



Patient Safety Patient Safety

Barbara Youngberg



Patient Safety Patient Safety:

The Patient Safety Handbook Barbara J. Youngberg, Martin J. Hatlie, 2004 *Quality Patient Safety Foundations in Patient Safety for Health Professionals* Kimberly A. Galt, Karen Paschal, 2009-10 To Err is Human said the 1999 landmark report published by the Institute of Medicine the report that highlighted tragic numbers of injury and harm the wide reaching nature of this problem and areas of need to reverse this growing trend was also a call to action Today health care professionals recognize the importance of patient safety education across many disciplines Based on an interprofessional course designed by faculty in bioethics business dentistry law medicine nursing occupational therapy pharmacy physical therapy and social work *Foundations of Patient Safety for Heal* **Patient Safety** Heather Gluyas, Paul Morrison, 2013-12-04 How can we make health care processes safer and more consistent How do we improve care outcomes for patients With a range of coaching tips 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 and Quality Improvement in Healthcare Rahul K. Shah, Sandip A. Godambe, 2020-12-15 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 **Patient Safety** Charles Vincent, 2011-07-20 When you are ready to implement measures to improve patient safety this is the book to consult Charles Vincent one of the world s pioneers in patient safety discusses each and every aspect clearly and compellingly He reviews the evidence of risks and harms to patients and he provides practical guidance on implementing safer practices in health care The second edition puts greater emphasis on this practical side Examples of team based initiatives show how patient safety can be improved by changing practices both cultural and technological throughout whole organisations Not only does this benefit patients it also impacts positively on health care delivery with consequent savings in the economy Patient Safety has been praised as a gateway to understanding the subject This second edition is more than that it is a revelation of the pervading influence of health care errors and a guide to how these can be overcome

The beauty of this book is that it describes the complexity of patient safety in a simple coherent way and captures the breadth of issues that encompass this fascinating field. The author provides numerous ways in which the reader can take this subject further with links to the international world of patient safety and evidence based research. One of the most difficult aspects of patient safety is that of implementation of safer practices and sustained change. Charles Vincent through this book provides all who read it clear examples to help with these challenges. From a review in Hospital Medicine by Dr Suzette Woodward, Director of Patient Safety, Access Essentials of Patient Safety, Free Online Introduction www.wiley.com/go/vincent/patientsafetyessentials. *Patient Safety* Institute of Medicine, Board on Health Care Services, Committee on Data Standards for Patient Safety, 2003-12-20. Americans should be able to count on receiving health care that is safe. To achieve this a new health care delivery system is needed, 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. **Patient Safety** Jacqueline Fowler Byers, Susan V. White, 2004-06-03. 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. **To Do No Harm** Julianne M. Morath, RN, MS, Joanne E. Turnbull, PHD, 2005-05-06. 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. *Assessing Patient Safety Practices and Outcomes in the U.S. Health Care System* Donna O. Farley, M. Susan Ridgely, Peter Mendel, Stephanie S. Teleki, Cheryl L. Damberg, 2009-09-02. 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 Making Healthcare Safe Lucian L. Leape,2021-05-28 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 *Advances in Patient Safety* Kerm Henriksen,2005 v 1 Research findings v 2 Concepts and methodology v 3 Implementation issues v 4 Programs tools and products **Patient Safety** Abha Agrawal,2013-10-04 Despite the evolution and growing awareness of patient safety many medical professionals are not a part of this important conversation Clinicians often believe they are too busy taking care of patients to adopt and implement patient safety initiatives and that acknowledging medical errors is an affront to their skills Patient Safety provides clinicians with a better understanding of the prevalence causes and solutions for medical errors bringing best practice principles to the bedside Written by experts from a variety of backgrounds each chapter features an analysis of clinical cases based on the Root Cause Analysis RCA methodology along with case based discussions on various patient safety topics The systems and processes outlined in the book are general and broadly applicable to institutions of all sizes and structures The

core ethic of medical professionals is to do no harm Patient Safety is a comprehensive resource for physicians nurses and students as well as healthcare leaders and administrators for identifying solving and preventing medical error **Keeping Patients Safe** Institute of Medicine,Board on Health Care Services,Committee on the Work Environment for Nurses and Patient Safety,2004-03-27 Building on the revolutionary Institute of Medicine reports To Err is Human and Crossing the Quality Chasm Keeping Patients Safe lays out guidelines for improving patient safety by changing nurses working conditions and demands Licensed nurses and unlicensed nursing assistants are critical participants in our national effort to protect patients from health care errors The nature of the activities nurses typically perform monitoring patients educating home caretakers performing treatments and rescuing patients who are in crisis provides an indispensable resource in detecting and remedying error producing defects in the U S health care system During the past two decades substantial changes have been made in the organization and delivery of health care and consequently in the job description and work environment of nurses As patients are increasingly cared for as outpatients nurses in hospitals and nursing homes deal with greater severity of illness Problems in management practices employee deployment work and workspace design and the basic safety culture of health care organizations place patients at further risk This newest edition in the groundbreaking Institute of Medicine Quality Chasm series discusses the key aspects of the work environment for nurses and reviews the potential improvements in working conditions that are likely to have an impact on patient safety *Meeting the International Patient Safety Goals* Paulo Reis,2007 Successfully meeting the International Patient Safety Goals set forth by Joint Commission International is an essential element in the accreditation process Meeting the International Patient Safety Goals will help you understand how your organization can meet the requirements of the six goals which involve the following crucial patient safety subjects

Patient Safety and Health Care Management Grant T. Savage,Eric W. Ford,2008-07-25 Contains four sections that include theoretical perspectives on managing patient safety top management perspectives on patient safety health information technology perspectives on patient safety and organizational behavior and change perspectives on patient safety

Health IT and Patient Safety Institute of Medicine,Board on Health Care Services,Committee on Patient Safety and Health Information Technology,2012-03-15 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 Lorri Zipperer, 2016-05-13 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

Fundamentals of Patient Safety in Medicine and Surgery S P Stawicki, 2015-01-01 This book presents a practical approach to patient safety issues with a focus on evolution and understanding the key concepts in health care and turning them into implementable actions With its contemporary approach and lucid presentation this book is a valuable resource for practicing doctors in medicine and surgery to treat their patients with care diligence and vigilance and contribute to a safer practice in health care

ABC of Patient Safety John Sandars, Gary Cook, 2009-04-08 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 **Principles of Risk Management and Patient Safety** Barbara Youngberg, 2010-10-15
Health Sciences Professions

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