Free read Understanding patient safety (2023)

Patient Safety Patient Safety Patient Safety: Research Into Practice To Do No Harm Patient Safety Foundations in Patient Safety for Health Professionals The Patient Safety Handbook Patient Safety Handbook First, Do Less Harm Patient Safety Patient Safety and Healthcare Improvement at a Glance A Socio-cultural Perspective on Patient Safety Patient Safety and Quality Improvement in Healthcare Patient Safety Patient Safety Patient Safety and Hospital Accreditation Advances in Patient Safety Patient Safety in Surgery Patient Safety Culture Global Patient Safety Case Studies in Patient Safety Implementing Patient Safety Patient Safety Patient Safety in Emergency Medicine Patient Safety and Health Care Management Patient Safety Textbook of Patient Safety and Clinical Risk Management Oxford Professional Practice: Handbook of Patient Safety A TEXTBOOK ON QUALITY IMPROVEMENT AND PATIENT SAFETY IN OPERATING ROOMS AND POST-ANESTHESIA CARE UNIT Principles of Risk Management and Patient Safety Understanding Patient Safety, Second Edition Making Healthcare Safe Nursing Pathways for Patient Safety E-book Patient Safety - Cultural Perspectives Practical Patient Safety Patient Safety: Delivering Cost-Contained, High Quality, Person-Centered, and Safe Healthcare Patient Safety and Quality: sect.IV: Working conditions and environment ABC of Patient Safety Innovating for Patient Safety in Medicine Accountability

Patient Safety *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

Patient Safety *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 wiley com go vincent patientsafety essentials

Patient Safety: Research Into Practice *2005-11-01*

presents a research based perspective on patient safety drawing together the most recent ideas on how to understand patient safety issues along with how research findings are used to shape policy and practice

To Do No Harm 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

Patient Safety *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

Foundations in Patient Safety for Health Professionals *2010-10-25*

covering a wide range of health care disciplines foundations in patient safety for health professionals is a practical comprehensive guide to creating a culture of safety in health care settings developed by faculty members in bioethics business dentistry law medicine nursing occupational therapy pharmacy physical therapy and social work this introductory textbook presents the history of safety and the core concepts of patient safety this important resource features a patient centered approach within a practice based context written in a straightforward style it uses personal and professional stories to illustrate the application of safety principles modules and case based exercises help students learn the importance of safety best practices and quality improvements practicing health care professionals will also find this book to be a valuable resource

The Patient Safety Handbook *2004*

quality patient safety

Patient Safety Handbook *2013*

examines the newest scientific advances in the science of safety

First, Do Less Harm *2012-04-23*

each year hospital acquired infections prescribing and treatment errors lost documents and test reports communication failures and other problems have caused thousands of deaths in the united states added millions of days to patients hospital stays and cost americans tens of billions of dollars despite and sometimes because of new medical information technology and numerous well intentioned initiatives to address these problems threats to patient safety remain and in some areas are on the rise in first do less harm twelve health care professionals and researchers plus two former patients look at patient safety from a variety of perspectives finding many of the proposed solutions to be inadequate or impractical several contributors to this book attribute the failure to confront patient safety concerns to the influence of the market model on medicine and emphasize the need for hospital wide teamwork and greater involvement from frontline workers from janitors and aides to nurses and physicians in planning implementing and evaluating effective safety initiatives several chapters in first do less harm focus on the critical role of interprofessional and occupational practice in patient safety rather than focusing on the usual suspects physicians safety champions or high level management these chapters expand the list of stakeholders and patient safety

advocates to include nurses patient care assistants and other staff as well as the health care unions that may represent them first do less harm also highlights workplace issues that negatively affect safety including sleeplessness excessive workloads outsourcing of hospital cleaning and lack of teamwork between physicians and other health care staff in two chapters experts explain why the promise of health care information technology to fix safety problems remains unrealized with examples that are at once humorous and frightening a book that will be required reading for physicians nurses hospital administrators public health officers quality and risk managers healthcare educators economists and policymakers first do less harm concludes with a list of twenty seven paradoxes and challenges facing everyone interested in making care safe for both patients and those who care for them

Patient Safety 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 authorsí 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

Patient Safety and Healthcare Improvement at a Glance *2014-06-16*

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

A Socio-cultural Perspective on Patient Safety *2012-10-01*

this edited volume of original chapters brings together researchers from around the world who are exploring the facets of health care organization and delivery that are sometimes marginal to mainstream patient safety theories and methodologies but offer important insights into the socio cultural and organizational context of patient safety by examining these critical insights or perspectives and drawing upon theories and methodologies often neglected by mainstream safety researchers this collection shows we can learn more about not only the barriers and drivers to implementing patient safety programmes but also about the more fundamental issues that shape notions of safety alternate strategies for enhancing safety and the wider implications of the safety agenda on the future of health care delivery in so doing a socio cultural perspective on patient safety challenges the taken for granted assumptions around

fundamental philosophical and political issues upon which mainstream orthodoxy relies the book draws upon a range of theoretical and empirical approaches from across the social sciences to investigate and question the patient safety movement each chapter takes as its focus and question a particular aspect of the patient safety reforms from its policy context and theoretical foundations to its practical application and manifestation in clinical practice whilst also considering the wider implications for the organization and delivery of health care services accordingly the chapters each draw upon a distinct theoretical or methodological approach to critically explore specific dimensions of the patient safety agenda taken as a whole the collection advances a strong coherent argument that is much needed to counter some of the uncritical assumptions that need to be described and analyzed if patient safety is indeed to be achieved

Patient Safety and Quality Improvement in Healthcare *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 *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 â a system that both prevents errors from occurring and learns from them when they do occur the development of such a system requires a commitment by all stakeholders to a culture of safety and to the development of improved information systems for the delivery of health care this national health information infrastructure is needed to provide immediate access to complete patient information and decision support tools for clinicians and their patients in addition this infrastructure must capture patient safety information as a by product of care and use this information to design even safer delivery systems health data standards are both a critical and time sensitive building block of the national health information infrastructure building on the institute of medicine reports to err is human and crossing the quality chasm patient safety puts forward a road map for the development and adoption of key health care data standards to support both information exchange and the reporting and analysis of patient safety data

Patient Safety *2016-04-19*

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

Patient Safety and Hospital Accreditation *2011-12-20*

print coursesmart

Advances in Patient Safety *2005*

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

Patient Safety in Surgery *2014-08-20*

in general surgeons strive to achieve excellent results and ideal patient outcomes however this noble task is frequently failed for patients surgical complications are analogous to friendly fire in wartime both scenarios imply that harm is unintentionally done by somebody whose aim was to help interestingly adverse events resulting from surgical interventions are more frequently related to system errors and a communication breakdown among providers rather than to the imminent threat of the surgical blade gone wrong patient safety in surgery aims to increase the safety and quality of care for patients undergoing surgical procedures in all fields of surgery patient safety in surgery covers all aspects related to patient safety in surgery including pertinent issues of interest to surgeons medical trainees students residents and fellows nurses anaesthesiologists patients patient families advocacy groups and medicolegal experts

Patient Safety Culture *2018-10-09*

how safe are hospitals why do some hospitals have higher rates of accident and errors involving patients how can we accurately measure and assess staff attitudes towards safety how can hospitals and other healthcare environments improve their safety culture and minimize harm to patients these and other questions have been the focus of research within the area of patient safety culture psc in the last decade more and more hospitals and healthcare managers are trying to understand the nature of the culture within their organisations and implement strategies for improving patient safety the main purpose of this book is to provide researchers healthcare managers and human factors practitioners with details of the latest developments within the theory and application of psc within healthcare it brings together contributions from the most prominent researchers and practitioners in the field of psc and covers the background to work on safety culture e g measuring safety culture in industries such as aviation and the nuclear industry the dominant theories and concepts within psc examples of psc tools methods of assessment and their application and details of the most prominent challenges for the future in the area patient safety culture theory methods and application is essential reading for all of the professional groups involved in patient safety and healthcare quality improvement filling an important gap in the current market

Global Patient Safety *2018-08-15*

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

Case Studies in Patient Safety *2016*

resource added for the nursing associate degree 105431 practical nursing 315431 and nursing assistant 305431 programs

Implementing Patient Safety *2019-09-11*

over the last two decades across the globe we have seen a multitude of programs projects and books to help improve the safety of patient care in healthcare however the full potential of these has not yet been reached most of the current approaches are top down programmatic and target driven these look at problems in isolation one harm at a time with simplistic solutions that fail to support a holistic systematic approach they are focused on collecting incident data and learning from failure using tools that are not fit for purpose in a complex nonlinear system very rarely do the solutions help build the conditions cultures and behaviours that support a safer system and help the people involved work safely healthcare is stuck in a relentlessly negative approach to safety those working in patient safety and healthcare are struggling and books on patient safety to date instruct the reader to continue doing the same things we have been doing for the last 20 years this book uniquely combines the latest thinking in safety including creating a balanced approach to learning from what works as a way to understand why it fails together with the evidence on building a just culture positive workplaces and working relationships that we now know are so important for safety it helps people understand how to address issues despite their complexities and improve safety with practical ways to truly understand what day to day healthcare work is actually like rather than what people imagine it is like this book builds on the author s first book rethinking patient safety which exposed what we need to do differently to truly transform our approach to patient safety it updates the reader further on the concepts explored in the first book but also vitally helps readers understand the how implementing patient safety goes beyond the rhetoric and provides the reader with ideas and examples for how the latest thinking can actually be achieved it is based on the author s personal experience of leading a national culture change campaign in the national health service for five years the lessons arise from helping hundreds of organisations and people rethink and implement a whole new way of thinking about improving patient safety in healthcare

Patient Safety 2011-11-08

with unintended harm during hospital care costing billions of dollars to the world economy not to mention millions of deaths each year it s no wonder the issue is equally front and center in the minds of healthcare providers and the public although the issue has been tackled in journal articles and conference proceedings there are very few books on the topic and none consider how methods and techniques developed in the area of engineering can handle safety and human error related problems until now written by an expert with vast know how in engineering management design reliability safety and quality patient safety an engineering approach brings together the pertinent information scattered throughout books and journals eliminating the need to consult many different and diverse sources to find what you need b s dhillon draws on his real world experience to demonstrate how to handle patient safety related problems using engineering techniques and backs this up with references for further reading at the end of each chapter he sets the stage with introductory chapters on mathematical patient safety and human factors concepts essential to understanding materials presented in subsequent chapters dhillon s clear concise discussion of the topics presents the information in such a way that no previous knowledge is required to understand the contents yet he does not present it at a merely rudimentary level he brings a fresh approach and engineering perspective to the issues giving you a new tool kit for performing

patient safety related analysis designing better medical systems devices and handling patient safety related problems from an engineering perspective

Patient Safety in Emergency Medicine *2009*

with the increased emphasis on reducing medical errors in an emergency setting this book will focus on patient safety within the emergency department where preventable medical errors often occur the book will provide both an overview of patient safety within health care the culture of safety importance of teamwork organizational change and specific guidelines on issues such as medication safety procedural complications and clinician fatigue to ensure quality care in the ed special sections discuss ed design medication safety and awareness of the culture of safety

Patient Safety and Health Care Management 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

Patient Safety *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

Textbook of Patient Safety and Clinical Risk Management 2020-12-14

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

Oxford Professional Practice: Handbook of Patient

Safety *2022-03-10*

every day doctors are faced with the challenge of keeping the people they treat safe and free from harm patient safety is a relatively new field of study but the field is expanding and there is now better understanding of what is needed to measure and achieve safety for patients the handbook of patient safety will empower doctors nurses and other professionals to be able to develop safe clinical processes that allow proactive management and minimisation of risk so that people are not harmed when they receive clinical care it gives the rationale for patient safety the theories behind the science of patient safety and then the practical methods that frontline staff can use on a daily basis to decrease harm pocket sized and practical this handbook is the ideal guide to support frontline staff and trainees as well as all allied professionals in the name of patient safety it reflects the world health organization s patient safety curriculum and is written by international experts in their field who have specialist interests and direct expertise in dealing with patient safety issues this book will demystify what is often seen as a complex topic helping doctors understand the methods needed to provide safe care

A TEXTBOOK ON QUALITY IMPROVEMENT AND PATIENT SAFETY IN OPERATING ROOMS AND POST-ANESTHESIA CARE UNIT *2019-02-01*

this textbook is divided in to eight units as follows unit 1 operating suite unit 2 education and training unit 3 holding area receiving area unit 4 peri operative care unit 4 care of patients unit 5 post operative unit 6 communication unit 7 safety in operating rooms unit 8 post anesthesia care unit pacu recovery room rr this text book is a very unique guide to implement the national and international healthcare accreditation standards in the operating rooms and post anesthesia care unit for providing the best quality healthcare services for the excellent outcomes and patient safety

Principles of Risk Management and Patient Safety *2010-08-10*

this book identifies changes in the industry and describes how these changes have influenced the functions of risk management in all aspects of healthcare the book is divided into four sections the first section describes the current state of the healthcare industry and looks at the importance of risk management and the emergence of patient safety it also explores the importance of working with other sectors of the health care industry such as the pharmaceutical and device manufacturers the last three sections focus on the three main components of the risk managers responsibility claims management risk financing and proactive loss control the final section touches on solutions for seamless integration between risk management and patient safety functions using an integrative approach this book offers a comprehensive review of the current issues which formulate the basis of a risk management program and provide the knowledge that a risk manager would be expected to have

Understanding Patient Safety, Second Edition *2012-05-23*

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

Making Healthcare Safe 2021

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

Nursing Pathways for Patient Safety E-book *2009-09-25*

with a wealth of helpful guidelines and assessment tools nursing pathways for patient safety makes it easy to identify the causes of practice breakdowns and to reduce health care errors it provides expert guidance from the national council of state boards of nursing ncsbn plus an overview of the tercap assessment tool the book systematically examines the causes of practice breakdowns resulting from practice styles health care environments teamwork and structural systems to promote patient safety an overview of the ncsbn practice breakdown initiative introduces the tercap assessment tool and provides a helpful framework for understanding the scope of problems along with ncsbn s approach to addressing them coverage of each type of practice breakdown systematically explores errors in areas such as clinical reasoning or judgment prevention and intervention case studies provide real life examples of practice breakdowns and help you learn to identify problems and propose solutions chapters on mandatory reporting and implementation of a whole systems approach offer practical information on understanding tercap and implementing a whole systems approach to preventing practice breakdowns

Patient Safety - Cultural Perspectives 2018-04-26

background shared values norms and beliefs of relevance for safety in health care can be described in terms of patient safety culture this concept overlaps with patient safety climate but culture represents the deeprooted values norms and beliefs whereas climate refers to attitudes and more superficial manifestations of culture there may be numerous subcultures within an organization including different professional cultures in recent years increased attention has been paid to patient safety culture in sweden and the patient safety culture climate in health care is regularly measured based on the assumption that patient safety culture climate can influence various

patient safety outcomes aim the overall aim of the thesis is to contribute to an improved understanding of patient safety culture and subcultures in swedish health care design and methods the thesis is based on four studies applying different methods study 1 was a survey that included 23 781 respondents data were analysed with quantitative methods with primarily descriptive results studies 2 and 3 were qualitative studies involving interviews with a total of 28 registered nurses 24 nurse assistants and 28 physicians interview data were analysed using content analysis study 4 evaluated an intervention intended to influence patient safety culture and included data from a questionnaire with both fixed and open ended questions which was answered by 200 respondents results a key result from study 1 was that professional groups differed in terms of their views and statements about patient safety culture climate registered nurses and nurse assistants in study 2 were found to have partially overlapping norms values and beliefs concerning patient safety which were identified at individual interpersonal and organizational level study 3 found four categories of values and norms among physicians of potential relevance for patient safety predominantly positive perceptions were found in study 4 concerning the walk rounds intervention among frontline staff members local managers and top level managers who participated in the intervention however there were also reflections on disadvantages and some suggestions for improvement conclusions according to the results of the patient safety culture climate questionnaire perceptions about safety culture climate dimensions contribute more to the rating of overall patient safety than background characteristics e g profession and years of experience there are differences in the patient safety culture between registered nurses and nurse assistants which imply that efforts for improved patient safety must be tailored to their respective values norms and beliefs several aspects of physicians professional culture may have relevance for patient safety expectations of being infallible reduce their willingness to talk about errors they make thus limiting opportunities for learning from errors walk rounds are perceived to contribute to increased learning concerning patient safety and could potentially have a positive influence on patient safety culture

Practical Patient Safety *2009-03-19*

following recent high profile cases of surgical error in the uk and usa patient safety has become a key issue in healthcare now placed at heart of junior doctor s training errors made by doctors are very similar to those made in other high risk organisations such as aviation nuclear and petrochemical industries practical patient safety aims to demonstrate how core principles of safety from these industries can be applied in surgical and medical practice in particular through training for health care professionals and healthcare managers whilst theoretical aspects of risk management form the backdrop the book focuses on key techniques and principles of patient safety in a practical way giving the reader practical advice on how to avoid personal errors and more importantly how to start patient safety training within his or her department or hospital

Patient Safety: Delivering Cost-Contained, High Quality, Person-Centered, and Safe Healthcare *2020-09-03*

this ebook is a collection of articles from a frontiers research topic frontiers research topics are very popular trademarks of the frontiers journals series they are collections of at least ten articles all centered on a particular subject with their unique mix of varied contributions from original research to review articles frontiers research topics unify the most influential researchers the latest key findings and historical advances in a hot research area find out more on how to host your own frontiers research topic or contribute to one as an author by contacting the frontiers editorial office frontiersin org about contact

Patient Safety and Quality: sect.IV: Working conditions and environment 2008

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

ABC of Patient Safety *2009-04-08*

this book helps the next generation of doctors understand how to contribute to making healthcare safer patient safety is increasingly important in medical practice today and is becoming a core part of training for medical students and foundation doctors this book will enable the student or junior doctor to challenge and innovate in practice to improve patient safety and care it takes a practical approach and explores what patient safety is why it is important how to involve patients the role of education technology and resources how to be an innovative practitioner and measuring the impact of patient safety initiatives

Innovating for Patient Safety in Medicine 2012-07-31

according to a recent institute of medicine report as many as 98 000 americans die each year as a result of medical error a figure higher than deaths from automobile accidents breast cancer or aids that astounding number of fatalities does not include the number of those serious mistakes that are grievous and damaging but not fatal who can forget the tragic case of 17 year old jésica santillán who died after receiving a heart lung transplant with an incompatible blood type what can be done about this what should be done how can patients and their families regain a sense of trust in the hospitals and clinicians that care for them where do we even begin the discussion accountability brings the issue to the table in response to the demand for patient safety and increased accountability regarding medical errors in an interdisciplinary approach virginia sharpe draws together the insights of patients and families who have suffered harm institutional leaders galvanized to reform by tragic events in their own hospitals philosophers historians and legal theorists many errors can be traced to flaws in complex systems of health care delivery not flaws in individual performance how then should we structure responsibility for medical mistakes so that justice for the injured can be achieved alongside the collection of information that can improve systems and prevent future error bringing together authoritative voices of family members health care providers and scholars from such disciplines as medical history economics health policy law philosophy and theology this book examines how conventional structures of accountability in law and medical structure structures paradoxically at odds with justice and safety should be replaced by more ethically informed federal state and institutional policies accountability calls for public policy that creates not only systems capable of openness concerning safety and error but policy that also delivers just compensation and honest and humane treatment to those patients and families who have suffered from harmful medical error

Accountability 2004-09-07

- cask of amontillado guide questions answers (Download Only)
- ks2 english comprehension age 9 11 sats practice workbook 2018 tests letts ks2 revision success Copy
- make this model lost temple usborne cut out models Full PDF
- handbook of polymer crystallization [PDF]
- certified associate in project management study guide Full PDF
- harry potter and the philosophers stone enchanted postcard harry potter postcard books Copy
- autocad 2012 preview guide cad studio (2023)
- signs and symbols of primordial man Full PDF
- 97 gmc suburban up repair guide file type (Download Only)
- living a life of awareness daily meditations on the toltec Copy
- tom boler Copy
- snap cards special offer photzy (PDF)
- ebm n4 first paper 2013 (Download Only)
- marketing grewal 4th edition .pdf
- excursions in modern mathematics 7th edition .pdf
- microlight building plans (2023)
- c3 ocr june 2013 paper (2023)
- poesie per ragazze ribelli Copy
- the lean manufacturing pocket handbook (2023)
- utm past exams papers Full PDF
- engineering mechanics dynamics 5th edition bedford fowler (Read Only)
- artificial intelligence third 3rd edition (Read Only)
- living with honor a memoir (Read Only)