Safe Patients Smart Hospitals How One Doctor S Che

Patient Safety United States Government Accountability Office.2017-09-23 millions of Americans benefit from the medical care they receive each year, this care also has the potential to harm patients. Medical care can be unsafe when it leads to adverse events, such as infections. Such adverse events occur even though evidence indicates that some could be reduced or eliminated through implementation of evidence-based patient safety practices. GAO was asked to review information on the implementation of patient safety practices in hospitals. This report describes (1) key factors that affect hospitals' implementation of evidence-based patient safety practices and their reported effects on adverse events; (2) the types of programs health care payers use to promote hospital patient safety and their reported effects on adverse events; and (3) gaps, if any, that experts identify in the available information on patient safety practices. GAO interviewed patient safety experts and officials from six selected hospitals, six selected insurers, and officials from CMS and AHRQ. GAO selected the hospitals based in part on their performance on certain quality measures related to patient safety and selected the insurers because they operated relevant patient safety programs. The information GAO obtained on the hospitals and insurers is not generalizable. GAO also reviewed literature on the field of patient safety research. In commenting on a draft of this report, HHS generally agreed with GAO's findings. GAO also received technical comments from HHS and incorporated them as appropriate. What GAO Found The six selected hospitals in GAO's study identified three key challenges that affected their efforts to implement evidence-based patient safety practices. Patient safety practices, such as using proper antiseptics, can reduce or eliminate adverse events, which GAO defined as events such as infections that harm patients and result from the medical care patients receive rather than patients' underlying diseases or conditions. Officials from selected hospitals identified the following challenges in implementing patient safety practices: 1) Obtaining data to identify adverse events in their own hospitals. According to hospital officials, obtaining useful information on adverse events can be challenging because, substantial time and resources are required to gather the necessary data, among other things. 2) Determining which patient safety practices should be implemented. Officials noted that they face challenges identifying which evidence-based patient safety practices should be implemented in their own hospitals, such as when only limited evidence exists on which practices are effective. For example, officials from one hospital told GAO that the hospital tried several different practices in an effort to reduce patient falls without knowing which, if any, would prove effective. 3) Ensuring that staff consistently implement the practices over time. Officials from the selected hospitals told GAO that the hospitals face challenges ensuring that hospital staff consistently implement the hospitals' patient safety practices; for example, hospitals must constantly monitor results to detect potential implementation problems. Officials reported taking various actions to address these challenges, and some reported that their actions led to reductions in adverse events. For example, officials at one hospital noted a 40 percent reduction in certain infections over 1 year after they hired a new infection control nurse. CMS and selected private insurers have pay-for-performance programs that provide financial incentives for hospitals to improve the quality of their care, including reducing adverse events. CMS, the Agency for Healthcare Research and Quality (AHRQ), and some of the private insurers in GAO's study also have nonfinancial programs to help hospitals improve patient safety that provide technical assistance and other support, such as providing data on best practices

Patient Safety Abha Agrawal,Jay Bhatt.2023-09-15 This book aims to serve as a playbook and a guide for the creation of a safer healthcare system in the contemporary healthcare ecosystem. It meets this goal through examinations of clinical case studies that illustrate core principles of patient safety, coverage of a broad range of medical errors including medication errors, and solutions to

reducing medical errors that are widely applicable in many settings. Throughout the book, the chapters offer viewpoints from healthcare leaders, accomplished practitioners, and experts in patient safety. In addition to highlighting important concepts in patient safety, the book also provides a vision of patient safety in the subsequent decade. Furthermore, it will describe what changes need to “fall into place” between now and the next 10-15 years to have that future realized. The book presents and analyzes a number of cases to illustrate the most common types of medical errors and to help readers learn the key clinical, organizational, and systems issues in patient safety. Patient Safety, 2nd edition, is an invaluable text for all physicians, healthcare workers, policymakers, and residents who are working towards a more equitable and effective healthcare system.

Big Data in Radiation Oncology Jun Deng,Lei Xing.2019-03-07 Big Data in Radiation Oncology gives readers an in-depth look into how big data is having an impact on the clinical care of cancer patients. While basic principles and key analytical and processing techniques are introduced in the early chapters, the rest of the book turns to clinical applications, in particular for cancer registries, informatics, radiomics, radiogenomics, patient safety and quality of care, patient-reported outcomes, comparative effectiveness, treatment planning, and clinical decision-making. More features of the book are: Offers the first focused treatment of the role of big data in the clinic and its impact on radiation therapy. Covers applications in cancer registry, radiomics, patient safety, quality of care, treatment planning, decision making, and other key areas. Discusses the fundamental principles and techniques for processing and analysis of big data. Address the use of big data in cancer prevention, detection, prognosis, and management. Provides practical guidance on implementation for clinicians and other stakeholders. Dr. Jun Deng is a professor at the Department of Therapeutic Radiology of Yale University School of Medicine and an ABR board certified medical physicist at Yale-New Haven Hospital. He has received numerous honors and awards such as Fellow of Institute of Physics in 2004, AAPM Medical Physics Travel Grant in 2008, ASTRO IGRT Symposium Travel Grant in 2009, AAPM-IPEM Medical Physics Travel Grant in 2011, and Fellow of AAPM in 2013. Lei Xing, Ph.D., is the Jacob Haimson Professor of Medical Physics and Director of Medical Physics Division of Radiation Oncology Department at Stanford University. His research has been focused on inverse treatment planning, tomographic image reconstruction, CT, optical and PET imaging instrumentations, image guided interventions, nanomedicine, and applications of molecular imaging in radiation oncology. Dr. Xing is on the editorial boards of a number of journals in radiation physics and medical imaging, and is recipient of numerous awards, including the American Cancer Society Research Scholar Award, The Whitaker Foundation Grant Award, and a Max Planck Institute Fellowship.

Making Healthcare Safe Lucian L. Leape.2021-05-28 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.

Still Not Safe Robert Wears,Kathleen Sutcliffe.2019-11-01 The term patient safety rose to popularity in the late nineties, as the medical community -- in particular, physicians working in nonmedical and administrative capacities -- sought to raise awareness of the tens of thousands of deaths in the US attributed to medical errors each year. But what was causing these medical errors? And what made these accidents to rise to epidemic levels, seemingly overnight? Still Not Safe is the story of the rise of the patient-safety movement -- and how an epidemic of medical errors was derived from a reality that didn't support such a characterization. Physician Robert Wears and organizational theorist Kathleen Sutcliffe trace the origins of patient safety to the emergence of market trends that challenged the place of doctors in the larger medical ecosystem: the rise in medical litigation and physicians' aversion to risk; institutional changes in the organization and control of healthcare; and a bureaucratic movement to rationalize medical practice -- to make a hospital run like a factory. If these social factors challenged the place of practitioners, then the patient-safety movement provided a means for readjustment. In spite of relatively constant rates of medical errors in the preceding decades, the epidemic was announced in 1999 with the publication of the Institute of Medicine report To Err Is Human; the reforms that followed came to be dominated by the very professions it set out to reform. Weaving together narratives from medicine, psychology, philosophy, and human performance, Still Not Safe offers a counterpoint to the presiding, doctor-centric narrative of contemporary American medicine. It is certain to raise difficult, important questions around the state of our healthcare system -- and provide an opening note for other challenging conversations.

Safety in Medication Use Mary Patricia Tully,Bryony Dean Franklin.2015-08-18 An estimated 1 in 20 patients are admitted to the hospital due to problems with their medication and 1 in 100 hospitalized patients are harmed due to medication errors during their stay. The prescribing of medications is the most common health care intervention and medication safety is relevant to all health care professionals and patients, in all

Patient Safety Institute of Medicine,Board on Health Care Services,Committee on Data Standards for Patient Safety.2003-12-20 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.

Unaccountable Marty Makary.2012-09-18 New York Times Bestseller “Every once in a while a book comes along that rocks the foundations of an established order that's seriously in need of being shaken. The modern American hospital is that establishment and Unaccountable is that book.”-Shannon Brownlee, author of Overtreated Dr. Marty Makary is co-developer of the life-saving checklist outlined in Atul Gawande's bestselling The Checklist Manifesto. As a busy surgeon who has worked in many of the best hospitals in the nation, he can testify to the amazing power of modern

medicine to cure. But he's also been a witness to a medical culture that routinely leaves surgical sponges inside patients, amputates the wrong limbs, and overdoses children because of sloppy handwriting. Over the last ten years, neither error rates nor costs have come down, despite scientific progress and efforts to curb expenses. Why? To patients, the healthcare system is a black box. Doctors and hospitals are unaccountable, and the lack of transparency leaves both bad doctors and systemic flaws unchecked. Patients need to know more of what healthcare workers know, so they can make informed choices. Accountability in healthcare would expose dangerous doctors, reward good performance, and force positive change nationally, using the power of the free market. Unaccountable is a powerful, no-nonsense, non-partisan diagnosis for healing our hospitals and reforming our broken healthcare system.

New York Magazine .1991-11-11 New York magazine was born in 1968 after a run as an insert of the New York Herald Tribune and quickly made a place for itself as the trusted resource for readers across the country. With award-winning writing and photography covering everything from politics and food to theater and fashion, the magazine's consistent mission has been to reflect back to its audience the energy and excitement of the city itself, while celebrating New York as both a place and an idea.

Vignettes in Patient Safety Michael S. Firstenberg,Stanislaw P. Stawicki.2018-01-10 Over the past two decades, the healthcare community increasingly recognized the importance and the impact of medical errors on patient safety and clinical outcomes. Medical and surgical errors continue to contribute to unnecessary and potentially preventable morbidity and/or mortality, affecting both ambulatory and hospital settings. The spectrum of contributing variables-ranging from minor errors that subsequently escalate to poor communication to lapses in appropriate protocols and processes (just to name a few)-is extensive, and solutions are only recently being described. As such, there is a growing body of research and experiences that can help provide an organized framework-based upon the best practices and evidence-based medical principles-for hospitals and clinics to foster patient safety culture and to develop institutional patient safety champions. Based upon the tremendous interest in the first volume of our Vignettes in Patient Safety series, this second volume follows a similar vignette-based model. Each chapter outlines a realistic case scenario designed to closely approximate experiences and clinical patterns that medical and surgical practitioners can easily relate to. Vignette presentations are then followed by an evidence-based overview of pertinent patient safety literature, relevant clinical evidence, and the formulation of preventive strategies and potential solutions that may be applicable to each corresponding scenario. Throughout the Vignettes in Patient Safety cycle, emphasis is placed on the identification and remediation of team-based and organizational factors associated with patient safety events. The second volume of the Vignettes in Patient Safety begins with an overview of recent high-impact studies in the area of patient safety. Subsequent chapters discuss a broad range of topics, including retained surgical items, wrong site procedures, disruptive healthcare workers, interhospital transfers, risks of emergency department overcrowding, dangers of inadequate handoff communication, and the association between provider fatigue and medical errors. By outlining some of the current best practices, structured experiences, and evidence-based recommendations, the authors and editors hope to provide our readers with new and significant insights into making healthcare safer for patients around the world.

ICCAP 2021 A Mohan,D. S. Vijayan.2021-12-22 This proceeding constitutes the thoroughly refereed proceedings of the 1st International Conference on Combinatorial and Optimization, ICCAP 2021, December 7-8, 2021. This event was organized by the group of Professors in Chennai. The Conference aims to provide the opportunities for informal conversations, have proven to be of great interest to other scientists and analysts employing these mathematical sciences in their professional work in business, industry, and government. The Conference continues to promote better understanding of the roles of modern applied mathematics, combinatorics, and computer science to acquaint the investigator in each of these areas with the various techniques and algorithms which are available to assist in his or her research. We selected 257 papers were carefully reviewed and selected from 741 submissions. The presentations covered multiple research fields like Computer

Science, Artificial Intelligence, internet technology, smart health care etc., brought the discussion on how to shape optimization methods around human and social needs.

Zero Harm: How to Achieve Patient and Workforce Safety in Healthcare Craig Clapper,Carole Stockmeier,James Merlino.2018-11-16 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.

Strategies for Hospitals to Improve Patient Safety Jiahui Wong,Hasmik Beglaryan,Change Foundation,Ontario Hospital Association.2004

Health IT and Patient Safety Institute of Medicine,Board on Health Care Services,Committee on Patient Safety and Health Information Technology.2012-04-15 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.

Impact of Smart Technologies and Artificial Intelligence (AI) Paving Path Towards Interdisciplinary

Research in the Fields of Engineering, Arts, Humanities, Commerce, Economics, Social Sciences, Law and Management - Challenges and Opportunities Dr. Sundari Suresh,Dr. S. Radha Rammohan,Dr. K. Bharath. This e-ISBN collection of 34 chapters draws on the diverse insights of the opportunities and emerging challenges, changes in the smart technologies and artificial intelligence{AI} paving path towards interdisciplinary research in the fields of Engineering, Arts, Humanities, Commerce, Economics, Social Sciences, Law and Management. It offers decision-makers a comprehensive picture of the impact of Smart technologies and Artificial Intelligence (AI) expected in the long-term changes, and inspiration to leverage the opportunities that offer to improve the state of education. Academicians must find and establish a new equilibrium and a new normal for learning amid the present challenges.

Patient Safety Abha Agrawal.2013-10-04 Despite the evolution and growing awareness of patient safety, many medical professionals are not a part of this important conversation. Clinicians often believe they are too busy taking care of patients to adopt and implement patient safety initiatives and that acknowledging medical errors is an affront to their skills. Patient Safety provides clinicians with a better understanding of the prevalence, causes and solutions for medical errors; bringing best practice principles to the bedside. Written by experts from a variety of backgrounds, each chapter features an analysis of clinical cases based on the Root Cause Analysis (RCA) methodology, along with case-based discussions on various patient safety topics. The systems and processes outlined in the book are general and broadly applicable to institutions of all sizes and structures. The core ethic of medical professionals is to “do no harm”. Patient Safety is a comprehensive resource for physicians, nurses and students, as well as healthcare leaders and administrators for identifying, solving and preventing medical error.

Achieving Safe Health Care Jan Compton.2015-11-18 Winner of a 2016 Shingo Research and Professional Publication Award! A recent article published in the Journal of Patient Safety estimated that more than 400,000 lives are lost each year due to preventable patient events in American hospitals. Preventable patient safety events are the third leading cause of death in the United States. While most health care organizations know they need to improve patient safety, most lack an understanding of the steps required to develop and implement an effective patient safety program. Baylor Scott & White Health has successfully created a strong culture of patient safety. In 2013, Baylor Health Care System published the book Achieving STEEEP Health Care, which describes its quality improvement journey via the STEEEP framework of delivering care that is Safe, Timely, Effective, Efficient, Equitable, and Patient-centered. This book provides a detailed overview of the Baylor Scott & White Health approach to the delivery of safe care, the leading aim of the STEEEP quality and patient safety framework. It presents real-life examples, practical approaches, and tools for improving patient safety. The book is structured around some of the key components of patient safety such as the importance of strategic efforts in categories of culture, processes, and technology. Maintaining a focus on human factors in patient safety and health care, the book explains the need for advanced analytics along with long-term learning and corporate resources. This book describes how to develop appropriate goals, formulate strategies to meet those goals, and implement techniques to improve patient safety based on the experience of Baylor Scott & White Health.

Improving Patient Safety Raghav Govindarajan.2019-01-15 Based on the IOM's estimate of 44,000 deaths annually, medical errors rank as the eighth leading cause of death in the U.S. Clearly medical errors are an epidemic that needs to be contained. Despite these numbers, patient safety and medical errors remain an issue for physicians and other clinicians. This book bridges the issues related to patient safety by providing clinically relevant, vignette-based description of the areas where most problems occur. Each vignette highlights a particular issue such as communication, human facturs, E.H.R., etc. and provides tools and strategies for improving quality in these areas and creating a safer environment for patients.

Pediatric Patient Safety and Quality Improvement Karen S. Frush.2014-11-05 The guidance you need to protect your pediatric patients from medical error From front-line treatment to critical policy issues, Pediatric Patient Safety and Quality Improvement provides all the knowledge and

insight you need to ensure your pediatric patients are treated safely and effectively. This unique guide addresses the specific challenges of medical professionals treating young patients. Packed with the newest research findings and best practices from top figures in the patient safety community, Pediatric Patient Safety and Quality Improvement will ensure that you provide optimum child care free of the oversights and errors for better patient outcomes. Pediatric Patient Safety and Quality Improvement offers the scientific information and current perspectives you need to: Build your expertise on the latest quality improvement methods Deepen your understanding of the human factors in medical mistakes Improve team efficacy for better care and outcomes in any setting
Image Processing and Capsule Networks Joy Iong-Zong Chen,João Manuel R. S. Tavares,Subarna Shakya,Abdullah M. Iliyasu.2020-07-23 This book emphasizes the emerging building block of image processing domain, which is known as capsule networks for performing deep image recognition and processing for next-generation imaging science. Recent years have witnessed the continuous development of technologies and methodologies related to image processing, analysis and 3D modeling which have been implemented in the field of computer and image vision. The significant development of these technologies has led to an efficient solution called capsule networks [CapsNet] to solve the intricate challenges in recognizing complex image poses, visual tasks, and object deformation. Moreover, the breakneck growth of computation complexities and computing efficiency has initiated the significant developments of the effective and sophisticated capsule network algorithms and artificial intelligence [AI] tools into existence. The main contribution of this book is to explain and summarize the significant state-of-the-art research advances in the areas of capsule network [CapsNet] algorithms and architectures with real-time implications in the areas of image detection, remote sensing, biomedical image analysis, computer communications, machine vision, Internet of things, and data analytics techniques.
The People's Hospital Book Ronald E. Gots,Arthur Kaufman.1981
Making Health Care Safer .2001
First, Do Less Harm Ross Koppel,Suzanne Gordon.2012-05-15 Each year, hospital-acquired infections, prescribing and treatment errors, lost documents and test reports, communication failures, and other problems have caused thousands of deaths in the United States, added millions of days to patients' hospital stays, and cost Americans tens of billions of dollars. Despite (and sometimes because of) new medical information technology and numerous well-intentioned initiatives to address these problems, threats to patient safety remain and in some areas are on the rise. In First, Do Less Harm, twelve health care professionals and researchers plus two former patients look at patient safety from a variety of perspectives, finding many of the proposed solutions to be inadequate or impractical. Several contributors to this book attribute the failure to confront patient safety concerns to the influence of the market model on medicine and emphasize the need for hospital-wide teamwork and greater involvement from frontline workers (from janitors and aides to nurses and physicians) in planning, implementing, and evaluating effective safety initiatives. Several chapters in First, Do Less Harm focus on the critical role of interprofessional and occupational practice in patient safety. Rather than focusing on the usual suspects—physicians, safety champions, or high level management—these chapters expand the list of stakeholders and patient safety advocates to include nurses, patient care assistants, and other staff, as well as the health care unions that may represent them. First, Do Less Harm also highlights workplace issues that negatively affect safety: including sleeplessness, excessive workloads, outsourcing of hospital cleaning, and lack of teamwork between physicians and other health care staff. In two chapters, experts explain why the promise of health care information technology to fix safety problems remains unrealized, with examples that are at once humorous and frightening. A book that will be required reading for physicians, nurses, hospital administrators, public health officers, quality and risk managers, healthcare educators, economists, and policymakers, First, Do Less Harm concludes with a list of twenty-seven paradoxes and challenges facing everyone interested in making care safe for both patients and those who care for them.
Safer Hospital Care Dev Raheja.2018-06-28 From newborns switched in the nursery to medication

mix-ups and hospital-acquired infections, we are all familiar with the horror stories about hospital safety, and unfortunately, the statistics say we aren't exaggerating. The safety issue in U.S. hospitals has become so profound and embedded, that we cannot hope to fix it without a paradigm shift
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.
How We Do Harm Otis Webb Brawley, MD,Paul Goldberg.2012-01-31 How We Do Harm exposes the underbelly of healthcare today—the overtreatment of the rich, the under treatment of the poor, the financial conflicts of interest that determine the care that physicians' provide, insurance companies that don't demand the best (or even the least expensive) care, and pharmaceutical companies concerned with selling drugs, regardless of whether they improve health or do harm. Dr. Otis Brawley is the chief medical and scientific officer of The American Cancer Society, an oncologist with a dazzling clinical, research, and policy career. How We Do Harm pulls back the curtain on how medicine is really practiced in America. Brawley tells of doctors who select treatment based on payment they will receive, rather than on demonstrated scientific results; hospitals and pharmaceutical companies that seek out patients to treat even if they are not actually ill (but as long as their insurance will pay); a public primed to swallow the latest pill, no matter the cost; and rising healthcare costs for unnecessary—and often unproven—treatments that we all pay for. Brawley calls for rational healthcare, healthcare drawn from results-based, scientifically justifiable treatments, and not just the peddling of hot new drugs. Brawley's personal history – from a childhood in the gang-ridden streets of black Detroit, to the green hallways of Grady Memorial Hospital, the largest public hospital in the U.S., to the boardrooms of The American Cancer Society—results in a passionate view of medicine and the politics of illness in America - and a deep understanding of healthcare today. How We Do Harm is his well-reasoned manifesto for change.
In Search of the Spiritual Paul Marcus.2018-04-17 Gabriel Marcel (1889-1973), the first French existentialist and phenomenologist, was a world-class Catholic philosopher, an accomplished playwright, drama critic and musician. He wrote brilliantly about many of the classic existential themes associated with Sartre, Heidegger, Jaspers and Buber, prior to the publication of their main works. As a self-described philosopher of the threshold and an awakener, his stated goal was to shed some light on the nature of spiritual reality, those moments when one experiences an upsurge of the love of life. In this book, Paul Marcus joins the best of Marcellian and psychoanalytic insights to help the reader develop an inner sensibility that is more receptive, responsive and responsible to the transforming sacred presences that grace everyday life, such as are experienced in selfless love, hoping beyond hope, and maintaining faith in the goodness of the world despite its harsh challenges.
Patient Safety Sidney Dekker.2016-04-19 Increased concern for patient safety has put the issue at the top of the agenda of practitioners, hospitals, and even governments. The risks to patients are many and diverse, and the complexity of the healthcare system that delivers them is huge. Yet the discourse is often oversimplified and underdeveloped. Written from a scientific, human factors
Impact of AI and Data Science in Response to Coronavirus Pandemic Sushruta Mishra,Pradeep Kumar Mallick,Hrudaya Kumar Tripathy,Gyoo-Soo Chae,Bhabani Shankar Prasad Mishra.2021-07-22 The book presents advanced AI based technologies in dealing with COVID-19 outbreak and provides an in-depth analysis of variety of COVID-19 datasets throughout globe. It discusses recent artificial intelligence based algorithms and models for data analysis of COVID-19 symptoms and its possible remedies. It provides a unique opportunity to present the work on state-of-the-art of modern artificial intelligence tools and technologies to track and forecast COVID-19 cases. It indicates insights and viewpoints from scholars regarding risk and resilience analytics for policy making and operations of large-scale systems on this epidemic. A snapshot of the latest architectures, frameworks in machine learning and data science are also highlighted to gather and aggregate data

records related to COVID-19 and to diagnose the virus. It delivers significant research outcomes and inspiring new real-world applications with respect to feasible AI based solutions in COVID-19 outbreak. In addition, it discusses strong preventive measures to control such pandemic.

Your Patient Safety Survival Guide Gretchen LeFever Watson.2017-08-03 Each year, one out of every four hospital patients in the United States will be harmed by the care they receive. Over 400,000 will die as a result. Dr. Gretchen LeFever Watson's definitive guide empowers patients to be patient safety advocates. It takes a village to combat preventable errors and omissions that cause millions of deaths and sickness in our nation’s hospitals and care facilities. Although most of these deaths are due to human and system errors—not faulty medical decisions or diagnoses—this annual death toll—as well as the millions of additional incidents of survivable patient harm—could be cut in half through consistent use of simple and nearly cost-free safety behaviors. In Your Patient Safety Survival Guide, Gretchen LeFever Watson delivers a patient-centered blueprint on how to transform the patient-safety movement so that millions of unnecessary illnesses and deaths in hospitals, outpatient facilities, and nursing homes can be avoided. She provides key safety habits that people must learn to recognize so they can be sure hospital personnel use them during every patient encounter. She also explains how addressing the most common safety problems will set the stage for tackling a wide range of issues, including healthcare’s role in the overuse of opiate painkillers and its related heroin epidemic. Watson’s call for a more sensible societal response to medical and human error in hospitals promotes a timely and full disclosure of all mistakes—an approach that has been proven to accelerate the emotional recovery of everyone affected by patient safety events while also reducing the financial burden on hospitals, providers, and patients. Readers will learn how to: • Change behavior to catch medical errors before they result in illness or death. • Prevent the spread of dangerous infections in hospitals and other care facilities. • Leverage the power of basic safety/hygiene habits. • Eliminate mistakes during surgery and other invasive procedures. • Avoid medication errors and the overuse of opiates • Raise awareness and inspire civic action in their communities.

To Err Is Human Institute of Medicine,Committee on Quality of Health Care in America.2000-04-01 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

Vignettes in Patient Safety - Volume 2 Michael S. Firstenberg,Stanislaw P. Stawicki.2018 Over the past two decades, the healthcare community increasingly recognized the importance and the impact of medical errors on patient safety and clinical outcomes. Medical and surgical errors continue to contribute to unnecessary and potentially preventable morbidity and/or mortality, affecting both ambulatory and hospital settings. The spectrum of contributing variables-ranging from minor errors that subsequently escalate to poor communication to lapses in appropriate protocols and processes (just to name a few)-is extensive, and solutions are only recently being described. As such, there is a growing body of research and experiences that can help provide an organized framework-based upon the best practices and evidence-based medical principles-for hospitals and clinics to foster patient safety culture and to develop institutional patient safety champions. Based upon the tremendous interest in the first volume of our Vignettes in Patient Safety series, this second volume follows a similar vignette-based model. Each chapter outlines a realistic case scenario designed to closely approximate experiences and clinical patterns that medical and surgical practitioners can easily relate to. Vignette presentations are then followed by an evidence-based overview of pertinent patient safety literature, relevant clinical evidence, and the formulation of preventive strategies and potential solutions that may be applicable to each corresponding scenario. Throughout the Vignettes in Patient Safety cycle, emphasis is placed on the identification and remediation of team-based and organizational factors associated with patient safety events. The second volume of the Vignettes in Patient Safety begins with an overview of recent high-impact studies in the area of patient safety. Subsequent chapters discuss a broad range of topics, including retained surgical items, wrong site procedures, disruptive healthcare workers, interhospital transfers, risks of emergency department overcrowding, dangers of inadequate handoff communication, and the association between provider fatigue and medical errors. By outlining some of the current best practices, structured experiences, and evidence-based recommendations, the authors and editors hope to provide our readers with new and significant insights into making healthcare safer for patients around the world.

Safe Patients, Smart Hospitals Peter Pronovost,Eric Vohr.2011-01-25 The tough-minded and revealing story of a leading doctor's crusade against medical harm...Fascinating reading. -Atul Gawande, author of The Checklist Manifesto. First, do no harm. Doctors, nurses, and clinicians swear by this code of conduct. Yet, medical errors are made every single day-avoidable mistakes that often cost lives. Inspired by two such mistakes, 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. Safe Patients, Smart Hospitals shows how Dr. Pronovost started a revolution by creating a simple checklist that standardized a common ICU procedure. His reforms are being implemented in all fifty states and have saved hundreds of lives by cutting hospital-acquired infection rates by 70%. Atul Gawande profiled Dr. Pronovost's reforms in a New Yorker article and his bestselling book The Checklist Manifesto is based upon Dr. Pronovost's success in patient safety. But Safe Patients, Smart Hospitals is the real story: an inspiring, thought-provoking, accessible insider's narrative about how doctors and nurses are improving patient care for all Americans, today.

Patient Safety and Quality Improvement in Healthcare Rahul K. Shah,Sandip A. Godambe.2020-12-15 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.

Making Healthcare Safe Lucian L. Leape.2021-05-29 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.

Resident's Handbook of Medical Quality and Safety Levi (Levan) Atanelov.2016-04-11 Drive to provide high value healthcare has created a field of medical quality improvement and safety. A Quality Improvement (QI) project would often aim in translate medical evidence (e.g. hand hygiene saves lives) into clinical practice (e.g. actually washing your hands before you see the patient, suffice it to say that not all hospitals are able to report 100% compliance with hand-hygiene). All doctoral residents in the United States must now satisfy a new requirement from the American College of Graduate Medical Education that they participate in a QI initiative. However, few departments are equipped to help their residents develop and implement a QI initiative. Resident's Handbook is a short, not fussy, and practical introduction to developing a QI initiative. Meant not only for residents seeking to jump-start a QI initiative but also for attending physicians looking to improve their clinical practice, residency program directors and even medical students already eyeing what residency training holds for them; the book introduces and explains the basic tools needed to conduct a QI project. It provides numerous real-life examples of QI projects by the residents, fellows and attendings who designed them, who discuss their successes and failures as well as the specific tools they used. Several chapters provide a more senior perspective on resident involvement in QI projects and feature contributions from several QI leaders, a hospital administration VP and a residency program director. Though originally designed with physicians in mind, the book will also be helpful for physician assistants, nurses, physical, occupational and speech language pathology therapists, as well as students in these disciplines. Since no QI intervention is likely to be successful if attempted in isolation more non-physician clinicians are joining the ranks of quality and safety leadership. Therefore several non-physician clinician led initiatives included in the manuscript constitute an integral part of this book.The book serves as a short introduction to the field of medical quality improvement and safety emphasizing the practical pointers of how to actually implement a project from its inception to publication. To our knowledge this is the first concise do-it-yourself

publication of its kind. Some of the topics covered include: how to perform an efficient literature search, how to get published, how to scope a project, how to generate improvement ideas, effective communication, team, project management and basic quality improvement tools like PDCA, DMAIC, Lean, Six Sigma, human factors, medical informatics etc.. Although no substitute for the services of a trained clinical statistician, chapters on statistics and critical assessment of the medical literature familiarizes residents with basic statistical methodologies, clinical trials and evidence based medicine (EBM). Since no QI project is complete without providing evidence for post-intervention improvement we provide a short introduction to the free statistical language R, which helps residents independently run basic statistical calculations. Because much of QI involves assessment of subjective human experiences, there is also a chapter on how to write surveys. Resident's Handbook of Medical Quality and Safety is not an exhaustive QI textbook but rather a hands-on pocket guide to supplement formal training by other means.div

Advances in Patient Safety Kerm Henriksen.2005 v. 1. Research findings -- v. 2. Concepts and methodology -- v. 3. Implementation issues -- v. 4. Programs, tools and products.

Make Healthcare Great Again Edward Shaheen, M D,Etch Shaheen.2020-05-26 Make Healthcare Great Again takes a look at America's broken healthcare system from the perspective of the patient. The author, Dr. Edward Shaheen, an emergency physician and Diplomat of the American Board of Emergency Medicine, examines various aspects within healthcare. Healthcare is complex but it does not need to be complicated. This book is written in a simple, easy to understand manner that allows you learn, be informed and become empowered. Armed with this information, you can obtain better healthcare for you and your loved ones and live a healthier life. The author does a great job of breaking down the Healthcare Complex. While doing so, a common theme seems to emerge: 1) Patients are kept in the dark about healthcare 2) Hospitals, insurers, drug companies etc. behaves in a manner than is best for themselves, not the patient 3) Patients are paying more and getting less 4) The public is being harmed because they are kept in the dark, do not understand and often do not know what to do. Dr. Shaheen discusses the Patient-Obsessed(c) approach to healthcare. To anticipate the needs of patients and deliver care and services that keep people healthy and prevent them from getting sick in the first place. Should someone get sick, access to quality care should be easy and be reasonably priced. The current system is profit driven. Insurance companies, hospitals, doctors, pharmaceutical companies, imaging centers, pharmacies, staffing companies, government, etc. are the Healthcare Complex players and Dr. Shaheen calls them out. He explains why each behaves the way they do and then offers innovative and simple solutions that can be done to revolutionize healthcare and make it better for patients and the public. His solutions include people having freedom to choose, incentives and disincentives to encourage better choices and emphasizes that everyone much be accountable in healthcare. He discusses the specifics and shows ways we can lower costs immediately. Make Healthcare Great Again serves as a great medical reference to help you know what to ask and look for. The book includes a useful glossary to help you understand many terms used by insurers, hospitals, doctors or others that may confuse us. Everyone, including doctors, nurses, medical students, nursing students, hospital administrators, insurance executives and leaders, pharmaceutical representatives, government officials, family and friends stand to learn and benefit from reading this book. The author does provides many solutions that would improve care, lower costs and save lives. He also discusses many popular topics such as Telemedicine, Medicare for ALL and introduces many innovative ideas that make sense and would improve healthcare and help patients and the public. Dr. Shaheen demonstrates great courage and unselfishness in writing this book as he exposes many within healthcare, and exposes some of the darkness that exists in healthcare. Dr. Shaheen went into medicine to help people. Now he is combining his love of people, medicine and knowledge to put forward what he has learned in hopes of helping more people than he would otherwise be able to. Make Healthcare Great Again is a must read for anyone who wants better health and a better healthcare system.

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

Patient Safety and Quality Ronda Hughes.2008 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/

Safe Patients Smart Hospitals How One Doctor S Che Book Review: Unveiling the Magic of Language

In an electronic era where connections and knowledge reign supreme, the enchanting power of language has become more apparent than ever. Its power to stir emotions, provoke thought, and instigate transformation is actually remarkable. This extraordinary book, aptly titled "**Safe Patients Smart Hospitals How One Doctor S Che**," written by a very acclaimed author, immerses readers in a captivating exploration of the significance of language and its profound effect on our existence. Throughout this critique, we shall delve in to the book is central themes, evaluate its unique writing style, and assess its overall influence on its readership.

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Safe Patients Smart Hospitals How One Doctor S Che Introduction

Safe Patients Smart Hospitals How One Doctor S Che Offers over 60,000 free eBooks, including many classics that are in the public domain. Open Library: Provides access to over 1 million free eBooks, including classic literature and contemporary works. Safe Patients Smart Hospitals How One Doctor S Che Offers a vast collection of books, some of which are available for free as PDF downloads, particularly older books in the public domain. Safe Patients Smart Hospitals How One Doctor S Che : This website hosts a vast collection of scientific articles, books, and textbooks. While it operates in a legal gray area due to copyright issues, its a popular resource for finding various publications. Internet Archive for Safe Patients Smart Hospitals How One Doctor S Che : Has an extensive collection of digital content, including books, articles, videos, and more. It has a massive library of free downloadable books. Free-eBooks Safe Patients Smart Hospitals How One Doctor S Che Offers a diverse range of free eBooks across various genres. Safe Patients Smart Hospitals How One Doctor S Che Focuses mainly on educational books, textbooks, and business books. It offers free PDF downloads for educational purposes. Safe Patients Smart Hospitals How One Doctor S Che Provides a large selection of free eBooks in different genres, which are available for download in various formats, including PDF. Finding specific Safe Patients Smart Hospitals How One Doctor S Che, especially related to Safe Patients Smart Hospitals How One Doctor S Che, might be challenging as theyre often artistic creations

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