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Measuring Patient Safety

**Jesse M. Pines, Helen Burstin, Jane
Hyatt Thorpe**



Measuring Patient Safety:

Measuring Patient Safety Simmons,2005-10 **Measuring Patient Safety** Robin Purdy Newhouse,Stephanie Poe,2005

The vital nature of improving patient safety requires nurses to assume leadership roles in measuring and improving the structures processes and patient outcomes in the clinical setting This book will enable them to impact patient safety with knowledge and confidence *Measuring Safety: A New Perspective on Outcomes of a Long-Term Intensive Case Management Program* ,2005 Patient safety is a critical dimension of program effectiveness Measuring patient safety in managed behavioral health care contexts presents challenges partly due to the lack of well defined safety measures A new perspective on measuring patient safety within the context of a managed behavioral health care intensive case management ICM program serving a high risk population from 16 States in the middle and western United States is presented Objectives Investigate the usefulness of community tenure inpatient utilization and length of stay functional health status and patient satisfaction as a constellation of patient safety indicators in an intensive case management program Methods Claims and self report data 12 months before entry into ICM were compared with matched data 12 months after discharge from ICM and with comparison group data Participants were safety sensitive with high suicide risk and psychiatric substance use and medical comorbidity Results Safety was enhanced for the ICM group as measured by 18 percent fewer inpatient days and 17 percent shorter length of stay 21 percent longer community tenure between admissions and improved functional health status Total cost of care was lower for ICM than comparison group Conclusions The constellation of measures forms an acceptable indicator of patient safety results support that ICM enhanced patient safety preserved patient satisfaction and reduced cost **Patient Safety Research in Medical Group Practices: Measurement and Data Challenges** ,2005 This paper attempts to identify and discuss some of the major challenges to conducting patient safety research in medical group practices First the authors identify the most important attributes of medical group practices to be considered in this type of research The measurement and specification of these variables are discussed and the problems associated with past research are noted Alternate ways of specifying key variables are discussed and examples of methods that have been shown to be effective are provided The authors then propose a definition of patient safety and discuss issues around its measurement Finally they discuss how the data requirements for this type of research are very complex and outline benefits and challenges related to using certain types of data Sections are as follows specifying and measuring group practice variables measuring patient safety and data sources including claims data group practice surveys patient surveys self reporting systems and electronic medical records EMRs **Oxford Professional Practice: Handbook of Patient Safety** Peter Lachman,Jane Runnacles,Anita Jayadev,John Brennan,John Fitzsimons,2022 Pocket sized and practical this handbook is the ideal guide to support frontline staff and trainees as well as all allied professionals in the name of patient safety It will aim to demystify what is often seen as a complex topic helping doctors understand the methods needed to provide safe care **Medical**

Emergency Teams Michael A. DeVita, Ken Hillman, Rinaldo Bellomo, 2007-07-03 Why Critical Care Evolved METs In early 2004 when Dr Michael DeVita informed me that he was considering a textbook on the new concept of Medical Emergency Teams METs I was surprised At Presbyterian University Hospital in Pittsburgh we introduced this idea some 15 years ago but did not think it was revolutionary enough to publish This even though our fellows in critical care medicine training were all involved and informed about the importance of Condition C Crisis as it was called to distinguish it from Condition A Arrest We thought it absurd to intervene only after cardiac arrest had occurred because most cases showed prior deterioration and cardiac arrest could be prevented with rapid team work to correct precluding problems The above thoughts were logical in Pittsburgh where the legendary Dr Peter Safar had been working since the late 1950s on improving current resuscitation techniques first ventilation victims of apneic from drowning treatment of smoke inhalation and so on This was followed by external cardiac compression upon demonstration of its efficiency in cases of unexpected sudden cardiac arrest Dr Safar devoted his entire professional life to improvement of cardiopulmonary resuscitation He and many others emphasized the importance of getting the CPR team to the hospital victims of cardiac arrest as quickly as possible *Patient Safety and Quality: sect.IV: Working conditions and environment* Ronda Hughes, 2008 *Patient Safety Culture* Patrick Waterson, 2018-10-09 How safe are hospitals Why do some hospitals have higher rates of accident and errors involving patients How can we accurately measure and assess staff attitudes towards safety How can hospitals and other healthcare environments improve their safety culture and minimize harm to patients These and other questions have been the focus of research within the area of Patient Safety Culture PSC in the last decade More and more hospitals and healthcare managers are trying to understand the nature of the culture within their organisations and implement strategies for improving patient safety The main purpose of this book is to provide researchers healthcare managers and human factors practitioners with details of the latest developments within the theory and application of PSC within healthcare It brings together contributions from the most prominent researchers and practitioners in the field of PSC and covers the background to work on safety culture e.g. measuring safety culture in industries such as aviation and the nuclear industry the dominant theories and concepts within PSC examples of PSC tools methods of assessment and their application and details of the most prominent challenges for the future in the area Patient Safety Culture Theory Methods and Application is essential reading for all of the professional groups involved in patient safety and healthcare quality improvement filling an important gap in the current market

Patient Safety in Developing Countries Yaser Al-Worafi, 2023-10-05 Understanding the various aspects of patient safety education practice and research in developing countries is vital in preparing a plan to overcome the challenges of improving patient safety This unique volume discusses patient safety in developing countries and the achievements and challenges faced in those places when trying to improve patient safety education and practice This book includes a compilation of over 100 case studies surrounding patient safety in all aspects of health care Both real and simulated

scenarios are provided to help medical students and professionals apply their knowledge to solve the cases and prepare for real practice Features Describes the achievements and challenges of patient safety in developing countries Includes real and simulated case studies and key answers on patient safety issues Prepares medical students and practitioners for real life situations Diverse audience including those in medication to safety testing patient education dispensing changes and the design of health systems Aids medical students and practitioners to improve their skills to solve cases **Global patient safety action plan 2021-2030** World Health Organization,2021-08-03 Patient safety is fundamental to the provision of health care in all settings However avoidable adverse events errors and risks associated with health care remain major challenges for patient safety globally The Seventy second World Health Assembly in 2019 adopted resolution WHA72.6 on global action on patient safety and mandated for development of a global patient safety action plan This global action plan was adopted by Seventy Fourth World Health Assembly in 2021 with a vision of a world in which no one is harmed in health care and every patient receives safe and respectful care every time everywhere The purpose of the action plan is to provide strategic direction for all stakeholders for eliminating avoidable harm in health care and improving patient safety in different practice domains through policy actions on safety and quality of health services as well as for implementation of recommendations at the point of care The action plan provides a framework for countries to develop their respective national action plans on patient safety as well to align existing strategic instruments for improving patient safety in all clinical and health related programmes *Patient Safety Coaching* Susanne Knowles,2024-09-19 This book argues that patient safety is the cornerstone of high quality healthcare and that we need to highlight the positive impact of a Safety 11 approach to risk management to improve the quality of patient services and care Moreover the author emphasizes the importance of upskilling leaders with coaching capability within the healthcare facility so that decisions can be made quickly to prevent adverse events In light of this this book aims to equip clinical leaders across all levels and in all areas of healthcare organizations with the knowledge and skills to develop a patient safety culture in their team and organization based on evidence based contemporary research into patient safety practices The author also proposes strengthening leader capability by outlining how they can create a psychologically safe working environment and adopt a coaching leadership style that promotes staff wellbeing and patient care This book provides strategies for leaders so they can ensure staff wellbeing at work and a patient centric approach to patient care It outlines how clinical leaders can support team members to reduce their stress better utilize their strengths practice mindfulness remain positive and build resilience in the face of adversity whilst also fostering a workplace culture of trust support and compassion Lastly this book aims to provide high level executives and experienced clinical leaders with contemporary knowledge of governance issues and the best practice methods concerning patient safety as a quality improvement strategy *Understanding Patient Safety, Second Edition* Robert Wachter,2012-05-23 Complete coverage of the core principles of patient safety Understanding Patient Safety 2e is the

essential text for anyone wishing to learn the key clinical organizational and systems issues in patient safety The book is filled with valuable cases and analyses as well as up to date tables graphics references and tools all designed to introduce the patient safety field to medical trainees and be the go to book for experienced clinicians and non clinicians alike Features NEW chapter on the critically important role of checklists in medical practice NEW case examples throughout Expanded coverage of the role of computers in patient safety and outcomes Expanded coverage of new patient initiatives from the Joint Commission

Reliability Technology, Human Error, and Quality in Health Care B.S. Dhillon, 2008-02-21 The effective and interrelated functioning of system reliability technology human factors and quality play an important role in the appropriate efficient and cost effective delivery of health care Simply put it can save you time money and more importantly lives Over the years a large number of journal and conference proceedings articles o

E-Health Systems Quality and Reliability: Models and Standards Moutzoglou, Anastasius, Kastania, Anastasia N., 2010-08-31 E Health Systems Quality and Reliability Models and Standards addresses the reason principles and functionality of health and health care systems and presents a novel framework for revealing understanding and implementing appropriate management interventions leading to qualitative improvement It also provides evidence on the quality and reliability of telemedicine and reviews standards and guidelines for practicing medicine at a distance

Patient Safety and Hospital Accreditation Sharon Myers, 2011-12-20 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

Patient Safety B.S. Dhillon, 2011-11-08 With unintended harm during hospital care costing billions of dollars to the world economy not to mention millions of deaths each year it is no wonder the issue is equally front and center in the minds of healthcare providers and the public. Although the issue has been tackled in journal articles and conference proceedings there are very few books on the topic. And none consider how methods and techniques developed in the area of engineering can handle safety and human error related problems. Until now. Written by an expert with vast know-how in engineering management design reliability safety and quality *Patient Safety: An Engineering Approach* brings together the pertinent information scattered throughout books and journals eliminating the need to consult many different and diverse sources to find what you need. B. S. Dhillon draws on his real world experience to demonstrate how to handle patient safety related problems using engineering techniques and backs this up with references for further reading at the end of each chapter. He sets the stage with introductory chapters on mathematical patient safety and human factors concepts essential to understanding materials presented in subsequent chapters. Dhillon's clear concise discussion of the topics presents the information in such a way that no previous knowledge is required to understand the contents yet he does not present it at a merely rudimentary level. He brings a fresh approach and engineering perspective to the issues giving you a new tool kit for performing patient safety related analysis designing better medical systems devices and handling patient safety related problems from an engineering perspective. *Fundamentals of Patient Safety in Medicine and Surgery* S. P.

Stawicki, 2015-01-01 This book presents a practical approach to patient safety issues with a focus on evolution and understanding the key concepts in health care and turning them into implementable actions. With its contemporary approach and lucid presentation this book is a valuable resource for practicing doctors in medicine and surgery to treat their patients with care diligence and vigilance and contribute to a safer practice in health care. *The Measurement and Monitoring of*

Safety Charles Vincent, Susan Burnett, Jane Carthey, 2013 Contemporary Ergonomics 2007 Philip D. Bust, 2018-02-06

Presenting the Proceedings of the Ergonomics Society's annual conference the series embraces the wide range of topics covered by ergonomics. Individual papers provide insight into current practice present new research findings and form an invaluable reference source. A wide range of topics are covered in these proceedings including Ergonomics Human Factors and User Centred Design. It also features related disciplines such as Psychology Engineering and Physiology. Particular emphasis is given to the utility of these disciplines in improving health safety efficiency and productivity. The 2007 Annual Conference features Human factors at the heart of systems engineering. As well as being of interest to mainstream ergonomists and human factors specialists *Contemporary Ergonomics* will appeal to all those who are concerned with the interaction of people with their working and leisure environment including designers manufacturing and production engineers health and safety specialists occupational applied and industrial psychologists and applied physiologists.

Quality Measurement in Healthcare Jesse M. Pines, Helen Burstin, Jane Hyatt Thorpe, 2025-10-27 A comprehensive guide

to improving outcomes and value based care In today s rapidly evolving healthcare landscape delivering high quality care is increasingly critical Edited by leading experts in the field Quality Measurement in Healthcare is an essential resource for understanding how to define implement and leverage quality measurement to drive meaningful improvements in patient outcomes Bridging the gap between theory and practice this comprehensive book equips readers with the tools to evaluate care delivery address disparities enhance patient safety and navigate the complexities of value based care and payment policy With 15 expertly curated chapters divided into four sections defining quality measuring quality driving change and future evolution Quality Measurement in Healthcare provides a detailed exploration of the history methodologies and applications of quality measurement The chapters delve into critical topics such as patient reported outcomes electronic health records diagnostic accuracy and rural healthcare challenges Empowering readers to identify care gaps implement targeted interventions and achieve accountability all while advancing equitable access and optimizing outcomes Quality Measurement in Healthcare Provides an international perspective with lessons applicable to healthcare systems worldwide Contains focused chapters on cutting edge topics such as patient reported outcomes diagnostic accuracy and rural healthcare Examines disparities in healthcare and strategies to address them through quality metrics Includes real world examples highlighting the connections between theoretical concepts and practical application Lists discussion questions at the end of each chapter to foster reflection in academic and professional settings Written by globally recognized experts in public health policy and quality improvement Quality Measurement in Healthcare is perfect for undergraduate and graduate public health students as well as professionals in healthcare quality measurement quality improvement and policy

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