

foundations in patient safety for health professionals

[#patient safety](#) [#healthcare safety](#) [#health professional education](#) [#medical error prevention](#) [#foundations of patient safety](#)

Explore the essential foundations of patient safety designed specifically for all health professionals. This resource delves into core principles, best practices, and strategies crucial for identifying and mitigating risks within healthcare settings. Enhance your understanding of medical error prevention and contribute to a safer, more effective patient care environment for improved patient outcomes.

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Foundations in Patient Safety for Health Professionals

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.

Foundations in Patient Safety for Health Professionals

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

Case Studies in Patient Safety

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.

Patient Safety: Research Into Practice

Patient 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 builds on the foundation of the first book with best practices, relevant exemplars, and important discussions about cultural aspects essential to sustainability. New material focuses on:

- High reliability performance during a pandemic
- Organizational learning and tiered safety huddles
- High reliability in infection prevention and ambulatory care
- The emerging field of human factors engineering within healthcare
- Creating a virtual resource toolkit for frontline staff

High Reliability Organizations, Second Edition

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

Examines the newest scientific advances in the science of safety.

High Reliability Organizations

This unique and engaging open access title provides a compelling and ground-breaking account of the patient safety movement in the United States, told from the perspective of one of its most prominent leaders, and arguably the movement's founder, Lucian L. Leape, MD. Covering the growth of the field from the late 1980s to 2015, Dr. Leape details the developments, actors, organizations, research, and policy-making activities that marked the evolution and major advances of patient safety in this time span. In addition, and perhaps most importantly, this book not only comprehensively details how and why human and systems errors too often occur in the process of providing health care, it also promotes an in-depth understanding of the principles and practices of patient safety, including how they were influenced by today's modern safety sciences and systems theory and design. Indeed, the book emphasizes how the growing awareness of systems-design thinking and the self-education and commitment to improving patient safety, by not only Dr. Leape but a wide range of other clinicians and health executives from both the private and public sectors, all converged to drive forward the patient safety movement in the US. *Making Healthcare Safe* is divided into four parts: I. In the Beginning describes the research and theory that defined patient safety and the early initiatives to enhance it. II. Institutional Responses tells the stories of the efforts of the major organizations that began to apply the new concepts and make patient safety a reality. Most of these stories have not been previously told, so this account becomes their histories as well. III. Getting to Work provides in-depth analyses of four key issues that cut across disciplinary lines impacting patient safety which required special attention. IV. Creating a Culture of Safety looks to the future, marshalling the best thinking about what it will take to achieve the safe care we all deserve. Captivatingly written with an "insider's" tone and a major contribution to the clinical literature, this title will be of immense value to health care professionals, to students in a range of academic disciplines, to medical trainees, to health administrators, to policymakers and even to lay readers with an interest in patient safety and in the critical quest to create safe care.

Patient Safety Handbook

Patient safety and quality are an ever-increasing concern to consumers, payers, providers, organizations, and governments. However, high reliability methods and science that can provide efficient and effective care have still not been totally implemented into our healthcare culture. Nurses, representing the majority of healthcare workers, are on the front line of the delivery and provision of safe and effective care and are ideally situated to drive the mission to achieve high reliability in healthcare. *High Reliability*

Organizations: A Healthcare Handbook for Patient Safety & Quality presents practical examples of HRO principles in order to establish a system that detects and prevents errors from happening even in the most difficult, high risk conditions. Authors Cynthia Oster and Jane Braaten provide healthcare professionals with tools and best practices that will improve and enhance patient safety and quality outcomes. This book provides: - An overview of HRO science as an organizing framework for quality and patient safety - Practical applications of HRO science, focusing on quality and patient safety - Knowledge and tools that can be applied to current quality and safety practices - Real-world examples of HRO principles employed in a variety of patient care areas -- Provided by publisher.

Making Healthcare Safe

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

High Reliability Organizations

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.

The Handbook of Patient Safety Compliance

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.

A Socio-cultural Perspective on 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.

To Do No Harm

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.

Patient Safety and Health Care Management

Patient Safety and Healthcare Improvement at a Glance is a timely and thorough overview of healthcare quality written specifically for students and junior doctors and healthcare professionals. It bridges the gap between the practical and the theoretical to ensure the safety and wellbeing of patients. Featuring essential step-by-step guides to interpreting and managing risk, quality improvement within clinical specialties, and practice development, this highly visual textbook offers the best preparation for the increased emphasis on patient safety and quality-driven focus in today's healthcare environment. Healthcare Improvement and Safety at a Glance: • Maps out and follows the World Health Organization Patient Safety curriculum • Draws upon the quality improvement work of the Institute for Healthcare Improvement This practical guide, covering a vital topic of increasing importance in healthcare, provides the first genuine introduction to patient safety and quality improvement grounded in clinical practice.

Health IT and Patient Safety

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 nurses' 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 — monitoring patients, educating home caretakers, performing treatments, and rescuing patients who are in crisis — 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 — 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.

Patient Safety and Healthcare Improvement at a Glance

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.

Keeping Patients Safe

Experts estimate that as many as 98,000 people die in any given year from medical errors that occur in hospitals. That's more than die from motor vehicle accidents, breast cancer, or AIDS—three causes that receive far more public attention. Indeed, more people die annually from medication errors than from workplace injuries. Add the financial cost to the human tragedy, and medical error easily rises to the top ranks of urgent, widespread public problems. *To Err Is Human* breaks the silence that has surrounded medical errors and their consequence—but not by pointing fingers at caring health care professionals who make honest mistakes. After all, to err is human. Instead, this book sets forth a national agenda—with state and local implications—for reducing medical errors and improving patient safety through the design of a safer health system. This volume reveals the often startling statistics of medical error and the disparity between the incidence of error and public perception of it, given many patients' expectations that the medical profession always performs perfectly. A careful examination is made of how the surrounding forces of legislation, regulation, and market activity influence the quality of care provided by health care organizations and then looks at their handling of medical mistakes. Using a detailed case study, the book reviews the current understanding of why these mistakes happen. A key theme is that legitimate liability concerns discourage reporting of errors—which begs the question, "How can we learn from our mistakes?" Balancing regulatory versus market-based initiatives and public versus private efforts, the Institute of Medicine presents wide-ranging recommendations for improving patient safety, in the areas of leadership, improved data collection and analysis, and development of effective systems at the level of direct patient care. *To Err Is Human* asserts that the problem is not bad people in health care—it is that good people are working in bad systems that need to be made safer. Comprehensive and straightforward, this book offers a clear prescription for raising the level of patient safety in American health care. It also explains how patients themselves can influence the quality of care that they receive once they check into the hospital. This book will be vitally important to federal, state, and local health policy makers and regulators, health professional licensing officials, hospital administrators, medical educators and students, health caregivers, health journalists, patient advocates—as well as patients themselves. First in a series of publications from the Quality of Health Care in America, a project initiated by the Institute of Medicine

Critical Conversations for Patient Safety

The purpose of this book is to provide a road map to help healthcare professionals establish a "culture of patient safety" in their facilities and practices, provide high quality healthcare, and increase patient and staff satisfaction by improving communication among staff members and between medical staff and patients. It achieves this by describing what each of six types of people will do in distress, by providing strategies that will allow healthcare professionals to deal more effectively with staff members and patients in distress, and by showing healthcare professionals how to keep themselves out of distress by getting their motivational needs met positively every day. The concepts described in this book are scientifically based and have withstood more than 40 years of scrutiny and scientific inquiry. They were first used as a clinical model to help patients help themselves, and indeed are still used clinically. The originator of the concepts, Dr. Taibi Kahler, is an internationally recognized clinical psychologist who was awarded the 1977 Eric Berne Memorial Scientific Award for the clinical application of a discovery he made in 1971. That discovery enabled clinicians to shorten significantly the treatment time of patients by reducing their resistance as a result of miscommunication between their doctors and themselves.

Innovating for Patient Safety in Medicine

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.

To Err Is Human

"Nurses play a vital role in improving the safety and quality of patient care -- 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/nursesdbk/>

Establishing a Culture of 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.

Patient Safety and Quality Improvement in Healthcare

Quality/Patient Safety

Patient Safety and Quality

Health Sciences & Professions

Patient Safety

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 Handbook

This volume, developed by the Observatory together with OECD, provides an overall conceptual framework for understanding and applying strategies aimed at improving quality of care. Crucially, it summarizes available evidence on different quality strategies and provides recommendations for their implementation. This book is intended to help policy-makers to understand concepts of quality and to support them to evaluate single strategies and combinations of strategies.

Principles of Risk Management and Patient Safety

The authors of this book set out a system of safety strategies and interventions for managing patient safety on a day-to-day basis and improving safety over the long term. These strategies are applicable at all levels of the healthcare system from the frontline to the regulation and governance of the system. There have been many advances in patient safety, but we now need a new and broader vision that encompasses care throughout the patient's journey. The authors argue that we need to see safety through the patient's eyes, to consider how safety is managed in different contexts and to develop a wider strategic and practical vision in which patient safety is recast as the management of risk over time. Most safety improvement strategies aim to improve reliability and move closer toward optimal care. However, healthcare will always be under pressure and we also require ways of managing safety when conditions are difficult. We need to make more use of strategies concerned with detecting, controlling, managing and responding to risk. Strategies for managing safety in highly standardised and controlled environments are necessarily different from those in which clinicians constantly have to adapt and respond to changing circumstances. This work is supported by the Health Foundation. The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK. The charity's aim is a healthier population in the UK, supported by high quality health

care that can be equitably accessed. The Foundation carries out policy analysis and makes grants to front-line teams to try ideas in practice and supports research into what works to make people's lives healthier and improve the health care system, with a particular emphasis on how to make successful change happen. A key part of the work is to make links between the knowledge of those working to deliver health and health care with research evidence and analysis. The aspiration is to create a virtuous circle, using what works on the ground to inform effective policymaking and vice versa. Good health and health care are vital for a flourishing society. Through sharing what is known, collaboration and building people's skills and knowledge, the Foundation aims to make a difference and contribute to a healthier population.

High Reliability Organizations, Second Edition

This work builds on 'Human Factors in Healthcare: Level One' by delving deeper into the challenges of leadership, conflict resolution, and decision making that healthcare professionals currently face. It is written in an easy to understand style and includes a wealth of real-life examples of errors and patient safety issues.

Improving Healthcare Quality in Europe Characteristics, Effectiveness and Implementation of Different Strategies

Practical Patient Safety demonstrates how core principles of safety from industries such as aviation, nuclear and petrochemical can be applied in surgical and medical practice, giving the reader practical advice on how to start patient safety training within his or her department or hospital.

Safer Healthcare

Providing professional perspective with insights from prominent patient safety experts, Patient Safety Ethics identifies hazard pitfalls and suggests concrete ways for clinicians and regulators to improve patient safety through an ethically cultivated program of "hazard awareness."

Human Factors in Healthcare

Influencing the Quality, Risk and Safety Movement in Healthcare explores the inner workings of some of the most influential minds in healthcare quality, risk and safety. The book was created in cooperation with the Master of Science in Healthcare Quality graduate program, developed and delivered by Queen's University, Canada. This is the only standalone interdisciplinary Master of Science graduate degree in Healthcare Quality in North America that focuses on creating tomorrow's healthcare leaders. Following a one-to-one collaboration between each leader in healthcare with a dedicated learner of the MSc(HQ), readers are presented with a synopsis of the leader's work followed by an in-depth interview with him or her. Interviews center around the leaders' contributions to and thoughts on quality, risk and safety in healthcare, dealing with topics such as the development of their body of work, their greatest achievements, what they wish they could change, and future direction of quality, risk and safety, etc. The book provides a unique and highly accessible view into how and why the science of healthcare quality has developed, as well as giving a first-hand account of the founders and key players in the movement. It will offer valuable insights to any undergraduate/graduate class with an interest in healthcare, as well as professionals working within any of the many disciplines that can influence the healthcare system.

Practical Patient Safety

This practical text provides an overview of the adverse consequences of health information technology (HIT) and its impact on patient safety. Specific cases of errors and risks related to various types of HIT are featured along with best practices for patient safety, workflows and organizational standards. The full impact of these challenges with meaningful solutions are openly examined. Written from a clinical perspective, healthcare professionals within multiple settings will find this timely book an invaluable resource to this essential and burgeoning technology.

Patient Safety Ethics

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 nurses' 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 — monitoring patients, educating home caretakers, performing treatments, and rescuing patients who are in crisis — 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 — 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.

Lessons in Patient Safety

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

Critical Conversations for Patient Safety

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

Influencing the Quality, Risk and Safety Movement in Healthcare

Enhancing Patient Safety and Reducing Errors in Health Care