Understanding Patient Safety

Patient safety is a predominant feature of quality healthcare and something that every patient has the right to expect. As a nurse, you must consider the safety of the patient as paramount in every aspect of your role; and it is now an increasingly important topic in pre-registration nursing programmes. This book aims to provide you with a greater understanding of how to manage patient safety and risk in your practice. The book focuses on the essentials that you need to know, and therefore provides a clear pathway through what can sometimes seem an overwhelmingly complex mass of rules, procedures and possible options. Key features: · A practical introduction to patient safety and risk management written specifically for nurses and nursing students · Case studies and scenarios help you to apply patient safety and risk management principles to actual practice · Each chapter is mapped to the relevant NMC standards and Essential Skills Clusters so that you can see how you are meeting the professional requirements · Activities throughout help you to think critically and reflect on practice.

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. Physician Robert Wears and organizational theorist Kathleen Sutcliffe trace the origins of patient safety to the emergence of market trends that challenged the place of doctors in the larger medical ecosystem: the rise in medical litigation and physicians' aversion to risk; institutional changes in the organization and control of healthcare; and a bureaucratic movement to "rationalize" medical practice -- to make a hospital run like a factory. If these social factors challenged the place of practitioners, then the patient-safety movement provided a means for readjustment. In spite of relatively constant rates of medical errors in the preceding decades, the "epidemic" was announced in 1999 with the publication of the Institute of Medicine report To Err Is Human; the reforms that followed came to be dominated by the very professions it set out to reform. Weaving together narratives from medicine, psychology, philosophy, and human performance, Still Not Safe offers a counterpoint to the presiding, doctor-centric narrative of contemporary American medicine. It is certain to raise difficult, important questions around the state of our healthcare system -- and provide an opening note for other challenging conversations.

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 case studies book is a unique, practical, cutting-edge, and indispensable go-to resource for front-line practitioners and educators in medicine. Each case study (chapter) is framed by a set of introductory learning objectives, an evaluation section, thought-provoking discussion questions, and references to further readings. Furthermore, the book is conveniently organized along the continuum of medical care delivery, providing quick access to ad-hoc solutions in safety- and quality-compromised situations, illustrating how skillful communication can be the key to a more effective prevention, intervention, and response to “close calls” and adverse events. The case studies book is unique and innovative in its interdisciplinary integration of the contemporary literature in communication science with current “hot buttons” of patient safety. It manifests a valuable interdisciplinary collaboration by translating the basic tenets of human communication science for practitioners of medicine, providing a conceptual, evidence-based foundation for formulating communication-based practice guidelines to advance patient safety and quality of care. The case studies put communication theory into practice to facilitate experiential learning, granting insights into the breadth and diverse aspects of safe and high quality healthcare delivery. Thought-provoking discussion questions and references for further reading make this book a valuable reference for medical practitioners across the world.

Charts the geneaology of patient safety both internationally and in the UK from the late 1980s, examines staff and patient roles and ends with the importance of learning lessons from safety failures.

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.
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.
v. 1. Research findings -- v. 2. Concepts and methodology -- v. 3. Implementation issues -- v. 4. Programs, tools and products.
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.
Experts estimate that as many as 98,000 people die in any given year from medical errors that occur in hospitals. That's more than die from motor vehicle accidents, breast cancer, or AIDS--three causes that receive far more public attention. Indeed, more people die annually from medication errors than from workplace injuries. Add the financial cost to the human tragedy, and medical error easily rises to the top ranks of urgent, widespread public problems. To Err Is Human breaks the silence that has surrounded medical errors and their consequence--but not by pointing fingers at caring health care professionals who make honest mistakes. After all, to err is human. Instead, this book sets forth a national agenda--with state and local implications--for reducing medical errors and improving patient safety through the design of a safer health system. This volume reveals the often startling statistics of medical error and the disparity between the incidence of error and public perception of it, given many patients' expectations that the medical profession always performs perfectly. A careful examination is made of how the surrounding forces of legislation, regulation, and market activity influence the quality of care provided by health care organizations and then looks at their handling of medical mistakes. Using a detailed case study, the book reviews the current understanding of why these mistakes happen. A key theme is that legitimate liability concerns discourage reporting of errors--which begs the question, "How can we learn from our mistakes?" Balancing regulatory versus market-based initiatives and public versus private efforts, the Institute of Medicine presents wide-ranging recommendations for improving patient safety, in the areas of leadership, improved data collection and analysis, and development of effective systems at the level of direct patient care. To Err Is Human asserts that the problem is not bad people in health care--it is that good people are working in bad systems that need to be made safer. Comprehensive and straightforward, this book offers a clear prescription for raising the level of patient safety in American health care. It also explains how patients themselves can influence the quality of care that they receive once they check into the hospital. This book will be vitally important to federal, state, and local health policy makers and regulators, health professional licensing officials, hospital administrators, medical educators and students, health caregivers, health journalists, patient advocates--as well as patients themselves. First in a series of publications from the Quality of Health Care in America, a project initiated by the Institute of Medicine
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.
Provide outstanding healthcare while keeping within budget with this comprehensive, engagingly written guide Understanding Value-Based Healthcare is a succinct, interestingly written primer on the core issues involved in maximizing the efficacy and outcomes of medical care when cost is a factor in the decision-making process. Written by internationally recognized experts on cost- and value-based healthcare, this timely book delivers practical and clinically focused guidance on one of the most debated topics in medicine and medicine administration today. Understanding Value-Based Healthcare is divided into three sections: Section 1 Introduction to Value in Healthcare lays the groundwork for understanding this complex topic. Coverage includes the current state of healthcare costs and waste in the USA, the challenges of understanding healthcare pricing, ethics of cost-conscious care, and more. Section 2 Causes of Waste covers important issues such as variation in resource utilization, the role of technology diffusion, lost opportunities to deliver value, and barriers to providing high-value care. Section 3 Solutions and Tools discusses teaching cost awareness and evidence-based medicine, the role of patients, high-value medication prescribing, screening and prevention, incentives, and implementing value-based initiatives. The authors include valuable case studies within each chapter to demonstrate how the material relates to real-world situations faced by clinicians on a daily basis. .
This case studies book is an indispensable resource for educators, students, and practitioners of nursing. It is innovative in its application of lessons from the communication sciences to common challenges in the delivery of safe patient care. The authors apply basic tenets of human communication to the context of nursing to provide a foundation for practices that can advance the safety and quality of care. The cases, which describe "close calls" and adverse events, are organized along the continuum of healthcare delivery, providing quick access to solutions in commonly encountered care situations. Each case is accompanied by a discussion of how skillful communication can be key to preventing and recovering from errors and adverse

events. Thought-provoking discussion questions and references for further reading make this book a valuable reference for nursing educators, students, and practitioners across the world.
Are you ready and willing to get to the root causes of problems? As Medicare, Medicaid, and major insurance companies increasingly deny payment for never events, it has become imperative that hospitals and doctors develop new ways to prevent these avoidable catastrophes from recurring. Proactive tools such as root cause analysis (RCA), basic failure mode and effects analysis (FMEA), and opportunity analysis (OA) are useful in preventing error, but in healthcare, such tools are often constrained by reticence to share information about mistakes and other problems inherent to the industry. ...well written and extremely applicable to health care. Every healthcare professional should have a copy. - Matthew C. Mireles, President / CEO, Community Medical Foundation for Patient Safety, Bellaire, Texas Patient Safety: The PROACT® Root Cause Analysis Approach addresses the proactive methodologies and organizational paradigms that must change in order to support and sustain such activities in the interest of patient safety. Written by reliability expert Robert J. Latino, this book provides a perspective on patient care from outside the health industry and culture. It teaches a proven approach that measures its effectiveness based on patient safety results, rather than compliance, and demonstrates the Return-On-Investment for using RCA to reduce and/or eliminate undesirable outcomes. Addressing the contribution of human error to physical consequences, Latino explores ways to identify conditions that are more prone to result in human error. It also uses FMEA to proactively identify unacceptable risks, and then uses the concepts of RCA to prevent risks from materializing.
Are you ready to be tenacious in your approach and completely honest in your assessment? Root Cause Analysis requires courage and honesty. When properly applied RCA will point out the problems and lead you to solutions. Visit the author's website; find out if RCA is right for your organization Robert J. Latino has spent the past 10 years researching the differences in industrial culture versus the healthcare culture. In this book, he expertly makes the appropriate modifications to proven methodologies to successfully bridge the proactive technologies from industry to healthcare. Additional information, including an audio-visual presentation by the author, is available on the PROACT website at http://www.proactforhealthcare.com
Health Sciences & Professions
Now revised and updated—the landmark patient safety primer written by the world’s leading authorities Medical errors are the unfortunate byproduct of an increasingly complex healthcare system. Now more than ever, keeping patients safe takes well-trained caregivers, relevant insights from a range of industries, additional investment—and a groundbreaking text like Understanding Patient Safety. Understanding Patient Safety is “must read” for those seeking to master the clinical, organizational, and systems issues of patient safety. In this bestselling primer, patient safety pioneer Robert Wachter and Kiran Gupta put all the essential tools and principles at your fingertips. Engaging and accessible, the book is filled with high-yield cases, analyses, tables, graphics, along with key points and references—all designed to help you optimize quality and safety. Understanding Patient Safety begins with an introduction to patient safety and medical errors. Its second section surveys specific types of medical errors, including those related to surgery, medications, diagnosis, transition and handoff, and infections. The third section covers proven solutions, from establishing reporting systems, to creating a culture of safety. The third edition reflects pivotal new developments in the field, including major updates in diagnostic errors, information technology and patient safety, ambulatory safety, and clinician burnout. Features: •Coverage of human factors and errors at the person-machine interface •Review of workplace issues, including supporting caregivers after major errors •How to organize an effective safety program •Coordination of patient education and training •Overview of the malpractice system •Discussion of the patient’s role
Resource added for the Nursing-Associate Degree 105431, Practical Nursing 315431, and Nursing Assistant 305431 programs.
This volume, developed by the Observatory together with OECD, provides an overall conceptual framework for understanding and applying strategies aimed at improving quality of care. Crucially, it summarizes available evidence on different quality strategies and provides recommendations for their implementation. This book is intended to help policy-makers to understand concepts of quality and to support them to evaluate single strategies and combinations of strategies.
This book explores patient safety themes in developed, developing and transitioning countries. A foundation premise is the concept of ‘reverse innovation’ as mutual learning from the chapters challenges traditional assumptions about the construction and location of knowledge. This edited collection can be seen to facilitate global learning. This book will, hopefully, form a bridge for those countries seeking to enhance their patient safety policies. Contributors to this book challenge many supposed generalisations about human societies, including consideration of how medical care is mediated within those societies and how patient safety is assured or compromised. By introducing major theories from the developing world in the book, readers are encouraged to reflect on their impact on the patient safety and the health quality debate. The development of practical patient safety policies for wider use is also encouraged. The volume presents a ground-breaking perspective by exploring fundamental issues relating to patient safety through different academic disciplines. It develops the possibility of a new patient safety and health quality synthesis and discourse relevant to all concerned with patient safety and health quality in a global context.
Patient Safety and Healthcare Improvement at a Glance isa timely and thorough overview of healthcare quality writtenspecifically for students and junior doctors and healthcareprofessionals. It bridges the gap between the practical and thetheoretical to ensure the safety and wellbeing of patients.Featuring essential step-by-step guides to interpreting andmanaging risk, quality improvement within clinical specialties, andpractice development, this highly visual textbook offers the bestpreparation for the increased emphasis on patient safety andquality-driven focus in today’s healthcare environment. Healthcare Improvement and Safety at a Glance: • Maps out and follows the World Health OrganizationPatient Safety curriculum • Draws upon the quality improvement work of theInstitute for Healthcare Improvement This practical guide, covering a vital topic of increasingimportance in healthcare, provides the first genuine introductionto patient safety and quality improvement grounded in clinicalpractice.
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.

The detection, reporting, measurement, and minimization of medical errors and harms is now a core requirement in clinical organizations throughout developed societies. This book focuses on this major new area in health care. It explores the nature of medical error, its incidence in different health care settings, and strategies for minimizing errors and their harmful consequences to patients. Written by leading authorities, it discusses the practical issues involved in reducing errors in health care - for the clinician, the health policy adviser, and ethical and legal health professionals.

From the nation’s leading experts in healthcare safety—the first comprehensive guide to delivering care that ensures the safety of patients and staff alike. One of the primary tenets among healthcare professionals is, “First, do no harm.” Achieving this goal means ensuring the safety of both patient and caregiver. Every year in the United States alone, an estimated 4.8 million hospital patients suffer serious harm that is preventable. To address this industry-wide problem—and provide evidence-based solutions—a team of award-winning safety specialists from Press Ganey/Healthcare Performance Improvement have applied their decades of experience and research to the subject of patient and workforce safety. Their mission is to achieve zero harm in the healthcare industry, a lofty goal that some hospitals have already accomplished—which you can, too. Combining the latest advances in safety science, data technology, and high reliability solutions, this step-by-step guide shows you how to implement 6 simple principles in your workplace. 1. Commit to the goal of zero harm.2. Become more patient-centric.3. Recognize the interdependency of safety, quality, and patient-centricity.4. Adopt good data and analytics.5. Transform culture and leadership.6. Focus on accountability and execution. In Zero Harm, the world’s leading safety experts share practical, day-to-day solutions that combine the latest tools and technologies in healthcare today with the best safety practices from high-risk, yet high-reliability industries, such as aviation, nuclear power, and the United States military. Using these field-tested methods, you can develop new leadership initiatives, educate workers on the universal skills that can save lives, organize and train safety action teams, implement reliability management systems, and create long-term, transformational change. You’ll read case studies and success stories from your industry colleagues—and discover the most effective ways to utilize patient data, information sharing, and other up-to-the-minute technologies. It’s a complete workplace-ready program that’s proven to reduce preventable errors and produce measurable results—by putting the patient, and safety, first.

Two doctors and experts in the study of patient safety and hospital quality provide a close-up look at the medical errors that occur in America's overburdened, underinsured, and often unaccountable health-care system, furnishing compelling real-life cases of medical mistakes and suggesting basic procedures and remedies to save lives. 75,000 first printing.

Gain a thorough understanding of the key principles of patient safety with the subject's pioneer text -- Now in full color "This highly readable yet comprehensive book will appeal to every member of the healthcare team. It is a must for every physician's bookshelf." -- Abraham Verghese, MD, Professor, Stanford University and author of the bestselling Cutting for Stone "Bob Wachter's quest to improve the safety of American healthcare represents the very essence of a physician's duty to put the patient first. His unflinching candor about the nature and magnitude of our current safety problems is matched only by his passion for improvement." -- Mark R. Chassin, MD, MPP, MPH, President, The Joint Commission "Amazingly readable for such a wealth of important information. This book should be required reading for every health professional and every healthcare executive." -- Christine Cassel, MD, President and CEO, American Board of Internal Medicine "In a single volume, Wachter accomplishes the seemingly impossible: furnishing the novice with a highly accessible, easy-to-read introduction to patient safety, while providing a comprehensive, fully annotated reference for the experienced patient safety practitioner. All of the important issues are addressed in individual chapters, each with a lively and relevant clinical example and a “key points” summary at the end bracketing full, balanced and lucid descriptions. A true gem, destined to be a close companion for all of us who strive to make healthcare safe." -- Lucian Leape, MD, Professor, Harvard School of Public Health and Chair, Lucian Leape Institute of the National Patient Safety Foundation "There's no more prominent authority on patient safety than Bob Wachter. And there's no more effective primer on patient safety than this one." -- Atul Gawande, MD, MPH, Associate Professor, Harvard Medical School, staff writer for the New Yorker, and bestselling author of Complications and The Checklist Manifesto "Compelling: a must read for all concerned with patient safety. Bob Wachter has a unique voice, incorporating clinical experience, research expertise, and policy implications…all with the patient front and center." -- Peter J. Pronovost, MD, PhD, Professor and Director of the Armstrong Institute for Patient Safety and Quality, Johns Hopkins Medicine Understanding Patient Safety, Second Edition is the essential book for anyone seeking to learn the core clinical, organizational, and systems issues of patient safety. Written in an engaging and accessible style by one of the world’s leading authorities on patient safety and quality, Understanding Patient Safety is filled with valuable cases and analyses, as well as tables, graphics, references, and tools. This classic reference is designed to make the patient safety field understandable to medical, nursing, pharmacy, hospital administration, and other trainees, and to be the go-to book for experienced clinicians and non-clinicians alike. The second edition has been revised to include coverage of the latest issues and trends, including: Information technology Measurements of safety, errors, and harm Checklist-based interventions Safety targets Policy issues in patient safety Balancing “no blame” and accountability Understanding Patient Safety, Second Edition delivers key insights to help you understand and prevent a a broad range of errors, including those related to medications, surgery, diagnosis, infections, and nursing care. The crucial contextual issues -- including errors at the person-machine interface, the role of culture, patient engagement in their own safety, and workforce and trainee considerations, are also well covered. Finally, the book provides a practical overview of how to organize an effective safety program, in both hospitals and clinics.

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.

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.

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.

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.

Increased concern for patient safety has put the issue at the top of the agenda of practitioners, hospitals, and even governments. The risks to patients are many and diverse, and the complexity of the healthcare system that delivers them is huge. Yet the discourse is often oversimplified and underdeveloped. Written from a scientific, human factors perspective, Patient Safety: A Human Factors Approach delineates a method that can enlighten and clarify this discourse as well as put us on a better path to correcting the issues. People often think, understandably, that safety lies mainly in the hands through which care ultimately flows to the patient—those who are closest to the patient, whose decisions can mean the difference between life and death, between health and morbidity. The human factors approach refuses to lay the responsibility for safety and risk solely at the feet of people at the sharp end. That is where we should intervene to make things safer, to tighten practice, to focus attention, to remind people to be careful, to impose rules and guidelines. The book defines an approach that looks relentlessly for sources of safety and risk everywhere in the system—the designs of devices; the teamwork and coordination between different practitioners; their communication across hierarchical and gender boundaries; the cognitive processes of individuals; the organization that surrounds, constrains, and empowers them; the economic and human resources offered; the technology available; the political landscape; and even the culture of the place. The breadth of the human factors approach is itself testimony to the realization that there are no easy answers or silver bullets for resolving the issues in patient safety. A user-friendly introduction to the approach, this book takes the complexity of health care seriously and doesn’t over simplify the problem. It demonstrates what the approach does do, that is offer the substance and guidance to consider the issues in all their nuance and complexity.

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

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.

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.

A difficult and recalcitrant phenomenon, medical error causes pervasive and expensive problems in terms of patient injury, ineffective treatment, and rising healthcare costs. Simple heightened awareness can help, but it requires organized, effective remedies and countermeasures that are reasonable, acceptable, and adaptable to see a truly significant drop in the intolerable rate of medical mistakes. Only with better understanding, knowledge, and directed techniques can there be rapid and marked improvement in medical error management discipline. Since medical error is situation specific and involves diverse variables in equipment, environment, and human performance, the correct choice of preventive and corrective techniques is critical. Providing a wealth of useful ideas, concepts, and techniques, Medical Error and Patient Safety: Human Factors in Medicine uses abroad perspective to present more than 500 remedies that can be applied and tailored to your unique circumstances. This detailed review of so many measures enables you to correctly identify needs and undertake appropriate actions to achieve a success that can be measured in avoided injuries, improved healthcare, and reduced cost. Thought provoking and useful, this book considers the potential for error and the possibility for improvement in every aspect of healthcare. After an introduction to general concepts and approaches, it examines vulnerabilities in medical services, including emergency services, healthcare facilities, and infection control. It covers risks in medical devices and product design; human factors such as fatigue and stress; management errors; errors in communication at all levels of the healthcare hierarchy; as well as mistakes in drug delivery including faulty labels and warnings. The authors also compare and contrast several analytical methods, their interpretation, and their translation into a plan of action.

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.

This book provides a comprehensive study of the science behind improving team performance in the delivery of clinical care.

Over the past decade it has been increasingly recognized that medical errors constitute an important determinant of patient safety, quality of care, and clinical outcomes. Such errors are both directly and indirectly responsible for unnecessary and potentially preventable morbidity and/or mortality across our healthcare institutions. The spectrum of contributing variables or "root causes" - ranging from minor errors that escalate, poor teamwork and/or communication, and lapses in appropriate protocols and processes (just to name a few) - is both extensive and heterogeneous. Moreover, effective solutions are few, and many have only recently been described. As our healthcare systems mature and their focus on patient safety solidifies, a growing body of research and experiences emerges to help provide an organized framework for continuous process improvement. Such a paradigm - based on best practices and evidence-based medical principles- sets the stage for hardwiring "the right things to do" into our institutional patient care matrix. Based on the tremendous interest in the first two volumes of The Vignettes in Patient Safety series, this third volume follows a similar model of case-based learning. Our goal is to share

clinically relevant, practical knowledge that approximates experiences that busy practicing clinicians can relate to. Then, by using evidence-based approaches to present contemporary literature and potential contributing factors and solutions to various commonly encountered clinical patient safety scenarios, we hope to give our readers the tools to help prevent similar occurrences in the future. In outlining some of the best practices and structured experiences, and highlighting the scope of the problem, the authors and editors can hopefully lend some insights into how we can make healthcare experiences for our patients safer.

"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.