

PATIENT SAFETY AND QUALITY CARE

A Handbook for Healthcare Professionals
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The Patient Safety Handbook

Girdha J Gyani, Alexander Thomas

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Patient Safety Handbook Barbara J. Youngberg, 2013 In the current climate of managed care tight cost controls limited resources and the growing demand for health care services conditions for medical errors are ripe Nearly 100 000 people die each year from medical errors and tens of thousands more are injured. This comprehensive handbook on patient safety reflects the goals of many in the health care industry to advance the reliability of healthcare systems worldwide With contributions from prominent thought leaders in the field this thoroughly revised Second Edition of The Patient Safety Handbook looks at all the recent changes in the industry and offers practical guidance on implementing systems and processes to improve outcomes and advance patient safety. The book covers the full spectrum of patient safety and risk reduction from the fundamentals of the science of safety through a thorough discussion of operational issues and the application of the principles of research Real life case studies from renowned health care organizations and their leadership help the reader understand the practical application of the strategies presented Key Features Offers contributions from prominent thought leaders in both academia and the profession Examines the newest scientific advances in the science of safety Includes real life case studies from renowned health care organizations Norwich Pod- the Patient Safety Handbook 2e Jones & Bartlett Learning, LLC, 2017-05-02 Instructor Resources PowerPoints Test Bank Transition Guide Available in August Contact your Account Specialist to be notified as these become available In the current climate of managed care tight cost controls limited resources and the growing demand for health care services conditions for medical errors are ripe Nearly 100 000 people die each year from medical errors and tens of thousands more are injured. This comprehensive handbook on patient safety reflects the goals of many in the health care industry to advance the reliability of healthcare systems worldwide With contributions from prominent thought leaders in the field this thoroughly revised Second Edition of The Patient Safety Handbook looks at all the recent changes in the industry and offers practical guidance on implementing systems and processes to improve outcomes and advance patient safety. The book covers the full spectrum of patient safety and risk reduction from the fundamentals of the science of safety through a thorough discussion of operational issues and the application of the principles of research Real life case studies from renowned health care organizations and their leadership help the reader understand the practical application of the strategies presented Key Features Offers contributions from prominent thought leaders in both academia and the profession Examines the newest scientific advances in the science of safety Includes real life case studies from renowned health care organizations Principles of Patient Safety Health Care Quality Quality Improvement in Health Care Risk Management and Patient Safety in Health Care 2013 650 pages Capella Pod- the Patient Safety Handbook 2e Jones & Bartlett Learning, LLC, 2017-06-07 Instructor Resources PowerPoints Test Bank Transition Guide Available in August Contact your Account Specialist to be notified as these become available In the current climate of managed care tight cost controls limited resources and the growing demand for health care services conditions for

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requirements implemented by federal state and accreditation agencies including the federal Patient Safety and Quality The Handbook of Patient Safety Compliance Fay A. Rozovsky, James R. Woods, Improvement Act of 2005 Ir., 2016-12-05 Written for virtually every professional and leader in the health care field as well as students who are preparing for careers in health services delivery this book presents a framework for developing a patient safety program shows how best to examine events that do occur and reveals how to ensure that appropriate corrective and preventative actions are reviewed for effectiveness. The book covers a comprehensive selection of topics including The link between patient safety and legal and regulatory compliance. The role of accreditation and standard setting organizations in patient safety Failure modes and effect analysis Voluntary and regulatory oversight of medical error Evidence based outcomes and standards of care Creation and preservation of reports data and device evidence in medical error situations Claims management when dealing with patient safety events Full disclosure Patient safety in human research Managing confidentiality in the face of litigation Managing patient safety compliance through accountability based credentialing for health care professionals Planning for the future Handbook of Perioperative and Procedural Patient Safety Juan A Sanchez, Robert S. D. Higgins, Paula S. Kent, 2023-03-10 Offering a concise yet comprehensive review of current practices in surgery and patient safety Handbook of Perioperative and Procedural Patient Safety is an up to date practical resource for practicing surgeons anesthesiologists surgical nurses hospital administrators and surgical office staff Edited by Drs Juan A Sanchez and Robert S D Higgins and authored by expert contributors from Johns Hopkins it provides an expansive look at the scope of the problem causes of error minimizing errors surgical suite and surgical team design patient experience and other related topics Presents the knowledge and experience of a multidisciplinary team from Johns Hopkins University which created the Comprehensive Unit based Safety Program CUSP an approach for improving safety culture and engaging frontline clinicians to identify and mitigate defects in care delivery Discusses the scope and prevalence of perioperative harm causes of error in healthcare and perioperative never events Covers safe practices cognitive workload and fatigue and the effects of noise in the OR Includes several team based chapters such as the dynamics of surgical teams safer perioperative team communication and the culture of safety Consolidates today s available information and guidance into a single High Reliability Organizations, Second Edition Cynthia A. Oster, Jane S. Braaten, 2020-11-02 Patient convenient resource safety and quality of care are critical concerns of healthcare consumers payers providers organizations health systems and governments Although a strong body of knowledge shows that high reliability methods enable the most efficient safe and effective care these methods have yet to be completely implemented across healthcare According to authors Cynthia Oster and Jane Braaten nurses who are on the frontline of providing safe and effective care are ideally situated to drive high reliability High Reliability Organizations A Healthcare Handbook for Patient Safety Quality Second Edition equips nurses and healthcare professionals with the tools necessary to establish an error detection and prevention system This new edition

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Safety Handbook Lorry Schoenly, 2018-02 High Reliability Organizations, Third Edition Cynthia A. Oster, Jane S. Braaten, 2025-10-02 Oster and Braaten outline the history of safety science and high reliability challenges and barriers in harm prevention in clinical practice and the importance of health equity This book is recommended reading for those who wish to strive for superb quality and safety in healthcare Ann Scott Blouin PhD RN LFACHE Assistant Professor Loyola University Chicago Marcella Niehoff School of Nursing Board Secretary Institute for Healthcare Improvement President PSQ Advisory retired Former Executive Vice President The Joint Commission Patient safety and quality of care are critical concerns of healthcare consumers payers providers organizations health systems and governments Evidence shows that high reliability methods enable the most efficient safe and effective care however these methods are not the standard in all healthcare systems Nurses who are on the front line of providing safe and effective care are ideally situated to drive high reliability High Reliability Organizations A Healthcare Handbook for Patient Safety Quality Third Edition equips nurses and healthcare professionals with the tools necessary to establish an error detection and prevention system In this new edition authors Cynthia A Oster and Jane S Braaten build on the foundation of previous editions with best practices relevant exemplars and important discussions about cultural aspects essential to sustainability solidifying process improvements and highlighting the contributing factors that lead to enhanced outcomes TABLE OF CONTENTS Part 1 High Reliability The Imperative Remains Chapter 1 High Reliability Organizations HROs Reflections on the Essence of HRO and the Application to Healthcare Chapter 2 Drivers for Patient Safety Chapter 3 Current Quality Drivers Chapter 4 Organizational Culture and Psychological Safety Breaking Down Barriers Chapter 5 Safety Leadership Commitment to High Reliability Organizing Chapter 6 Health Equity and High Reliability Connecting the Dots for Patient Safety Part 2 HRO Concepts and Application to Practice Preoccupation With Failure Chapter 7 Using Failure Mode and Effects Analysis to Predict Failure Chapter 8 Paying Attention to Close Calls and Near Misses Part 3 HRO Concepts and Application to Practice Reluctance to Simplify Chapter 9 Human Factors Engineering for Reducing and Recovering From Error Chapter 10 10 Root Cause Analysis Effective Investigations for High Reliability Chapter 11 Fostering Just Culture in High Reliability Organizations How Far Have We Come Part 4 HRO Concepts and Application to Practice Sensitivity to Operations Chapter 12 Alarm Safety Working Solutions Chapter 13 Innovative Technology Standardization and the Impact on High Reliability Chapter 14 Tiered Safety Huddles Part 5 HRO Concepts and Application to Practice Deference to Expertise Chapter 15 The Current Need for Interprofessional Collaborative Care and Teamwork Chapter 16 Meaningful Patient Engagement Best Practice for High Reliability Chapter 17 Pediatric Patient Safety Utilizing Safety Coaching as a Strategy Toward Zero Harm Part 6 HRO Concepts and Application to Practice Commitment to Resilience Chapter 18 Designing Resilience Into the Work Environment Chapter 19 Building High Reliability Through Simulation Chapter 20 Building Resilience Through Team Training Rapid Response and In Hospital Cardiac Arrest Events Chapter 21 Sustaining a Culture of Safety Part 7 Assimilation Into Practice Across the Continuum

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Understanding Patient Safety, Third Edition Robert Wachter, Kiran Gupta, 2017-11-23 Publisher's Note Products purchased from Third Party sellers are not guaranteed by the publisher for quality authenticity or access to any online entitlements included with the product Now revised and updated the landmark patient safety primer written by the world s leading authorities Medical errors are the unfortunate byproduct of an increasingly complex healthcare system Now more than ever keeping patients safe takes well trained caregivers relevant insights from a range of industries additional investment and a groundbreaking text like Understanding Patient Safety Understanding Patient Safety is must read for those seeking to master the clinical organizational and systems issues of patient safety. In this bestselling primer patient safety pioneer Robert Wachter and Kiran Gupta put all the essential tools and principles at your fingertips Engaging and accessible the book is filled with high yield cases analyses tables graphics along with key points and references all designed to help you optimize quality and safety Understanding Patient Safety begins with an introduction to patient safety and medical errors Its second section surveys specific types of medical errors including those related to surgery medications diagnosis transition and handoff and infections The third section covers proven solutions from establishing reporting systems to creating a culture of safety The third edition reflects pivotal new developments in the field including major updates in diagnostic errors information technology and patient safety ambulatory safety and clinician burnout Features Coverage of human factors and errors at the person machine interface Review of workplace issues including supporting caregivers after major errors How to organize an effective safety program Coordination of patient education and training Overview of the malpractice system Discussion of the patient s role **High Reliability Organizations, Second Edition** Cynthia A. Oster, Jane S. Braaten, 2020-11-30 Equips nurses and healthcare professionals with the tools necessary to establish an error detection and

prevention system Includes Instructor's Guide and Student Workbook The Patient Safety Committee Handbook Handbook of Research on Patient Safety and Quality Care Through Health Informatics Sandra L. Patterson, 2003 Vaughan Michell, Deborah J. Rosenorn-Lanng, Stephen Gulliver, Wendy Currie, 2013-09-30 This book highlights current research and trends from both professionals and researchers on health informatics as applied to the needs of patient safety and quality care offering theory and practical approaches for patient needs Patient Safety Lorri Zipperer, 2016-05-13 Patient Safety Perspectives on Evidence Information and Knowledge Transfer provides background on the patient safety movement systems safety human error and other key philosophies that support change and innovation in the reduction of medical error The book draws from multidisciplinary areas within the acute care environment to share models that support the proactive changes necessary to provide safe care delivery The publication discusses how the tenets of safety described in the beginning of the book can be actively applied in the field to make evidence information and knowledge EIK sharing processes reliable effective and safe This is a wide ranging and important book that is designed to raise awareness of the latent risks for patient safety that are present in the EIK identification acquisition and distribution processes structures and systems of many healthcare institutions across the world The expert contributors offer systemic evidence based improvement processes assessment concepts and innovative activities to identify these risks to minimize their potential to adversely impact care These ideas are presented to create opportunities for the field to design and use strategies that enable meaningful implementation and management of EIK Their thoughts will enable healthcare staff to see EIK as a tangible element contributing toward sustainable patient safety improvements

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