To Err Is Human Building A Safer Health System En

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Human Error National Academies Press
This Dictionary presents a broad range of topics relevant in present-day global bioethics. With more than 500 entries, this dictionary covers organizations working in the field of global bioethics, international documents concerning bioethics, personalities that have played a role in the development of global bioethics, as well as specific topics in the field.The book is not only useful for students and professionals in global health activities, but can also serve as a basic tool that explains relevant ethical notions and terms. The dictionary furthers the ideals of cosmopolitanism: solidarity, equality, respect for difference and concern with what human beings- and specifically patients - have in common, regardless of their backgrounds, hometowns, religions, gender, etc. Global problems such as pandemic diseases, disasters, lack of care and medication, homelessness and displacement call for global responses.This book demonstrates that a moral vision of global health is necessary and it helps to quickly understand the basic ideas of global bioethics.
Building a Culture of Patient Safety Through Simulation "O'Reilly Media, Inc."
"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."--Dust jacket.

The Brain That Changes Itself McGraw Hill Professional

Bad design is everywhere, and its cost is much higher than we think. In this thought-provoking book, authors Jonathan Shariat and Cynthia Savard Saucier explain how poorly designed products can anger, sadden, exclude, and even kill people who use them. The designers responsible certainly didn ' t intend harm, so what can you do to avoid making similar mistakes? Tragic Design examines real case studies that show how certain design choices adversely affected users, and includes in-depth interviews with authorities in the design industry. Pick up this book and learn how you can be an agent of change in the design community and at your company. You ' ll explore: Designs that can kill, including the bad interface that doomed a young cancer patient Designs that anger, through impolite technology and dark patterns How design can inadvertently cause emotional pain Designs that exclude people through lack of accessibility, diversity, and justice How to advocate for ethical design when it isn ' t easy to do so Tools and techniques that can help you avoid harmful design decisions Inspiring professionals who use design to improve our world

Tragic Design John Wiley & Sons

When you are ready to implement measures to improve patient safety, this is the book to consult. Charles Vincent, one of the world's pioneers in patient safety, discusses each and every aspect clearly and compellingly. He reviews the evidence of risks and harms to patients, and he provides practical guidance on implementing safer practices in health care. The second edition puts greater emphasis on this practical side. Examples of team based initiatives show how patient safety can be improved by changing practices, both cultural and technological, throughout whole organisations. Not only does this benefit patients; it also impacts positively on health care delivery, with consequent savings in the economy. Patient Safety has been praised as a gateway to understanding the subject. This second edition is more than that – it is a revelation of the pervading influence of health care errors, and a guide to how these can be overcome. "... The beauty of this book is that it describes the complexity of patient safety in a simple coherent way and captures the breadth of issues that encompass this fascinating field. The author provides numerous ways in which the reader can take this subject further with links to the international world of patient safety and evidence based research... One of the most difficult aspects of patient safety is that of implementation of safer practices and sustained change. Charles Vincent, through this book, provides all who read it clear examples to help with these challenges" From a review in Hospital Medicine by Dr Suzette Woodward, Director of Patient Safety. Access 'Essentials of Patient Safety – Free Online Introduction': www.wiley.com/go/vincent/patientsafety/essentials

Health Professions Education IGI Global

Americans are accustomed to anecdotal evidence of the health care crisis. Yet, personal or local stories do not provide a comprehensive nationwide picture of our access to health care. Now, this book offers the long-awaited health equivalent of national economic indicators. This useful volume defines a set of national objectives and identifies indicatorsâ€"measures of utilization and outcomeâ€"that can "sense" when and where problems occur in accessing specific health care services. Using the indicators, the committee presents significant conclusions about the situation today, examining the relationships between access to care and factors such as income, race, ethnic origin, and location. The committee offers recommendations to federal, state, and local agencies for improving data collection and monitoring. This highly readable and well-organized volume will be essential for policymakers, public health officials, insurance companies, hospitals, physicians and nurses, and interested individuals.

Transforming Public Health in Developing Nations Watson-Guptill

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.

Design for Health Jones & Bartlett Learning

In 1999, the Institute of Medicine published its landmark report, “To Err Is Human: Building a Safer Health System,” in which it stated that nearly 98,000 people die needlessly every year due to preventable medical mistakes. In 2009, the Consumer’s Union published a report, “To Err Is Human—To Delay Is Deadly,” stating that we are no better off today than we were ten years ago and that a million lives have been lost and billions of dollars wasted due to medical mistakes. Enter Dr. Mary Sue McAslan, pharmacist and medication safety expert. With over thirty years’ experience, she provides clever, easy-to-follow safety tips for the average healthcare consumer. These simple tips will prevent serious medication errors from happening at the hospital, the doctor’s office, the pharmacy, and at home.

Patient Safety Springer Nature

“Fascinating. Doidge’s book is a remarkable and hopeful portrait of the endless adaptability of the human brain.”—Oliver Sacks, MD, author of The Man Who Mistook His Wife for a Hat What is neuroplasticity? Is it possible to change your brain? Norman Doidge’s inspiring guide to the new brain science explains all of this and more An astonishing new science called neuroplasticity is overthrowing the centuries-old notion that the human brain is immutable, and proving that it is, in fact, possible to

change your brain. Psychoanalyst, Norman Doidge, M.D., traveled the country to meet both the brilliant scientists championing neuroplasticity, its healing powers, and the people whose lives they've transformed—people whose mental limitations, brain damage or brain trauma were seen as unalterable. We see a woman born with half a brain that rewired itself to work as a whole, blind people who learn to see, learning disorders cured, IQs raised, aging brains rejuvenated, stroke patients learning to speak, children with cerebral palsy learning to move with more grace, depression and anxiety disorders successfully treated, and lifelong character traits changed. Using these marvelous stories to probe mysteries of the body, emotion, love, sex, culture, and education, Dr. Doidge has written an immensely moving, inspiring book that will permanently alter the way we look at our brains, human nature, and human potential.

Crossing the Quality Chasm Penguin

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

Taking Action Against Clinician Burnout Joseph Henry Press

The rise of globalized business has created a world village wherein ideas and industry transcend national boundaries. Unfortunately, the resulting increase in travel has accelerated the transmission of diseases, generating a surge in worldwide epidemics and increasing the necessity of innovative strategies for prevention, containment, and communication related to global health issues. Transforming Public Health in Developing Nations showcases the latest developments, trends, and challenges within the field of international public health. Featuring empirical studies, case studies, reviews, and discussion notes, this authoritative text highlights diverse, important global health issues, making it an essential resource for professionals, researchers, and academics seeking insight on the latest developments in contemporary healthcare. This reference work highlights a broad scope of current issues including global epidemics, worldwide health systems, mental health issues in developing nations, barriers to healthcare, sanitation and infection, cultural diversity in healthcare administration, cultural perceptions of reproductive health issues, international health costs and budgets, and health information technology.

Making Health Care Safer National Academies Press

The 140 articles in the 4-volume set represent the efforts of AHRQ-funded patient safety researchers as well as the patient safety initiatives of other parts of the Federal Government. The articles cover a wide range of research paradigms, clinical settings, and patient populations, and they cover various stages of the research process. The volumes include the articles research that is complete and from research still in process, as well as a series of articles that address implementation issues and provide useful tools and products that can be used to improve patient safety.

Cross-cultural Perspectives in Medical Ethics BalboaPress

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 AIDSâ€"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 consequenceâ€"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 agendaâ€"with state and local implicationsâ€"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 errorsâ€"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 careâ€"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 advocatesâ€"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

Advances in Patient Safety National Academies Press

Handbook of Human Factors in Healthcare Design: Novel Trends and Applications takes a deep dive into critical issues in healthcare and patient safety, and examines how human factors play a role in these domains. Using the Design for X (DfX) methodology to discuss a wide range of criteria that need to be considered in the design of safe and usable healthcare ecosystems. Each chapter discusses a specific criteria (remote monitoring, eHealth, mHealth, medical devices, pediatric care, etc), reviews the literature on the concept, and presents a case or empirical study that demonstrates how human factors techniques and principles have been used to design or improve that particular concept. Handbook of Human Factors in Healthcare Design is an essential resource for those in medical device and pharmaceutical industries, consumer IT, and hospital settings; it covers novel technologies such as ingestible pills linked to smartphone applications, the world's smallest implantable pacemaker,

Keeping Patients Safe Penguin

The study of human body measurements on a comparative basis is known as anthropometrics. Its applicability to the design process is seen in the physical fit, or interface, between the human body and the various components of interior space. Human Dimension and Interior Space is the first major anthropometrically based reference book of design standards for use by all those involved with the physical planning and detailing of interiors, including interior designers, architects, furniture designers, builders, industrial designers, and students of design. The use of anthropometric data, although no substitute for good design or sound professional judgment should be viewed as one of the many tools required in the design process. This

comprehensive overview of anthropometrics consists of three parts. The first part deals with the theory and application of anthropometrics and includes a special section dealing with physically disabled and elderly people. It provides the designer with the fundamentals of anthropometrics and a basic understanding of how interior design standards are established. The second part contains easy-to-read, illustrated anthropometric tables, which provide the most current data available on human body size, organized by age and percentile groupings. Also included is data relative to the range of joint motion and body sizes of children. The third part contains hundreds of dimensioned drawings, illustrating in plan and section the proper anthropometrically based relationship between user and space. The types of spaces range from residential and commercial to recreational and institutional, and all dimensions include metric conversions. In the Epilogue, the authors challenge the interior design profession, the building industry, and the furniture manufacturer to seriously explore the problem of adjustability in design. They expose the fallacy of designing to accommodate the so-called average man, who, in fact, does not exist. Using government data, including studies prepared by Dr. Howard Stoudt, Dr. Albert Damon, and Dr. Ross McFarland, formerly of the Harvard School of Public Health, and Jean Roberts of the U.S. Public Health Service, Panero and Zelnik have devised a system of interior design reference standards, easily understood through a series of charts and situation drawings. With Human Dimension and Interior Space, these standards are now accessible to all designers of interior environments.

Making Healthcare Safe National Academies Press

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.

Emotional Intelligence in Nursing John Wiley & Sons

Cross- Cultural Perspectives in Medical Ethics, Second Edition, is an anthology of the latest and best readings on the medical ethics of as many of the major religious, philosophical, and medical traditions that are available today.

E-Health and Telemedicine: Concepts, Methodologies, Tools, and Applications National Academies Press

"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.

Patient Safety and Quality National Academies Press

Patient-centered, high-quality health care relies on the well-being, health, and safety of health care clinicians. However, alarmingly high rates of clinician burnout in the United States are detrimental to the quality of care being provided, harmful to individuals in the workforce, and costly. It is important to take a systemic approach to address burnout that focuses on the structure, organization, and culture of health care. Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being builds upon two groundbreaking reports from the past twenty years, To Err Is Human: Building a Safer Health System and Crossing the Quality Chasm: A New Health System for the 21st Century, which both called attention to the issues around patient safety and quality of care. This report explores the extent, consequences, and contributing factors of clinician burnout and provides a framework for a systems approach to clinician burnout and professional well-being, a research agenda to advance clinician well-being, and recommendations for the field.

Understanding Patient Safety, Second Edition Bloomsbury Publishing USA

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.

TeamSTEPPS 2.0 CRC Press

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.