

## Understanding Patient Safety

The Patient Safety Handbook Patient Safety Patient Safety and Quality Improvement in Healthcare To Do No Harm Patient Safety Assessing Patient Safety Practices and Outcomes in the U.S. Health Care System Understanding Patient Safety, Second Edition Patient Safety Achieving Safe Health Care Still Not Safe Patient Safety Your Patient Safety Survival Guide Health IT and Patient Safety Advances in Patient Safety ABC of Patient Safety Foundations in Patient Safety for Health Professionals Error Reduction in Health Care Patient Safety and Health Care Management Making Healthcare Safe High Reliability Organizations, Second Edition Barbara J. Youngberg Jacqueline Fowler Byers Rahul K. Shah Julianne M. Morath, RN, MS Lorri Zipperer Donna Farley Robert Wachter Institute of Medicine Jan Compton Robert Wears Abha Agrawal Gretchen LeFever Watson Institute of Medicine Kerm Henriksen John Sandars Kimberly A. Galt Patrice L. Spath Grant T. Savage Lucian L. Leape Cynthia A. Oster The Patient Safety Handbook Patient Safety Patient Safety and Quality Improvement in Healthcare To Do No Harm Patient Safety Assessing Patient Safety Practices and Outcomes in the U.S. Health Care System Understanding Patient Safety, Second Edition Patient Safety Achieving Safe Health Care Still Not Safe Patient Safety Your Patient Safety Survival Guide Health IT and Patient Safety Advances in Patient Safety ABC of Patient Safety Foundations in Patient Safety for Health Professionals Error Reduction in Health Care Patient Safety and Health Care Management Making Healthcare Safe High Reliability Organizations, Second Edition *Barbara J. Youngberg Jacqueline Fowler Byers Rahul K. Shah Julianne M. Morath, RN, MS Lorri Zipperer Donna Farley Robert Wachter Institute of Medicine Jan Compton Robert Wears Abha Agrawal Gretchen LeFever Watson Institute of Medicine Kerm Henriksen John Sandars Kimberly A. Galt Patrice L. Spath Grant T. Savage Lucian L. Leape Cynthia A. Oster*

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

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 authors' 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

this text uses a case based approach to share knowledge and techniques on how to operationalize much of the theoretical underpinnings of hospital quality and safety written and edited by leaders in healthcare education and engineering these 22 chapters provide insights as to where the field of improvement and safety science is with regards to the views and aspirations of healthcare advocates and patients each chapter also includes vignettes to further solidify the theoretical underpinnings and drive home learning end of chapter commentary by the editors highlight important concepts and connections between various chapters in the text patient safety and quality improvement in healthcare a case based approach presents a novel approach towards hospital safety and quality with the goal to help healthcare providers reach zero harm within their organizations

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

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

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

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

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

winner of a 2016 shingo research and professional publication award a recent article published in the journal of patient safety estimated that more than 400 000 lives are lost each year due to preventable patient events in american hospitals preventable patient safety events are the third leading cause of death in the united states while most hea

the term patient safety rose to popularity in the late nineties as the medical community in particular physicians working in nonmedical and administrative capacities sought to raise awareness of the tens of thousands of deaths in the us attributed to medical errors each year but what was causing these medical errors and what made these accidents to rise to epidemic levels seemingly overnight still not safe is the story of the rise of the patient safety movement and how an epidemic of medical errors was derived from a reality that didn t support such a characterization

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

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

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

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

this brand new title in the popular abc series offers an up to date introduction on improving patient safety in primary and secondary care the abc of patient safety covers an area of increasing importance in healthcare and provides a clear description of the underlying principles that influence practice patient safety is now an integral part of the training for all foundation doctors and is rapidly becoming a component of many undergraduate and postgraduate exams including the nmrcgp this book is an ideal companion for this training a wide variety of clinical staff and managers in primary and secondary care will find this book an essential text offering an ideal theoretical and practical aid to patient safety gps and practice managers will find this book of particular interest as well as medical and nursing students

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

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

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

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 captivatingly written with an insider s tone and a major contribution to the clinical literature this title will be of immense value to health care professionals to students in a range of academic disciplines to medical trainees to health administrators to policymakers and even to lay readers with an interest in patient safety and in the critical quest to create safe care

patient safety and quality of care are critical concerns of healthcare consumers payers providers organizations health systems and governments although a strong body of knowledge shows that high reliability methods enable the most efficient safe and effective care these methods have yet to be completely implemented across healthcare according to authors cynthia oster and jane braaten nurses who are on the frontline of providing safe and effective care are ideally situated to drive high reliability high reliability organizations a healthcare handbook for patient safety quality second edition equips nurses and healthcare

professionals with the tools necessary to establish an error detection and prevention system this new edition builds on the foundation of the first book with best practices relevant exemplars and important discussions about cultural aspects essential to sustainability new material focuses on high reliability performance during a pandemic organizational learning and tiered safety huddles high reliability in infection prevention and ambulatory care the emerging field of human factors engineering within healthcare creating a virtual resource toolkit for frontline staff

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