Patient Safety In Emergency Medicine

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Making Healthcare Safe National Academies Press
Written for a global audience, by an international team, the book provides practical, case-based emergency department leadership skills.
Current Emergency Diagnosis & Treatment Springer Nature
Experts estimate that as many as 98,000 people die in any given year from medical errors that occur in hospitals. That's more than die from motor vehicle accidents, breast cancer, or AIDS â € "three causes that receive far more public attention. Indeed, more people die annually from medication errors than from workplace injuries. Add the financial cost to the human tragedy, and medical error easily rises to the top ranks of urgent, widespread public problems. To Err Is Human breaks the silence that has surrounded medical errors and their consequence â € "but not by pointing fingers at caring health care professionals who make honest mistakes. After all, to err is human. Instead, this book sets forth a national agenda â € "with state and local implications â € "for reducing medical errors and improving patient safety through the design of a safer health system. This volume reveals the often startling statistics of medical error and the disparity between the incidence of error and public perception of it, given many patients' expectations that the medical profession always performs perfectly. A careful examination is made of how the surrounding forces of legislation, regulation, and market activity influence the quality of care provided by health care organizations and then looks at their handling of medical mistakes. Using a detailed case study, the book reviews the current understanding of why these mistakes happen. A key theme is that legitimate liability concerns discourage reporting of errors â € "which begs the question, "How can we learn from our mistakes?" Balancing regulatory versus market-based initiatives and public versus private efforts, the Institute of Medicine presents wide-ranging recommendations for improving patient safety, in the areas of leadership, improved data collection and analysis, and development of effective systems at the level of direct patient care. To Err Is Human asserts that the problem is not bad people in health care â € "it is that good people are working in bad systems that need to be made safer. Comprehensive and straightforward, this book offers a clear prescription for raising the level of patient safety in American health care. It also explains how patients themselves can influence the quality of care that they receive once they check into the hospital. This book will be vitally important to federal, state, and local health policy makers and regulators, health professional licensing officials, hospital administrators, medical educators and students, health caregivers, health journalists, patient advocates â € "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
Building a Culture of Patient Safety Through Simulation National Academies Press
An important new work developed to improve medication safety and direct patient care in the Emergency Department.
Communication in Emergency Medicine Springer Nature
The occurrence of failures and mistakes in health care, from primary care procedures to the complexities of the operating room, has become a hot-button issue with the general public and within the medical community. Around the Patient Bed: Human Factors and Safety in Health Care examines the problem and investigates the tools to improve health care quality and safety from a human factors engineering viewpoint—the applied scientific field engaged in the interaction between the human operator (functionary, worker), task requirements, the governing technical systems, and the characteristics of the work environment. The book presents a systematic human factors-based, proactive approach to the improvement of health care work and patient safety. The proposed approach delineates a more direct and powerful alternative to the contemporary dominant focus on error investigation and care providers' accountability. It demonstrates how significant improvements in the quality of care and enhancement of patient safety are contingent on a major shift from efforts and investments driven by a retroactive study of errors, incidents, and adverse events, to an emphasis on proactive human factors-driven intervention and the development of corresponding conceptual approaches and methods for its systematic implementation. Edited by Yoel Donchin, representing the medical profession, and Daniel Gopher, from the human factors engineering field, the book brings together experts who have collaborated to present studies that reveal a wide range of problems and weaknesses of the contemporary health care system, which impair safety and quality and increase workload. The book presents practical solutions based on human factors engineering components and cognitive psychology, and explains their driving principles and methodologies. This approach provides tools to significantly reduce the number of errors, creates a safe environment, and improves the quality of health care.
An Introduction to Clinical Governance and Patient Safety Springer Publishing Company
It is clearly recognized that medical errors represent a significant source of preventable healthcare-related morbidity and mortality. Furthermore, evidence shows that such complications are often the result of a series of smaller errors,

missed opportunities, poor communication, breakdowns in established guidelines or protocols, or system-based deficiencies. While such events often start with the misadventures of an individual, it is how such events are managed that can determine outcomes and hopefully prevent future adverse events. The goal of Vignettes in Patient Safety is to illustrate and discuss, in a clinically relevant format, examples in which evidence-based approaches to patient care, using established methodologies to develop highly functional multidisciplinary teams, can help foster an institutional culture of patient safety and high-quality care delivery.

Patient Safety and Quality Oxford University Press

The two-volume Emergency Medical Services: Clinical Practice and Systems Oversight delivers a thorough foundation upon which to succeed as an EMS medical director and prepare for the NAEMSP National EMS Medical Directors Course and Practicum. Focusing on EMS in the 'real world', the book offers specific management tools that will be useful in the reader's own local EMS system and provides contextual understanding of how EMS functions within the broader emergency care system at a state, local, and national level. The two volumes offer the core knowledge trainees will need to successfully complete their training and begin their career as EMS physicians, regardless of the EMS systems in use in their areas. A companion website rounds out the book's offerings with audio and video clips of EMS best practice in action. Readers will also benefit from the inclusion of: A thorough introduction to the history of EMS An exploration of EMS airway management, including procedures and challenges, as well as how to manage ventilation, oxygenation, and breathing in patients, including cases of respiratory distress Practical discussions of medical problems, including the challenges posed by the undifferentiated patient, altered mental status, cardiac arrest and dysrhythmias, seizures, stroke, and allergic reactions An examination of EMS systems, structure, and leadership

Medical Quality Management OUP Oxford

Implementing safety practices in healthcare saves lives and improves the quality of care: it is therefore vital to apply good clinical practices, such as the WHO surgical checklist, to adopt the most appropriate measures for the prevention of assistance-related risks, and to identify the potential ones using tools such as reporting & learning systems. The culture of safety in the care environment and of human factors influencing it should be developed from the beginning of medical studies and in the first years of professional practice, in order to have the maximum impact on clinicians' and nurses' behavior. Medical errors tend to vary with the level of proficiency and experience, and this must be taken into account in adverse events prevention. Human factors assume a decisive importance in resilient organizations, and an understanding of risk control and containment is fundamental for all medical and surgical specialties. This open access book offers recommendations and examples of how to improve patient safety by changing practices, introducing organizational and technological innovations, and creating effective, patient-centered, timely, efficient, and equitable care systems, in order to spread the quality and patient safety culture among the new generation of healthcare professionals, and is intended for residents and young professionals in different clinical specialties.

Emergency Care for Children Springer Nature

A new book from ACEP that will help you participate effectively-or lead the way-in the successful design of your emergency department. Emergency Department Design will teach you the design and planning process so that you and other caregivers can make decisions about what's best for your department. Whether you're building a new department, remodeling an existing one, expanding, or simply adding a new service, the critical decisions you'll make must be based on an understanding of the design process. Time and time again, the best results are achieved when caregivers drive this process, working with design professionals to plan not just for today's patients, but also for those of the future. Read this book and learn how to: Assess your space needs Set physical design goals that meet operational outcomes Define the scope of your project Select a design professional Evaluate the "workability" of proposed design solutions ...and much more. You'll minimize the complexity of the challenge, reduce wasted time, and focus on creating a design that fulfills your vision of how emergency care should be provided. The author is Jon Huddy, AIA, with FreemanWhite, Inc., a nationally renowned architectural firm specializing in emergency department design. Mr. Huddy brings a passion for emergency department design, a commitment to include caregivers in the design process, and an entertaining, energetic presentation style to this book. Michael T. Rapp, MD, JD, FACEP, past president of ACEP, served as editor and contributed his insights in a special introductory chapter, "The Emergency Physician's Perspective." Plus, more than 20 other emergency care professionals and architects have contributed case studies and "pearls and pitfalls" from their own personal experiences with emergency department design projects.

Emergency Department Design BoD – Books on Demand

This is the first textbook designed to introduce the six areas of nursing competencies, as developed by the Quality and Safety Education for Nurses (QSEN) initiative, which are required

content in undergraduate nursing programs.

Hospital Management and Emergency Medicine: Breakthroughs in Research and Practice ASHP

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.

Patient Safety in Emergency Medicine National Academies Press

Clinical Governance is integral to healthcare and all doctors must have an understanding of both basic principles, and how to apply them in daily practice. Within the Clinical Governance framework, patient safety is the top priority for all healthcare organisations, with the prevention of avoidable harm a key goal. Traditionally medical training has concentrated on the acquisition of knowledge and skills related to diagnostic intervention and therapeutic procedures. The need to focus on non-technical aspects of clinical practice, including communication and team working, is now evident; ensuring tomorrow's staff are competent to function effectively in any healthcare facility. This book provides a guide to how healthcare systems work; their structure, regulation and inspection, and key areas including risk management, resource effectiveness and wider aspects of knowledge management. Changing curricula at undergraduate level reflect this, but post-graduate training is lagging behind and does not always equip trainees appropriately for a hectic clinical environment. An Introduction to Clinical Governance and Patient Safety presents a simple overview of clinical governance in context, highlighting important principles required to function effectively in a pressurised healthcare environment. It is presented in short sections based on the original seven pillars of clinical governance. These have been expanded to include the fundamental principles of systems, team working, leadership, accountability, and ownership in healthcare, with examples from everyday practice. This format is designed to facilitate use as a 'pocket guide' which can be dipped into during the working day, as well as for general reading. Examples from all branches of medicine are presented to facilitate understanding. Contributors are taken from a broad base - from junior doctors to internationally recognised experts - ensuring issues are addressed from all perspectives.

Atlas of Emergency Medicine CRC Press

Despite diagnosis being the key feature of a physician's clinical performance, this is the first book that deals specifically with the topic. In recent years, however, considerable interest has been shown in this area and significant developments have occurred in two main areas: a) an awareness and increasing understanding of the critical role of clinical decision making in the process of diagnosis, and of the multiple factors that impact it, and b) a similar appreciation of the role of the healthcare system in supporting clinicians in their efforts to make accurate diagnoses. Although medicine has seen major gains in knowledge and technology over the last few decades, there is a consensus that the diagnostic failure rate remains in the order of 10-15%. This book provides an overview of the major issues in this area, in particular focusing on where the diagnostic process fails, and where improvements might be made.

Emergency Department Leadership and Management Oxford University Press

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.

The Evolving Role of Emergency Departments in the United States National Academies Press

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 perspective, Patient Safety: A Human Factors Approach delineates a method that can enlighten and clarify this discourse as well as put us on a better path to correcting the issues. People often think, understandably, that safety lies mainly in the hands through which care ultimately flows to the patient—those who are closest to the patient, whose decisions can mean the difference between life and death, between health and morbidity. The human factors approach refuses to lay the responsibility for safety and risk solely at the feet of people at the sharp end. That is where we should intervene to make things safer, to tighten practice, to focus attention, to remind people to be careful, to impose rules and guidelines. The book defines an approach that looks relentlessly for sources of safety and risk everywhere in the system—the designs of devices; the teamwork and coordination between different practitioners; their communication across hierarchical and gender boundaries; the cognitive processes of individuals; the organization that surrounds, constrains, and empowers them; the economic and human resources offered; the technology available; the political landscape; and even the culture of the place. The breadth of the human factors approach is itself testimony to the realization that there are no easy answers or silver bullets for resolving the issues in patient safety. A user-friendly introduction to the approach, this book takes the complexity of health care seriously and doesn't over simplify the problem. It demonstrates what the approach does do, that is offer the substance and guidance to consider the issues in all their nuance and complexity.

Resident Duty Hours Cambridge University Press

"If a picture is worth a thousand words, this text speaks volumes." - Review of the First Edition, Academic Emergency Medicine *The primary visual sourcebook for diagnosis of emergency conditions *Features 700 high quality full-color photos *Covers diagnosis and clinical features for a broad spectrum of typical and atypical conditions *New to this edition: chapters on HIV, wounds and forensic evaluation, coverage of pneumonia, additional toxins, and treatment techniques

Clinical Risk Management Cambridge University Press

As US health care systems undergo a period of transformative change, so too will emergency care, and more specifically emergency departments. This transformation will include: The development of new diagnostic, therapeutic, and information technologies A growing need to prepare and respond to emerging public health threats The expansion of the role of allied health professionals to address the workforce crisis Novel expectations for care coordination The fundamental economics of emergency care under new payment models, and The key relationship with American law. Emergency Care and the Public's Health explores the complex role of emergency care in the context of these changes and as an increasingly vital component of health care systems both within and outside the US. From an expert emergency medicine team, this new title is a reference for emergency care and critical care providers, allied health professionals and hospital administrators. It is also for relevant for public policy and healthcare policy professionals.

Hospital-Based Emergency Care National Academies Press

Fully-updated edition of this award-winning textbook, arranged by presenting complaints with full-color images throughout. For students, residents, and emergency physicians.

Crossing the Quality Chasm Lippincott Williams & Wilkins

This book provides a comprehensive study of the science behind improving team performance in the delivery of clinical care.

Diagnosis National Academies Press

Concise, portable, and user-friendly, The Washington Manual® of Patient

Safety and Quality Improvement covers essential information in every area of this complex field. With a focus on improving systems and processes, preventing errors, and promoting transparency, this practical reference provides an overview of PS/QI fundamentals, as well as insight into how these principles apply to a variety of clinical settings. Part of the popular Washington Manual® series, this unique volume provides the knowledge and skills necessary for an effective, proactive approach to patient safety and quality improvement.

Pediatric Patient Safety in the Emergency Department John Wiley & Sons

Medical residents in hospitals are often required to be on duty for long hours. In 2003 the organization overseeing graduate medical education adopted common program requirements to restrict resident workweeks, including limits to an average of 80 hours over 4 weeks and the longest consecutive period of work to 30 hours in order to protect patients and residents from unsafe conditions resulting from excessive fatigue. Resident Duty Hours provides a timely examination of how those requirements were implemented and their impact on safety, education, and the training institutions. An in-depth review of the evidence on sleep and human performance indicated a need to increase opportunities for sleep during residency training to prevent acute and chronic sleep deprivation and minimize the risk of fatigue-related errors. In addition to recommending opportunities for on-duty sleep during long duty periods and breaks for sleep of appropriate lengths between work periods, the committee also recommends enhancements of supervision, appropriate workload, and changes in the work environment to improve conditions for safety and learning. All residents, medical educators, those involved with academic training institutions, specialty societies, professional groups, and consumer/patient safety organizations will find this book useful to advocate for an improved culture of safety.