically evaluated consistent with the complexity of the topic the author takes a multi level approach to patient safety which includes a review of individual team and organizational factors and outcomes the book describes how these factors by themselves and in combination can facilitate or impede patient safety individual factors include safety relevant knowledge skills abilities and personality traits such as conscientiousness and emotional stability team factors include group communication training and leadership finally organizational factors include the safety culture and climate throughout the book different evidence based intervention programs are described that can help practitioners promote patient safety and prevent accidents the book is a valuable resource for both researchers and practitioners interested in understanding maintaining and improving patient safety in a variety of applied settings it is based on the most up to date research evidence from psychology and neighboring disciplines and it is written in a clear and non technical language understandable for a wide audience

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

complete coverage of the core principles of patient safety understanding patient safety 2e is the essential text for anyone wishing to learn the key clinical organizational and systems issues in patient safety the book is filled with valuable cases and analyses as well as up to date tables graphics references and tools all designed to introduce the patient safety field to medical trainees and be the go to book for experienced clinicians and non clinicians alike features new chapter on the critically important role of checklists in medical practice new case examples throughout expanded coverage of the role of computers in patient safety and outcomes expanded coverage of new patient initiatives from the joint commission

this unique and engaging open access title provides a compelling and ground breaking account of the patient safety movement in the united states told from the perspective of one of its most prominent leaders and arguably the movement's founder lucian l leape md covering the growth of the field from the late 1980s to 2015 dr leape details the developments actors organizations research and policy making activities that marked the evolution and major advances of patient safety in this time span in addition and perhaps most importantly this book not only comprehensively details how and why human and systems errors too often occur in the process of providing health care it also promotes an in depth understanding of the principles and practices of patient safety including how they were influenced by today's modern safety sciences and systems theory and design indeed the book emphasizes how the growing awareness of systems design thinking and the self education and commitment to improving patient safety by not only dr leape but a wide range of other clinicians and health executives from both the private and public sectors all converged to drive forward the patient safety movement in the us making healthcare safe is divided into four parts i in the beginning describes the research and theory that defined patient safety and the early initiatives to enhance it ii institutional responses tells the stories of the efforts of the major organizations that began to apply the new concepts and make patient safety a reality most of these stories have not been previously told so this account becomes their histories as well iii getting to work provides in depth analyses of four key issues that cut across disciplinary lines impacting patient safety which

required special attention iv creating a culture of safety looks to the future marshalling the best thinking about what it will take to achieve the safe care we all deserve

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

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

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