Patient Safety Perspectives On Evidence Information And Knowledge Transfer

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Resilient Health Care, Volume 2

Precise and flawless medical practice is imperative due to the delicate nature of patient lives and health. Without methods and technologies to detect medical mistakes, many lives would be compromised. Impact of Medical Errors and Malpractice on Health Economics, Quality, and Patient Safety is an essential reference source for the latest research on the detection and analysis of the various implications of medical errors and addresses the hidden malpractices that exist in healthcare systems globally. Featuring extensive coverage on a broad range of topics such as clinical pathways, decision-making techniques, and health information technology, this book is ideally designed for practitioners, professionals, and researchers seeking current research on various issues in healthcare provision.

Vignettes in Patient Safety

While the healthcare system continues to shift towards more emphasis on quality metrics, there remains a substantial gap between the expectations of healthcare policies and standards of hospital administrations vs. the realistic care provided by

the average healthcare provider. This book offers the perspective of the healthcare provider and aims to fulfill the unmet need to educate other healthcare providers on recognizing quality measures and understanding how to achieve them to meet standards of quality care. This book covers the historical perspective of quality measures, the context of their existence, their utility, and the contemporary issues related to their use. Simultaneously, it critically addresses the quality of these quality metrics and presents the evidence available to date on the efficacy and the limitations of these quality measures. This text is all-inclusive and is organized into chapters that include the evolution of quality metrics in healthcare, the practical role of hospitals, as well as the practical role of individual healthcare providers in addressing quality metrics. The chapters also include assessment of quality metrics that uniquely pertain to medical and surgical practices, as well as non-clinical quality metrics that specifically target undergraduate and graduate medical training. Finally, the book reflects on the use of contemporary quality metrics and their impact on outcomes, patient care, and public health and policy making. In these chapters, tables and illustrations, including algorithms, will be used to provide systematic approaches to common issues related to quality metrics. In addition, historical anecdotes and case presentations will be used to address pearls in contemporary practice of quality metrics. Quality Measures is the definitive reference on quality metrics in healthcare and is a valuable resource for healthcare providers, trainees, administrators and public health agencies.

An Introduction to Clinical Governance and Patient Safety

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.

Still Not Safe

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.

Resident Duty Hours

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

Resilient Health Care

Winner of the Basis of Medicine Award in the BMA Book Medical Book Competition 2006! In many countries, during the last decade there has been a growing public realization that healthcare organisations are often dangerous places to be. Reports published in Australia, Canada, New Zealand, United Kingdom and the USA have served to focus public and policy attention on the safety of patients and to highlight the alarmingly high incidence of errors and adverse events that lead to some kind of harm or injury. This book presents a research-based perspective on patient safety, drawing together the most recent ideas and thinking from researchers on how to research and understand patient safety issues, and how research findings are used to shape policy and practice. The book examines key issues, including: Analysis and measurement of patient safety Approaches to improving patient safety Future policy and practice regarding patient safety The legal dimensions of patient safety Patient Safety is essential reading for researchers, policy makers and practitioners involved in, or interested in, patient safety. The book is also of interest to the growing number of postgraduate students on health policy and health management programmes that focus upon healthcare quality, risk management and patient safety. Contributors: Sally Adams, Tony Avery, Maureen Baker, Paul Beatty, Ruth Boaden, Tanya Claridge, Gary Cook, Caroline Davy, Susan Dovey, Aneez Esmail, Rachel Finn, Martin Fletcher, Sally Giles, John Hickner, Rachel Howard, Amanda Howe, Michael A. Jones, Sue Kirk,

Rebecca Lawton, Martin Marshall, Caroline Morris, Dianne Parker, Shirley Pearce, Bob Phillips, Steve Rogers, Richard Thomson, Charles Vincent, Kieran Walshe, Justin Waring, Alison Watkin, Fiona Watts, Liz West, Maria Woloshynowych.

Patient Safety

Drawing on the universal values in health care, the second edition of Quality and Safety in Nursing continues to devote itself to the nursing community and explores their role in improving quality of care and patient safety. Edited by key members of the Quality and Safety Education for Nursing (QSEN) steering team, Quality and Safety in Nursing is divided into three sections. Itfirst looks at the national initiative for quality and safety and links it to its origins in the IOM report. The second section defines each of the six QSEN competencies as well as providing teaching and clinical application strategies, resources and current references. The final section now features redesigned chapters on implementing quality and safety across settings. New to this edition includes: Instructional and practice approaches including narrative pedagogy and integrating the competencies in simulation A new chapter exploring the application of clinical learning and the critical nature of inter-professional teamwork A revised chapter on the mirror of education and practice to better understand teaching approaches This ground-breaking unique text addresses the challenges of preparing future nurses with the knowledge, skills, and attitudes (KSAs) necessary to continuously improve the health care

system in which they practice.

A Socio-cultural Perspective on Patient Safety

v. 1. Research findings -- v. 2. Concepts and methodology -- v. 3. Implementation issues -- v. 4. Programs, tools and products.

Making Health Care Safer

Building on the revolutionary Institute of Medicine reports To Err is Human and Crossing the Quality Chasm, Keeping Patients Safe lays out guidelines for improving patient safety by changing nursesâ€™ working conditions and demands. Licensed nurses and unlicensed nursing assistants are critical participants in our national effort to protect patients from health care errors. The nature of the activities nurses typically perform â€" monitoring patients, educating home caretakers, performing treatments, and rescuing patients who are in crisis â€" provides an indispensable resource in detecting and remedying error-producing defects in the U.S. health care system. During the past two decades, substantial changes have been made in the organization and delivery of health care â€" and consequently in the job description and work environment of nurses. As patients are increasingly cared for as outpatients, nurses in hospitals and nursing homes

deal with greater severity of illness. Problems in management practices, employee deployment, work and workspace design, and the basic safety culture of health care organizations place patients at further risk. This newest edition in the groundbreaking Institute of Medicine Quality Chasm series discusses the key aspects of the work environment for nurses and reviews the potential improvements in working conditions that are likely to have an impact on patient safety.

E-Health Technologies and Improving Patient Safety: Exploring Organizational Factors

Health care is everywhere under tremendous pressure with regard to efficiency, safety, and economic viability - to say nothing of having to meet various political agendas - and has responded by eagerly adopting techniques that have been useful in other industries, such as quality management, lean production, and high reliability. This has on the whole been met with limited success because health care as a non-trivial and multifaceted system differs significantly from most traditional industries. In order to allow health care systems to perform as expected and required, it is necessary to have concepts and methods that are able to cope with this complexity. Resilience engineering provides that capacity because its focus is on a system’s overall ability to sustain required operations under both

expected and unexpected conditions rather than on individual features or qualities. Resilience engineering's unique approach emphasises the usefulness of performance variability, and that successes and failures have the same aetiology. This book contains contributions from acknowledged international experts in health care, organisational studies and patient safety, as well as resilience engineering. Whereas current safety approaches primarily aim to reduce or eliminate the number of things that go wrong, Resilient Health Care aims to increase and improve the number of things that go right. Just as the WHO argues that health is more than the absence of illness, so does Resilient Health Care argue that safety is more than the absence of risk and accidents. This can be achieved by making use of the concrete experiences of resilience engineering, both conceptually (ways of thinking) and practically (ways of acting).

Neuromorphic Olfaction

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.

Crossing the Quality Chasm

"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.

Quality Measures

Health systems everywhere are expected to meet increasing public and political demands for accessible, high-quality care. Policy-makers, managers, and clinicians use their best efforts to improve efficiency, safety, quality, and economic viability. One solution has been to mimic approaches that have been shown to work in other domains, such as quality management, lean production, and high reliability. In the enthusiasm for such solutions, scant attention has been paid to the fact that health care as a multifaceted system differs significantly from most traditional industries. Solutions based on linear thinking in engineered systems do not work well in complicated, multi-stakeholder non-engineered systems, of which health care is a leading example. A prerequisite for improving health care and making it more resilient is that the nature of everyday clinical work be well understood. Yet the focus of the majority of policy or management solutions, as well as that of accreditation and regulation, is work as it ought to be (also known as 'work-as-imagined'). The aim of policy-makers and managers, whether the priority is safety, quality, or efficiency, is therefore to make everyday clinical work - or work-as-done - comply with work-as-imagined. This fails to recognise that this normative conception of work is often oversimplified, incomplete, and outdated. There is therefore an urgent need to better understand everyday clinical work as it is done. Despite the common focus on deviations and failures, it is undeniable that clinical work goes right far more often than it goes wrong, and that we only can make it better if we understand how this happens. This second volume of Resilient Health Care continues the line of thinking of the first book, but takes it further through a

range of chapters from leading international thinkers on resilience and health care. Where the first book provided the rationale and basic concepts of RHC, the Resilience of Everyday Clinical Work breaks new ground by analysing everyday work situations in primary, secondary, and tertiary care to identify and describe the fundamental strategies that clinicians everywhere have developed and use with a fluency that belies the demands to be resolved and the dilemmas to be balanced. Because everyday clinical work is at the heart of resilience, it is essential to appreciate how it functions, and to understand its characteristics.

Health IT and Patient Safety

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.

Safe Patients, Smart Hospitals

Quantitative research -- Qualitative research -- Mixed methods research -- Data analysis -- Navigating the institutional review board (IRB) -- Critical appraisal of research-based evidence -- Scholarship of administrative practice -- Evidence-based leadership practices -- Evaluating organizational frameworks for systems change -- The nature of the evidence: microsystems, macrosystems, and mesosystems -- Quality improvement and safety science : historical and future perspectives -- Improvement science : impact on quality and patient safety --

Health policy and evidence-based practice : the quality, safety, and financial -- Incentive link -- Scholarship of clinical practice -- Philosophical and theoretical perspectives guiding inquiry -- Introduction to evidence-based research -- Technology supporting the search for evidence -- A doctor of nursing practice systems change project : educating for early -- Intervention in methamphetamine-exposed children and families -- Integrating research-based evidence into clinical practice -- Evidence-based practice in the global community : building bridges -- Barriers to evidence-based practice in developing countries -- Dissemination of the evidence

Keeping Patients Safe

Medication safety is the most challenging goal for pharmacy practice and patient safety professionals in all health care facilities.

Patient Safety and Hospital Accreditation

Over the past two decades, the healthcare community increasingly recognized the importance and the impact of medical errors on patient safety and clinical outcomes. Medical and surgical errors continue to contribute to unnecessary and potentially preventable morbidity and/or mortality, affecting both ambulatory and

hospital settings. The spectrum of contributing variables-ranging from minor errors that subsequently escalate to poor communication to lapses in appropriate protocols and processes (just to name a few)-is extensive, and solutions are only recently being described. As such, there is a growing body of research and experiences that can help provide an organized framework-based upon the best practices and evidence-based medical principles-for hospitals and clinics to foster patient safety culture and to develop institutional patient safety champions. Based upon the tremendous interest in the first volume of our Vignettes in Patient Safety series, this second volume follows a similar vignette-based model. Each chapter outlines a realistic case scenario designed to closely approximate experiences and clinical patterns that medical and surgical practitioners can easily relate to. Vignette presentations are then followed by an evidence-based overview of pertinent patient safety literature, relevant clinical evidence, and the formulation of preventive strategies and potential solutions that may be applicable to each corresponding scenario. Throughout the Vignettes in Patient Safety cycle, emphasis is placed on the identification and remediation of team-based and organizational factors associated with patient safety events. The second volume of the Vignettes in Patient Safety begins with an overview of recent high-impact studies in the area of patient safety. Subsequent chapters discuss a broad range of topics, including retained surgical items, wrong site procedures, disruptive healthcare workers, interhospital transfers, risks of emergency department overcrowding, dangers of inadequate handoff communication, and the association

between provider fatigue and medical errors. By outlining some of the current best practices, structured experiences, and evidence-based recommendations, the authors and editors hope to provide our readers with new and significant insights into making healthcare safer for patients around the world.

Patient Safety and Quality

This edited volume of original essays 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.

Patient Safety: Research Into Practice

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.

Patient Safety

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.

Healthcare Reform, Quality and Safety

Health systems everywhere are expected to meet increasing public and political demands for accessible, high-quality care. Policy-makers, managers, and clinicians use their best efforts to improve efficiency, safety, quality, and economic viability. One solution has been to mimic approaches that have been shown to work in other domains, such as quality management, lean production, and high reliability. In the enthusiasm for such solutions, scant attention has been paid to the fact that health care as a multifaceted system differs significantly from most traditional industries. Solutions based on linear thinking in engineered systems do not work well in complicated, multi-stakeholder non-engineered systems, of which health care is a leading example. A prerequisite for improving health care and making it more resilient is that the nature of everyday clinical work be well understood. Yet the focus of the majority of policy or management solutions, as well as that of accreditation and regulation, is work as it ought to be (also known as 'work-as-imagined'). The aim of policy-makers and managers, whether the priority is safety, quality, or efficiency, is therefore to make everyday clinical work - or work-as-done - comply with work-as-imagined. This fails to recognise that this normative conception of work is often oversimplified, incomplete, and outdated. There is

therefore an urgent need to better understand everyday clinical work as it is done. Despite the common focus on deviations and failures, it is undeniable that clinical work goes right far more often than it goes wrong, and that we only can make it better if we understand how this happens. This second volume of Resilient Health Care continues the line of thinking of the first book, but takes it further through a range of chapters from leading international thinkers on resilience and health care. Where the first book provided the rationale and basic concepts of RHC, the Resilience of Everyday Clinical Work breaks new ground by analysing everyday work situations in primary, secondary, and tertiary care to identify and describe the fundamental strategies that clinicians everywhere have developed and use with a fluency that belies the demands to be resolved and the dilemmas to be balanced. Because everyday clinical work is at the heart of resilience, it is essential to appreciate how it functions, and to understand its characteristics.

New Horizons in Patient Safety: Safe Communication

Clinical Governance is integral to healthcare and all doctors must have an understanding of both basic principles, and how to apply them in daily practice. Within the Clinical Governance framework, patient safety is the top priority for all healthcare organisations, with the prevention of avoidable harm a key goal. Traditionally medical training has concentrated on the acquisition of knowledge and skills related to diagnostic intervention and therapeutic procedures. The need

to focus on non-technical aspects of clinical practice, including communication and team working, is now evident; ensuring tomorrow's staff are competent to function effectively in any healthcare facility. This book provides a guide to how healthcare systems work; their structure, regulation and inspection, and key areas including risk management, resource effectiveness and wider aspects of knowledge management. Changing curricula at undergraduate level reflect this, but post-graduate training is lagging behind and does not always equip trainees appropriately for a hectic clinical environment. An Introduction to Clinical Governance and Patient Safety presents a simple overview of clinical governance in context, highlighting important principles required to function effectively in a pressurised healthcare environment. It is presented in short sections based on the original seven pillars of clinical governance. These have been expanded to include the fundamental principles of systems, team working, leadership, accountability, and ownership in healthcare, with examples from everyday practice. This format is designed to facilitate use as a 'pocket guide' which can be dipped into during the working day, as well as for general reading. Examples from all branches of medicine are presented to facilitate understanding. Contributors are taken from a broad base - from junior doctors to internationally recognised experts - ensuring issues are addressed from all perspectives.

Quality and Safety in Nursing

This book focuses on the interface between the patient and the healthcare system as the entryway to high-quality care and improved outcomes. Unlike other texts, this book puts the patient back in the center of care while integrating the various practices and challenges. Written by interdisciplinary experts, the book begins by evaluating the entire quality landscape before giving voice to all parties involved, including physicians, nurses, administrators, patients, and families. The text then focuses on how to develop a structure that meets needs of all of these groups, effectively addressing common threats to positive outcomes and patient satisfaction. The text tackles the most common challenges clinicians face in a hospital setting, including infection prevention, medication error and stewardship that may jeopardize recovery, complex care, and employee-patient engagement. The Patient and Healthcare System: Perspectives on High-Quality Care is an excellent resource for physicians across broad specialties, nurses, hospital administrators, social workers, patient caregivers and all healthcare professionals concerned with infection prevention, quality and safety of care delivery, and patient satisfaction.

Vignettes in Patient Safety

Researching Patient Safety and Quality in Health Care: A Nordic Perspective is an anthology based on contributions from leading researchers on quality and safety in healthcare in the Nordic countries together with four internationally renowned

patient safety authors. Research on patient safety and quality has been dominated by countries such as the USA, England, Canada, and Australia. This book addresses the current debates in research on patient safety and quality in healthcare from a Nordic perspective. What are the flavours of Nordic research within these topics? What does it add to the international research literature? This book illustrates the unique nature of researching patient safety and quality with the Nordic perspective as well as showcasing representative work. The book presents an overview of the status and evidence of international and Nordic research on quality and safety in healthcare. Four different perspectives are used to present the trends within the research field: a patient perspective, a methodological perspective, a theoretical perspective, and a clinical perspective. The book then presents the status of Nordic research in the field and displays a set of illustrative work and current research topics within the Nordic context, concluding with a discussion of the characteristic features of Nordic research on patient safety and quality in healthcare. The anthology presents an inter-professional perspective and researchers from disciplines such as medical and nursing sciences, humanities, social sciences and engineering. It is written to contribute to the patient safety cause with translational knowledge that will be useful to researchers, policy makers and healthcare managers within Nordic countries and internationally.

Patient Safety - Cultural Perspectives

Improving the culture of safety in our health care institutions is an essential component of preventing or reducing errors as well as improving overall health care quality. This book presents the clinically tested Myer's Patient Safety Model for health care system leaders, middle managers, and administrators to build their patient safety program and to help sustain, renew, or obtain accreditation. The author provides detailed explanations of why medical errors still occur in accredited hospitals, and provides the much needed organization-wide steps to prevent these errors and enhance patient safety for improved outcomes. Current patient safety challenges are discussed with an emphasis on the concept of reliability. The Myers Model is examined in detail, along with current evidence for its three interrelated levels of organizational structure-the leadership (system) level, the unit (microsystem) level, and the individual level. The text includes interviews about key aspects of patient safety with three leaders of major health care accreditation programs in the U.S., Canada, and Australia. Additionally, it provides an overview of reporting systems within the U.S. and covers two essential tools for patient safety-root cause analysis and failure mode and effect analysis. The book links all aspects of patient safety with accreditation standards at the national level, and also discusses efforts to globalize accreditation criteria and procedures. Key Features: Presents a clinically tested model for building a patient safety program and helping to sustain, renew, or obtain accreditation Provides tools for use in ensuring patient safety and accreditation, including root cause analysis and failure mode and effect analysis Discusses how aggregate data inform

patient safety documentation and accreditation through integrated perspectives Offers a global view of accreditation and patient safety Includes techniques to improve communication among members of health care teams

The Patient and Health Care System: Perspectives on High-Quality Care

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.

Healthcare Hazard Control and Safety Management

Advancements in technology regularly influence the healthcare field and developing aspects on medical patient safety. Implementing electronic health records, decision support systems, and computerized physician order entry systems reduces risk in the potential for e-health to make errors leading to adverse events. E-Health Technologies and Improving Patient Safety: Exploring Organizational Factors presents an overview on information and communication technologies and addresses the impacts on the field of both patient safety and e-health. This book offers insightful perspectives and concentrated research on concepts related to these areas, as well as issues and current trends in patient safety in e-health.

Advances in Patient Safety

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.

Researching Patient Safety and Quality in Healthcare

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.

Evidence-Based Practice

This illuminating study explores the role of professionals, patients, regulation and law in improving patient safety.

Regulating Patient Safety

The inspiring story of how a leading innovator in patient safety found a simple way to save countless lives. First, do no harm-doctors, nurses and clinicians swear by this code of conduct. Yet in hospitals and doctors' offices across the country, errors are made every single day - avoidable, simple mistakes that often cost lives. Inspired by two medical mistakes that not only ended in unnecessary deaths but

hit close to home, Dr. Peter Pronovost made it his personal mission to improve patient safety and make preventable deaths a thing of the past, one hospital at a time. Dr. Pronovost began with simple improvements to a common procedure in the ER and ICU units at Johns Hopkins Hospital. Creating an easy five-step checklist based on the most up-to-date research for his fellow doctors and nurses to follow, he hoped that streamlining the procedure itself could slow the rate of infections patients often died from. But what Dr. Pronovost discovered was that doctors and nurses needed more than a checklist: the day-to-day environment needed to be more patient-driven and staff needed to see scientific results in order to know their efforts were a success. After those changes took effect, the units Dr. Pronovost worked with decreased their rate of infection by 70%. Today, all fifty states are implementing Dr. Pronovost's programs, which have the potential to save more lives than any other medical innovation in the past twenty-five years. But his ideas are just the beginning of the changes being made by doctors and nurses across the country making huge leaps to improve patient care. In Safe Patients, Smart Hospitals, Dr. Pronovost shares his own experience, anecdotal stories from his colleagues at Johns Hopkins and other hospitals that have made his approach their own, alongside comprehensive research-showing readers how small changes make a huge difference in patient care. Inspiring and thought provoking, this compelling book shows how one person with a cause really can make a huge difference in our lives.

Patient Safety and Health Care Management

Knowledge management goes beyond data and information capture in computerized health records and ordering systems; it seeks to leverage the experiences of all who interact in healthcare to enhance care delivery, teamwork, and organizational learning. Knowledge management - if envisioned thoughtfully - takes a systemic approach to implementation that includes the embodiment of a learning culture. Knowledge is then used to support that culture and the knowledge workers within it to encourage them to share what they know, thusly enabling their peers, their organizations and ultimately their patients to benefit from their experience to proactively dismantle hierarchy and encourage sharing about what works, and what doesn't to focus efforts on improvement. Knowledge Management in Healthcare draws on relevant business, clinical and health administration literature plus the analysis of discussions with a variety of clinical, administrative, leadership, patient and information experts. The result is a book that will inform thinking on knowledge access needs to mitigate potential failures, design lasting improvements and support the sharing of what is known to enable work towards attaining high reliability. It can be used as a general tool for leaders and individuals wishing to devise and implement a knowledge-sharing culture in their institution, design innovative activities supporting transparency and communication to strengthen existing programs intended to enhance knowledge sharing behaviours and contribute to high quality, safe care.

Patient Safety

Many advances have been made in the last decade in the understanding of the computational principles underlying olfactory system functioning. Neuromorphic Olfaction is a collaboration among European researchers who, through NEUROCHEM (Fp7-Grant Agreement Number 216916)—a challenging and innovative European-funded project—introduce novel computing paradigms and biomimetic artifacts for chemical sensing. The implications of these findings are relevant to a wide audience, including researchers in artifical olfaction, neuroscientists, physiologists, and scientists working with chemical sensors. Developing neuromorphic olfaction from conceptual points of view to practical applications, this cross-disciplinary book examines: The biological components of vertebrate and invertebrate chemical sensing systems The early coding pathways in the biological olfactory system, showing how nonspecific receptor populations may have significant advantages in encoding odor intensity as well as odor identity The redundancy and the massive convergence of the olfactory receptor neurons to the olfactory bulb A neuromorphic approach to artificial olfaction in robots Reactive and cognitive search strategies for olfactory robots The implementation of a computational model of the mammalian olfactory system The book's primary focus is on translating aspects of olfaction into computationally practical algorithms. These algorithms can help us understand the underlying behavior of the chemical senses in biological systems. They can also be translated into practical

applications, such as robotic navigation and systems for uniquely detecting chemical species in a complex background.

Healthcare Administration for Patient Safety and Engagement

Surpassing the standard set by the first edition, Healthcare Hazard Control and Safety Management, Second Edition presents expansive coverage for healthcare professionals serving in safety, occupational health, hazard materials management, quality improvement, and risk management positions. Comprehensive in scope, the book covers all major issues i

Case Studies in Patient Safety

"This project aimed to collect and critically review the existing evidence on practices relevant to improving patient safety"--P. v.

Impact of Medical Errors and Malpractice on Health Economics, Quality, and Patient Safety

Resource added for the Nursing-Associate Degree 105431, Practical Nursing 315431, and Nursing Assistant 305431 programs.

Resilient Health Care, Volume 2

Medical residents in hospitals are often required to be on duty for long hours. In 2003 the organization overseeing graduate medical education adopted common program requirements to restrict resident workweeks, including limits to an average of 80 hours over 4 weeks and the longest consecutive period of work to 30 hours in order to protect patients and residents from unsafe conditions resulting from excessive fatigue. Resident Duty Hours provides a timely examination of how those requirements were implemented and their impact on safety, education, and the training institutions. An in-depth review of the evidence on sleep and human performance indicated a need to increase opportunities for sleep during residency training to prevent acute and chronic sleep deprivation and minimize the risk of fatigue-related errors. In addition to recommending opportunities for on-duty sleep during long duty periods and breaks for sleep of appropriate lengths between work periods, the committee also recommends enhancements of supervision, appropriate workload, and changes in the work environment to improve conditions for safety and learning. All residents, medical educators, those involved with academic training institutions, specialty societies, professional groups, and consumer/patient safety organizations will find this book useful to advocate for an improved culture of safety.

Medication Safety

It is clearly recognized that medical errors represent a significant source of preventable healthcare-related morbidity and mortality. Furthermore, evidence shows that such complications are often the result of a series of smaller errors, missed opportunities, poor communication, breakdowns in established guidelines or protocols, or system-based deficiencies. While such events often start with the misadventures of an individual, it is how such events are managed that can determine outcomes and hopefully prevent future adverse events. The goal of Vignettes in Patient Safety is to illustrate and discuss, in a clinically relevant format, examples in which evidence-based approaches to patient care, using established methodologies to develop highly functional multidisciplinary teams, can help foster an institutional culture of patient safety and high-quality care delivery.

Knowledge Management in Healthcare

This book offers a global perspective on healthcare reform and its relationship with efforts to improve quality and safety. It looks at the ways reforms have developed in 30 countries, and specifically the impact national reform initiatives have had on the quality and safety of care. It explores how reforms drive quality and safety

improvement, and equally how they act to negate such goals. Every country included in this book is involved in a reform and improvement process, but each takes place in a particular social, cultural, economic and developmental context, leading to differing emphases and varied progress. Methods for tackling common problems - financing, efficiencies, effectiveness, evidence-based practice, institutional reforms, quality improvement, and patient safety initiatives - also differ. Representatives from each nation provide a chapter to convey their own situation. The editors draw a conclusion from these numerous contributions and synthesize the themes emerging into a coherent 'lessons learned' summary that delivers value to the numerous stakeholders. Healthcare Reform, Quality and Safety forms a compendium of the current 'state of the art' in global healthcare reform. This is the first book of its type, and offers a unique opportunity for cross-fertilization of ideas to the mutual benefit of countries involved in the project. The content will be of interest to governments, policymakers, managers and leaders, clinicians, teaching academics, researchers and students.

Vignettes in Patient Safety

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.

ROMANCE ACTION & ADVENTURE MYSTERY & THRILLER BIOGRAPHIES & HISTORY CHILDREN'S YOUNG ADULT FANTASY HISTORICAL FICTION HORROR LITERARY FICTION NON-FICTION SCIENCE FICTION