

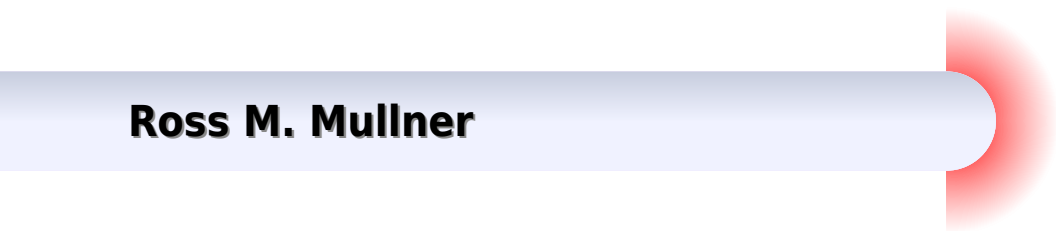
The Handbook of Patient Safety Compliance

A PRACTICAL GUIDE FOR HEALTH CARE ORGANIZATIONS

Fay A. Rozovsky
James R. Woods, Jr.
Editors

Patient Safety Compliance Handbook A Practical Guide For Health Care Organizations

Ross M. Mullner



Patient Safety Compliance Handbook A Practical Guide For Health Care Organizations:

The Handbook of Patient Safety Compliance Fay A. Rozovsky, James R. Woods, Jr., 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 **Risk Management Handbook for Health Care Organizations, 3 Volume Set**, 2011-01-06 Continuing its superiority in the health care risk management field this sixth edition of The Risk Management Handbook for Health Care Organizations is written by the key practitioners and consultant in the field It contains more practical chapters and health care examples and additional material on methods and techniques of risk reduction and management It also revises the structure of the previous edition and focuses on operational and organizational structure rather than risk areas and functions The three volumes are written using a practical and user friendly approach **Quality and Safety in Radiotherapy** Todd Pawlicki, Peter Dunscombe, Arno J. Mundt, Pierre Scalliet, 2010-12-20 The first text to focus solely on quality and safety in radiotherapy this work encompasses not only traditional more technically oriented quality assurance activities but also general approaches of quality and safety It includes contributions from experts both inside and outside the field to present a global view The task of assuring quality

Patient Safety Robert J. Latino, 2008-10-14 Are you ready and willing to get to the root causes of problems As Medicare Medicaid and major insurance companies increasingly deny payment for never events it has become imperative that hospitals and doctors develop new ways to prevent these avoidable catastrophes from recurring Proactive tools such as root cause analysis RCA basic failur **Handbook of Public Information Systems** Judith Graham, Alison Kelly, 2010-03-10 Delivering IT projects on time and within budget while maintaining privacy security and accountability remains one of the major public challenges of our time In the four short years since the publication of the second edition of the Handbook of Public Information Systems the field of public information systems has continued to evolve This ev **Debates on U.S. Health Care** Jennie Jacobs Kronenfeld, Wendy E. Parmet, Mark A. Zezza, 2012-09-27 This issues based reference work available in both print and electronic formats shines a spotlight on health care policy and practice in the United States Impassioned debates about the best solutions to health care in America have perennially erupted among politicians scholars of public

policy medical professionals and the general public The fight over the Health Care Reform Act of 2010 brought to light a multitude of fears challenges obstacles and passions that often had the effect of complicating rather than clarifying the debate The discourse has never been more heated The complex issues that animate the health care debate have forced the American public to grapple with the exigencies of the present system with regard to economic fiscal and monetary policy especially as they relate to philosophical often ideologically driven approaches to the problem Americans have also had to examine their ideas about the relationship of the individual to and interaction with the state and the varied social and cultural beliefs about what an American solution to the problem of health care looks like In light of the need to keep students researchers and other interested readers informed and up to date on the issues surrounding health care in the U S this volume uses introductory essays followed by point counterpoint articles to explore prominent and perennially important debates providing readers with views on multiple sides of this complex issue Features Benefits The volume is divided into three sections each with its own Section Editor Quality of Care Debates Dr Jennie Kronenfeld Economic Fiscal Debates Dr Mark Zezza and Political Philosophical Legal Debates Prof Wendy Parmet Sections open with a Preface by the Section Editor to introduce the broad theme at hand and provide historical underpinnings Each Section holds 12 chapters addressing varied aspects of the broad theme of the section Chapters open with an objective lead in piece or headnote followed by a point article and a counterpoint article All pieces headnote point article counterpoint article are signed For each chapter students are referred to further readings data sources and other resources as a jumping off spot for further research and more in depth exploration Finally the volume concludes with a comprehensive index and the electronic version of the book includes search and browse features as well as the ability to link to further readings cited within chapters should they be available to the library in electronic format

Encyclopedia of Health Services Research Ross M. Mullner, 2009-05-15 Today as never before healthcare has the ability to enhance the quality and duration of life At the same time healthcare has become so costly that it can easily bankrupt governments and impoverish individuals and families Health services research is a highly multidisciplinary field including such areas as health administration health economics medical sociology medicine political science public health and public policy The Encyclopedia of Health Services Research is the first single reference source to capture the diversity and complexity of the field With more than 400 entries these two volumes investigate the relationship between the factors of cost quality and access to healthcare and their impact upon medical outcomes such as death disability disease discomfort and dissatisfaction with care Key Features Examines the growing healthcare crisis facing the United States Encompasses the structure process and outcomes of healthcare Aims to improve the equity efficiency effectiveness and safety of healthcare by influencing and developing public policies Describes healthcare systems and issues from around the globe Key Themes Access to Care Accreditation Associations Foundations and Research Organizations Biographies of Current and Past Leaders Cost of Care Economics Finance and Payment Mechanisms Disease Disability Health and Health

Behavior Government and International Healthcare Organizations Health Insurance Health Professionals and Healthcare Organizations Health Services Research Laws Regulations and Ethics Measurement Data Sources and Coding and Research Methods Outcomes of Care Policy Issues Healthcare Reform and International Comparisons Public Health Quality and Safety of Care Special and Vulnerable Groups The Encyclopedia is designed to be an introduction to the various topics of health services research for an audience including undergraduate students graduate students and general readers seeking non technical descriptions of the field and its practices It is also useful for healthcare practitioners wishing to stay abreast of the changes and updates in the field

Risk Management Handbook for Health Care Organizations American Society for Healthcare Risk Management (ASHRM), 2009-04-27 Risk Management Handbook for Health Care Organizations Student Edition This comprehensive textbook provides a complete introduction to risk management in health care Risk Management Handbook Student Edition covers general risk management techniques standards of health care risk management administration federal state and local laws and methods for integrating patient safety and enterprise risk management into a comprehensive risk management program The Student Edition is applicable to all health care settings including acute care hospital to hospice and long term care Written for students and those new to the topic each chapter highlights key points and learning objectives lists key terms and offers questions for discussion An instructor's supplement with cases and other material is also available American Society for Healthcare Risk Management ASHRM is a personal membership group of the American Hospital Association with more than 5 000 members representing health care insurance law and other related professions ASHRM promotes effective and innovative risk management strategies and professional leadership through education recognition advocacy publications networking and interactions with leading health care organizations and government agencies ASHRM initiatives focus on developing and implementing safe and effective patient care practices preserving financial resources and maintaining safe working environments

Root Cause Analysis Mark A. Latino, Robert J. Latino, Kenneth C. Latino, 2019-06-26 This book comprehensively outlines what a holistic and effective Root Cause Analysis RCA system looks like From the designing of the support infrastructure to the measuring of effectiveness on the bottom line this book provides the blueprint for making it happen While traditionally RCA is viewed as a reactive tool the authors will show how it can be applied proactively to prevent failures from occurring in the first place RCA is a key element of any successful Reliability Engineering initiative Such initiatives are comprised of equipment process and human reliability foundations Human reliability is critical to the success of a true RCA approach This book explores the anatomy of a failure undesirable outcome as well as a potential failure high risks Virtually all failures are triggered by errors of omission or commission by human beings The methodologies described in this book are applicable to any industry because the focus is on the human being's ability to think through why things go wrong not on the industry or the nature of the failure This book correlates reliability to safety as well as human performance improvement efforts The author has provided a healthy balance

between theory and practical application wrapping up with case studies demonstrating bottom line results Features Outlines in detail every aspect of an effective RCA system Displays appreciation for the role of understanding the physics of a failure as well as the human and system s contribution Demonstrates the role of RCA in a comprehensive Asset Performance Management APM system Explores the correlation between Reliability Engineering and Safety Integrates the concepts of Human Performance Improvement Learning Teams and Human Error Reduction approaches into RCA *The PROACT® Root Cause Analysis* Kenneth C. Latino, Mark A. Latino, Robert J. Latino, 2020-09-10 Root Cause Analysis or RCA What is it Everyone uses the term but everyone does it differently How can we have any uniformity in our approach much less accurately compare our results if we re applying different definitions At a high level we will explain the difference between RCA and Shallow Cause Analysis because that is the difference between allowing a failure to recur or dramatically reducing the risk of recurrence In this book we will get down to basics about RCA the fundamentals of blocking and tackling and explain the common steps of any investigative occupation Common investigation steps include Preserving evidence data not allowing hearsay to fly as fact Organizing an appropriate team minimizing potential bias Analyzing the events reconstructing the incident based on actual evidence Communicating findings and recommendations ensuring effective recommendations are actually developed and implemented Tracking bottom line results ensuring that identified meaningful metrics were attained We explore Why don t things always go as planned When our actual plans deviate from our intended plans we usually experience some type of undesirable or unintended outcome We analyze the anatomy of a failure undesirable outcome and provide a step by step guide to conducting a comprehensive RCA based on our 3 decades of applying RCA as we have successfully practiced it in the field This book is written as a how to guide to effectively apply the PROACT RCA methodology to any undesirable outcome is directed at practitioners who have to do the real work focuses on the core elements of any investigation and provides a field proven case as a model for effective application This book is for anyone charged with having a thorough understanding of why something went wrong such as those in EH S maintenance reliability quality engineering and operations to name just a few

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