Patient Safety Handbook

Whether you're new to medication safety or an experienced Medication Safety Officer, this guide will be an invaluable resource. TheMedication Safety Officer's Handbook offers expert guidance in every area of your work, from setting up safety systems to dealing with personnel problems, along with sample forms, checklists and other job tools.

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. Important Notice: The digital edition of this book is missing some of the images or content found in the physical edition.

The essential healthcare guide to doing more with existing resources The healthcare industry faces foundational challenges to how it sustains itself. As the gap between cost and revenue continues to widen, and as cost-effectiveness remains an elusive imperative, the question persists: how can healthcare organizations do more with the same resources? The Hospital and Clinic Improvement Handbook is a practical guide to how operations management -- in particular Lean and the Theory of Constraints (TOC) -- can rapidly advance value and performance in any healthcare organization. Utilizing a systems approach that will be relevant for healthcare managers and executives, it unpacks and demystifies concepts such as performance measures, operations, quality, cost accounting, pricing, and value enhancement, all as they relate to eliminating waste and non-value-adding activities. Enriched with dozens of examples and building on the authors' experience teaching and refining these concepts for healthcare, this text is an essential guide for executives and managers across the industry.

"Nurses play a vital role in improving the safety and quality of patient car -- not only in the hospital or ambulatory treatment facility, but also of community-based care and the care performed by family members. Nurses need know what proven techniques and interventions they can use to enhance patient outcomes. To address this need, the Agency for Healthcare Research and Quality (AHRQ), with additional funding from the Robert Wood Johnson Foundation, has prepared this comprehensive, 1,400-page, handbook for nurses on patient safety and quality -- Patient Safety and Quality: An Evidence-Based Handbook for Nurses. (AHRQ Publication No. 08-0043)."--Online AHRQ blurb, http://www.ahrq.gov/qual/nurseshdbk.

Ambulatory care organizations are challenged by medication safety, infection prevention and control, environment of

care, communication, and other patient safety issues; however, most available benchmarks and initiatives concerning patient safety were developed specifically for hospitals and do not translate easily to ambulatory care settings. Ambulatory surgical centers, office-based surgery practices, community health centers, diagnostic imaging centers, urgent care centers, medical and dental centers, and other ambulatory care facilities face critical and unique patient safety issues on a daily basis. A Patient Safety Handbook for Ambulatory Health Care provides proven solutions for keeping patients safe in an ambulatory setting and addresses challenging patient safety concerns. The book explores seven system-level issues: patient-centered care, communication, medication use, surgical safety, infection prevention and control, environment and equipment, and staff education and training. It contains useful tools that educate staff and physicians about patient safety in ambulatory care: Easy-to-adapt forms, checklists, and solutions Critical lessons learned about which approaches work, which don't, and why Real-life case studies on improving patient safety in ambulatory settings Discussions on growing concerns in ambulatory health care, such as the following: Safe medication use, such as chemotherapy drugs and multi-use medication vials Anesthesia issues, such as undiagnosed sleep apnea, patient falls, and malignant hyperthermia Effective infection control, such as hand hygiene and flash sterilization
The occurrence of failures and mistakes in health care, from primary care procedures to the complexities of the operating room, has become a hot-button issue with the general public and within the medical community. Around the Patient Bed: Human Factors and Safety in Health Care examines the problem and investigates the tools to improve health care quality and safety from a human factors engineering viewpoint—the applied scientific field engaged in the interaction between the human operator (functionary, worker), task requirements, the governing technical systems, and the characteristics of the work environment. The book presents a systematic human factors-based, proactive approach to the improvement of health care work and patient safety. The proposed approach delineates a more direct and powerful alternative to the contemporary dominant focus on error investigation and care providers' accountability. It demonstrates how significant improvements in the quality of care and enhancement of patient safety are contingent on a major shift from efforts and investments driven by a retroactive study of errors, incidents, and adverse events, to an emphasis on proactive human factors-driven intervention and the development of corresponding conceptual approaches and methods for its systematic implementation. Edited by Yoel Donchin, representing the medical profession, and Daniel Gopher, from the human factors engineering field, the book brings together experts who have collaborated to present studies that reveal a wide range of problems and weaknesses of the contemporary health care system, which impair safety and quality and increase workload. The book presents practical solutions based on human factors engineering components and cognitive psychology, and explains their driving principles and methodologies. This approach provides tools to significantly reduce

the number of errors, creates a safe environment, and improves the quality of health care.
The Correctional Health Care Patient Safety Handbook provides practical evidence-based help to improve your clinical program and, thereby, reduce clinical error, managing risk and improving clinical quality. By reading this book, you will discover: How a patient safety framework can reduce legal liability while enhancing continuous quality improvement efforts The best methods to assess and improve an organizational culture to support patient safety The key ways therapeutic systems support patient safety Why communication and teamwork are so important for reducing clinical error How to involve your patients to reduce errors and liability The practitioner issues that can sink your clinical program and what to do about them This book is a must-read for anyone working in the correctional health care setting, but especially for those who have opportunity to create and improve systems of care such as: Health Service Administrators Medical Directors Directors of Nursing Risk Management Professionals Operational Leaders Lorry Schoenly is a nurse author and educator specializing in correctional health care. She provides consulting services to jails and prisons across the country on projects to improve professional nursing practice and patient safety. Dr. Schoenly actively promotes correctional health care through social media outlets and increases the visibility of the specialty through her popular blog - CorrectionalNurse.Net. Her podcast, Correctional Nursing Today, reviews correctional healthcare news and interviews correctional health care leaders. She is recipient of the National Commission on Correctional Health Care 2013 B. Jaye Anno Award of Excellence in Communication. Lorry is co-editor and chapter author of Essentials of Correctional Nursing, the first primary practice text for the correctional nursing specialty. She resides in the mountains of north central Pennsylvania.
Patients have always been encouraged to be active participants in managing their health. New technologies, cultural shifts, trends in healthcare delivery, and policies have brought the patients' role in healthcare to the forefront. This 2-volume set reviews and advances the emerging discipline of Patient Ergonomics. The set focuses on patients and their performance. It presents practical recommendations and case studies useful for researchers and practitioners. It covers diverse healthcare settings outside of hospitals and clinics, and provides a combination of foundational content and specific applications in detail. The 2-volume set will be ideal for academics working in healthcare and patient-centered research, their students, human factors practitioners (consultants, employees of health systems and technology/medical device compaines), healthcare professionals (physicians, nurses, pharmacists), and organizational leaders (healthcare administrators and executives).
Drive to provide high value healthcare has created a field of medical quality improvement and safety. A Quality Improvement (QI) project would often aim in translate medical evidence (e.g. hand hygiene saves lives) into clinical practice (e.g. actually washing your hands before you see the patient, suffice it to say that not all hospitals are able to report 100% compliance with hand-hygiene). All doctoral residents in the United States must now satisfy a new requirement from the American College of Graduate

Medical Education that they participate in a QI initiative. However, few departments are equipped to help their residents develop and implement a QI initiative. Resident's Handbook is a short, not fussy, and practical introduction to developing a QI initiative. Meant not only for residents seeking to jump-start a QI initiative but also for attending physicians looking to improve their clinical practice, residency program directors and even medical students already eyeing what residency training holds for them; the book introduces and explains the basic tools needed to conduct a QI project. It provides numerous real-life examples of QI projects by the residents, fellows and attendings who designed them, who discuss their successes and failures as well as the specific tools they used. Several chapters provide a more senior perspective on resident involvement in QI projects and feature contributions from several QI leaders, a hospital administration VP and a residency program director. Though originally designed with physicians in mind, the book will also be helpful for physician assistants, nurses, physical, occupational and speech language pathology therapists, as well as students in these disciplines. Since no QI intervention is likely to be successful if attempted in isolation more non-physician clinicians are joining the ranks of quality and safety leadership. Therefore several non-physician clinician led initiatives included in the manuscript constitute an integral part of this book.The book serves as a short introduction to the field of medical quality improvement and safety emphasizing the practical pointers of how to actually implement a project from its inception to publication. To our knowledge this is the first concise do-it-yourself publication of its kind. Some of the topics covered include: how to perform an efficient literature search, how to get published, how to scope a project, how to generate improvement ideas, effective communication, team, project management and basic quality improvement tools like PDCA, DMAIC, Lean, Six Sigma, human factors, medical informatics etc.. Although no substitute for the services of a trained clinical statistician, chapters on statistics and critical assessment of the medical literature familiarizes residents with basic statistical methodologies, clinical trials and evidence based medicine (EBM). Since no QI project is complete without providing evidence for post-intervention improvement we provide a short introduction to the free statistical language R, which helps residents independently run basic statistical calculations. Because much of QI involves assessment of subjective human experiences, there is also a chapter on how to write surveys. Resident's Handbook of Medical Quality and Safety is not an exhaustive QI textbook but rather a hands-on pocket guide to supplement formal training by other means.div

Learn how financial management fits into the healthcare organization. Financial Management for Nurse Managers and Executives, 5th Edition covers the latest accounting and financial management practices distinctly from the nurse manager's point of view. Topics include how financial management fits into the health care organization, financial accounting, cost analysis, planning and control management of the organization's financial resources, various management tools, and the future of financial management with respect to healthcare reform and international accounting standards. This new edition includes updated information on the Affordable Care Act, Accountable Care Organizations, Value Based Payment, and Team and Population Based Care. Nursing-focused content thoroughly describes healthcare finance and accounting from the nurse manager's point of view. Numerous worksheets and tables including healthcare spreadsheets, budgets, and calculations provide you with specific examples of how to

apply financial management principles to nursing practice. NEW! Information about the Affordable Care Act details how changes and developments affects coverage for millions of Americans. NEW! Value-Based Payment reimbursement information details what nurse executives need to know in order to use this new system NEW! Coverage of Accountable Care Organizations provides current information on one of the emerging forms of managed care and how it works within the financial system of healthcare. NEW! Team-and Population-Based care information covers how to work with healthcare professionals outside of nursing.

Medical and health activities can greatly benefit from the effective use of health informatics. By capturing, processing, and disseminating information to the correct systems and processes, decision-making can be more successful and quality care and patient safety would see significant improvements. The Handbook of Research on Patient Safety and Quality Care through Health Informatics highlights current research and trends from both professionals and researchers on health informatics as applied to the needs of patient safety and quality care. Bringing together theory and practical approaches for patient needs, this book is essential for educators and trainers at multiple experience levels in the fields of medicine and medical informatics.

The Hospital Safety Professional's Handbook, Fifth Edition Cindy Taylor, ARM, CSPHP This trusted resource is your guide through the complex and changing world of healthcare safety and regulatory compliance. Completely updated, this book removes the stress from the role of healthcare safety professional by providing straightforward coverage of all the most important topics, including life safety and emergency management scenarios, keeping up with The Joint Commission, and the increased presence of CMS in the safety space. The Hospital Safety Professional's Handbook, Fifth Edition, gives you the necessary resources to handle evolving safety requirements. With a new emphasis on risk assessment, emergency planning, and complex issues such as hazardous waste disposal, this is the one handbook you need to handle all of your safety duties! This book will help you: Emphasize risk assessment as a core measure of planning, growth, and continuity of operations Meet the regulatory requirements related to life safety and emergency management Train hospital staff on communication and safety topics, including safety-related staff competency requirements based on revised Joint Commission standards Clarify key issues such as the 96-hour rule, corridor clutter, Sentinel Event Alerts, and more Strategically integrate building safety and patient safety, infection control, and relevant National Patient Safety Goals Navigate the safety director's role during construction and renovation projects Table of Contents: Chapter 1: An Overview: The Hospital Safety Professional Chapter 2: Managing Risks in Healthcare Chapter 3: Setting Up and Organizing Your Program Chapter 4: Budgeting for Safety Chapter 5: Creating a Safety Manual Chapter 6: Safety & Security Management Chapter 7: Hazardous Materials and Wastes Chapter 8: Preparing for and Responding to Emergencies (Including Utility Systems Capabilities) Chapter 9: Life and Fire Safety Management (Including ILSMs) Chapter 10: Medical Equipment and Utilities Chapter 11: Performance Improvement/Effective Organization/Management of Your EOC Committee Chapter 12: Education and Training Chapter 13: Final Recommendations

This Handbook provides an authoritative overview of current issues and debates in the field of health care management. It contains over twenty chapters from well-known and eminent academic authors, who were carefully selected for their expertise and

asked to provide a broad and critical overview of developments in their particular topic area. The development of an international perspective and body of knowledge is a key feature of the book. The Handbook secondly makes a case for bringing back a social science perspective into the study of the field of health care management. It therefore contains a number of contrasting and theoretically orientated chapters (e.g. on institutionalism; critical management studies). This social science based approach is a refreshing alternative to much existing work in this domain and offers a good way into current academic debates in this field. The Handbook thirdly explores a variety of important policy and organizational developments apparent within the current health care field (e.g. new organizational forms; growth of management consulting in health care organizations). It therefore explores and comments on major contemporary trends apparent in the practice field.

Provides step-by-step instructions on how to establish a patient safety plan for a variety of healthcare settings, summarizing each of the key patient safety requirements implemented by federal, state, and accreditation agencies, including the federal Patient Safety and Quality Improvement Act of 2005.

Ethical medical treatment is an important aspect of healthcare that is affected by multiple influencing factors in, both private and public, medical organizations. By understanding and adapting the components of the health system to these influencing factors, healthcare can have better outcomes for patients and practitioners. Healthcare Administration for Patient Safety and Engagement provides emerging research on the theoretical and practical aspects of healthcare management for optimal patient care and communication. While highlighting topics, such as clinical communication, ethical dilemmas, and preventive medicine, this book will teach readers about the tools and applications of ethical treatment and hospital behavior in both private and public medical organizations. This book is an important resource for managers and employees of health units, physicians, medical students, psychology and sociology professionals, and researchers seeking current research on healthcare organization and patient satisfaction.

Offering a concise yet comprehensive review of current practices in surgery and patient safety, Handbook of Perioperative and Procedural Patient Safety is an up-to date, practical resource for practicing surgeons, anesthesiologists, surgical nurses, hospital administrators, and surgical office staff. Edited by Drs. Juan A. Sanchez and Robert S. D. Higgins and authored by expert contributors from Johns Hopkins, it provides an expansive look at the scope of the problem, causes of error, minimizing errors, surgical suite and surgical team design, patient experience, and other related topics. Presents the knowledge and experience of a multidisciplinary team from Johns Hopkins University, which created the Comprehensive Unit-based Safety Program (CUSP), an approach for improving safety culture and engaging frontline clinicians to identify and mitigate defects in care delivery. Discusses the scope and prevalence of perioperative harm, causes of error in healthcare, and perioperative never events. Covers safe practices, cognitive workload and

fatigue, and the effects of noise in the OR. Includes several team-based chapters such as the dynamics of surgical teams, safer perioperative team communication, and the culture of safety. Consolidates today's available information and guidance into a single, convenient resource.

Patients are increasingly encouraged to take an active role in managing their health and health care. New technologies, cultural shifts, trends in healthcare delivery, and policies have brought to the forefront the "work" patients, families, and other non-professionals perform in the pursuit of health. This volume closely examines notable application areas for the emerging discipline of Patient Ergonomics – the science of patient work. The Patient Factor: Applications of Patient Ergonomics, Volume II reviews the definition of Patient Ergonomics and discusses the application of Patient Ergonomics across contexts. It analyzes patient work performed in emergency departments, transitions of care, home and community settings, retail pharmacies, and online communities. It also examines applications to groups including veterans, pediatric patients, older adults, the underserved, and people engaged in health promotion. The Patient Factor is ideal for academics working in health care and patient-centered research, their students, human factors practitioners working in healthcare organizations or at technology companies, frontline healthcare professionals, and leaders of healthcare delivery organizations.

Health Sciences & Professions

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 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.

The first comprehensive, authoritative review of one of the most fundamental and important issues in infection control and patient safety, hand hygiene. Developed and presented by the world's leading scholar-clinicians, Hand Hygiene is an essential resource for all medical professionals. Developed and presented by the world leaders in this fundamental topic Fully integrates World Health Organization (WHO) guidelines and policies Offers a global perspective in tackling hand hygiene issues in developed and developing countries Coverage of basic and highly complex clinical applications of hand hygiene practices Includes novel and unusual aspects and issues in hand hygiene such as religious and cultural aspects and patient participation Offers guidance at the individual, institutional, and organizational levels for national and worldwide hygiene promotion campaigns

The Essential Guide for Patient Safety Officers, Second Edition, copublished with the Institute for Healthcare Improvement (IHI), is a comprehensive and authoritative repository of essential knowledge on operationalizing patient safety. Patient safety officers must make sure their organizations create a safety culture, implement new safety practices, and improve safety-related management and operations. This updated edition of a JCR best seller, with many new chapters, will help them do that. Edited by Allan Frankel, MD; Michael Leonard, MD; Frank Federico, RPh; Karen Frush, MD; and Carol Haraden, PhD, this book provides: * Core knowledge and insights for patient safety leaders, clinicians, change agents, and other staff * Strategies and best practices for day-to-day operational issues * Patient safety strategies and initiatives * Tools, checklists, and guidelines to assess, improve, and monitor patient safety functions * Expert guidance on leadership's role, assessing and improving safety culture, designing for reliability and resilience, ensuring patient involvement, using technology to enhance safety, and building and sustaining a learning system -- and other essential topics The work described in the book reveals growing insight into the complex task of taking care of patients safely as an intrinsic, inseparable part of quality care. To do this we need to create a systematic, integrated approach, and this book shows us how to do it. -- Gary S. Kaplan, MD, Chairman and CEO, Virginia Mason Medical Center, Seattle

Patient safety and quality are an ever-increasing concern to consumers, payers, providers, organizations, and governments. However, high reliability methods and science that can provide efficient and effective care have still not been totally implemented into our healthcare culture.

Nurses, representing the majority of healthcare workers, are on the front line of the delivery and provision of safe and effective care and are ideally situated to drive the mission to achieve high reliability in healthcare. High Reliability Organizations: A Healthcare Handbook for Patient Safety & Quality presents practical examples of HRO principles in order to establish a system that detects and prevents errors from happening even in the most difficult, high risk conditions. Authors Cynthia Oster and Jane Braaten provide healthcare professionals with tools and best practices that will improve and enhance patient safety and quality outcomes. This book provides: An overview of HRO science as an organizing framework for quality and patient safety, practical applications of HRO science, focusing on quality and patient safety, knowledge and tools that can be applied to current quality and safety practices and real-world examples of HRO principles employed in a variety of patient care areas.

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/patientsafety/essentials

Risk Management Handbook for Health Care Organizations, Student Edition This comprehensive textbook provides a complete introduction to risk management in health care. Risk Management Handbook, Student Edition, covers general risk management techniques; standards of health care risk management administration; federal, state and local laws; and methods for integrating patient safety and enterprise risk management into a comprehensive risk management program. The Student Edition is applicable to all health care settings including acute care hospital to hospice, and long term care. Written for students and those new to the topic, each chapter highlights key points and learning objectives, lists key terms, and offers questions for discussion. An instructor's supplement with cases and other material is also available. American Society for Healthcare Risk Management (ASHRM) is a personal membership group of the American Hospital Association with more than 5,000 members representing health care, insurance, law, and other related professions. ASHRM promotes effective and innovative risk management strategies and professional leadership through education, recognition, advocacy, publications, networking, and interactions with leading health care organizations and government agencies. ASHRM initiatives focus on developing and implementing safe and effective patient care practices, preserving financial resources, and maintaining safe working environments.

Second in a series of publications from the Institute of Medicine's Quality of Health Care in America project Today's health care providers have more research findings and more technology available to them than ever before. Yet recent reports have raised serious doubts about

the quality of health care in America. Crossing the Quality Chasm makes an urgent call for fundamental change to close the quality gap. This book recommends a sweeping redesign of the American health care system and provides overarching principles for specific direction for policymakers, health care leaders, clinicians, regulators, purchasers, and others. In this comprehensive volume the committee offers: A set of performance expectations for the 21st century health care system. A set of 10 new rules to guide patient-clinician relationships. A suggested organizing framework to better align the incentives inherent in payment and accountability with improvements in quality. Key steps to promote evidence-based practice and strengthen clinical information systems. Analyzing health care organizations as complex systems, Crossing the Quality Chasm also documents the causes of the quality gap, identifies current practices that impede quality care, and explores how systems approaches can be used to implement change.

Patient Safety HandbookJones & Bartlett Publishers

Clinical Engineering Handbook, Second Edition, covers modern clinical engineering topics, giving experienced professionals the necessary skills and knowledge for this fast-evolving field. Featuring insights from leading international experts, this book presents traditional practices, such as healthcare technology management, medical device service, and technology application. In addition, readers will find valuable information on the newest research and groundbreaking developments in clinical engineering, such as health technology assessment, disaster preparedness, decision support systems, mobile medicine, and prospects and guidelines on the future of clinical engineering. As the biomedical engineering field expands throughout the world, clinical engineers play an increasingly important role as translators between the medical, engineering and business professions. In addition, they influence procedures and policies at research facilities, universities, and in private and government agencies. This book explores their current and continuing reach and its importance. Presents a definitive, comprehensive, and up-to-date resource on clinical engineering Written by worldwide experts with ties to IFMBE, IUPESM, Global CE Advisory Board, IEEE, ACCE, and more Includes coverage of new topics, such as Health Technology Assessment (HTA), Decision Support Systems (DSS), Mobile Apps, Success Stories in Clinical Engineering, and Human Factors Engineering

Concise, portable, and user-friendly, The Washington Manual® of Patient Safety and Quality Improvement covers essential information in every area of this complex field. With a focus on improving systems and processes, preventing errors, and promoting transparency, this practical reference provides an overview of PS/QI fundamentals, as well as insight into how these principles apply to a variety of clinical settings. Part of the popular Washington Manual® series, this unique volume provides the knowledge and skills necessary for an effective, proactive approach to patient safety and quality improvement.

The first edition of Handbook of Human Factors and Ergonomics in Health Care and Patient Safety took the medical and ergonomics communities by storm with in-depth coverage of human factors and ergonomics research, concepts, theories, models, methods, and interventions and how they can be applied in health care. Other books focus on particular human factors and ergonomics issues such as human error or design of medical devices or a specific application such as emergency medicine. This book draws on both areas to provide a compendium of human factors and ergonomics issues relevant to health care and patient safety. The second edition takes a more practical approach with coverage of methods, interventions, and applications and a greater range of domains such as medication safety, surgery, anesthesia, and infection prevention. New topics include: work

schedules error recovery telemedicine workflow analysis simulation health information technology development and design patient safety management Reflecting developments and advances in the five years since the first edition, the book explores medical technology and telemedicine and puts a special emphasis on the contributions of human factors and ergonomics to the improvement of patient safety and quality of care. In order to take patient safety to the next level, collaboration between human factors professionals and health care providers must occur. This book brings both groups closer to achieving that goal.

Written for virtually every professional and leader in the health care field, as well as students who are preparing for careers in health services delivery, this book presents a framework for developing a patient safety program, shows how best to examine events that do occur, and reveals how to ensure that appropriate corrective and preventative actions are reviewed for effectiveness. The book covers a comprehensive selection of topics including The link between patient safety and legal and regulatory compliance The role of accreditation and standard-setting organizations in patient safety Failure modes and effect analysis Voluntary and regulatory oversight of medical error Evidence-based outcomes and standards of care Creation and preservation of reports, data, and device evidence in medical error situations Claims management when dealing with patient safety events Full disclosure Patient safety in human research Managing confidentiality in the face of litigation Managing patient safety compliance through accountability-based credentialing for health care professionals Planning for the future

The Vaccine Handbook has a simple purpose- to draw together authoritative information about vaccines into a simple and concise resource that can be used in the office, clinic, and hospital. Not an encyclopedia or scientific textbook, The Vaccine Handbook gives practical advice and provides enough background for the practitioner to understand the recommendations and explain them to his or her patients. For each vaccine, the authors discuss the disease and its epidemiology, the vaccine’s efficacy and safety, and the practical questions most frequently asked about the vaccine’s use. The authors also discuss problems such as allergies, breastfeeding, dosing intervals and missed vaccines, and immunocompromised individuals. This handbook is also available electronically for handheld computers. See Media listing for details.