

Root Cause Analysis In Surgical Site Infections Ssis

This book will provide anyone with an interest in the clinic with a basic guide on those things that are not taught during medical school or any other pre-clinical trainings. The line-up of authors was carefully assembled to include experts in all respective fields to give this volume the authority it requires to be a relevant text for many.

Practical Healthcare Epidemiology takes a hands-on approach to infection prevention for physicians, healthcare epidemiologists, infection preventionists, microbiologists, nurses, and other healthcare professionals. Increased regulatory requirements and patient knowledge and involvement has elevated patient safety, healthcare-associated infections, antibiotic stewardship and quality-of-care to healthcare wide issues. This fully updated new edition brings together the expertise of leaders in healthcare epidemiology to provide best practice expert guidance on infection prevention for adult and pediatric patients in all types of healthcare facilities, from community hospitals and academic institutions, to long-term care and resource limited settings. Written in clear, straightforward terms to address prevention planning and immediate responses to specific situations, this is the go-to resource for any practitioners in medicine or public health involved in infection prevention, regardless of their current expertise in the field.

Mohs Micrographic Surgery, an advanced treatment procedure for skin cancer, offers the highest potential for recovery—even if the skin cancer has been previously treated. This procedure is a state-of-the-art treatment in which the physician serves as surgeon, pathologist, and reconstructive surgeon. It relies on the accuracy of a microscope to trace and ensure removal of skin cancer down to its roots. This procedure allows dermatologists trained in Mohs Surgery to see beyond the visible disease and to precisely identify and remove the entire tumor, leaving healthy tissue unharmed. This procedure is most often used in treating two of the most common forms of skin cancer: basal cell carcinoma and squamous cell carcinoma. The cure rate for Mohs Micrographic Surgery is the highest of all treatments for skin cancer—up to 99 percent even if other forms of treatment have failed. This procedure, the most exact and precise method of tumor removal, minimizes the chance of regrowth and lessens the potential for scarring or disfigurement.

The 1st edition of Error Reduction and Prevention in Surgical Pathology was an opportunity to pull together into one place all the ideas related to errors in surgical pathology and to organize a discipline in error reduction. This 2nd edition is an opportunity to refine this information, to reorganize the book to improve its usability and practicality, and to include topics that were not previously addressed. This book serves as a guide to pathologists to successfully avoid errors and deliver the best diagnosis possible with all relevant information needed to manage patients. The introductory section includes general principles and ideas that are necessary to understand the context of error reduction. In addition to general principles of error reduction and legal and regulatory responsibilities, a chapter on regulatory affairs and payment systems which increasingly may be impacted by error reduction and improvement activities was added. This later chapter is particularly important in view of the implementation of various value-based payment programs, such as the Medicare Merit-Based Incentive Payment System that became law in 2015. The remainder of the book is organized in a similar manner to the 1st edition with chapters devoted to all aspects of the test cycle, including pre-analytic, analytic and post-analytic. The 2nd Edition of Error Reduction and Prevention in Surgical Pathology serves as an essential guide to a successfully managed laboratory and contains all relevant information needed to manage specimens and deliver the best diagnosis.

Surgical Ethics

Improving Performance for Bottom-Line Results, Fifth Edition

Air Embolism

To Err Is Human

Global Hand Surgery: Learning and Contributing in Low- and Middle-Income Countries

Quality and Safety in Radiology

This book constitutes the refereed joint proceedings of the First International Workshop on OR 2.0 Context-Aware Operating Theaters, OR 2.0 2018, 5th International Workshop on Computer Assisted Endoscopy, CARE 2018, 7th International Workshop on Clinical Image-Based Procedures, CLIP 2018, and the First International Workshop on Skin Image Analysis, ISIC 2018, held in conjunction with the 21st International Conference on Medical Imaging and Computer-Assisted Intervention, MICCAI 2018, in Granada, Spain, in September 2018. The 11 full papers presented at OR 2.0 2018, the 5 full papers presented at CARE 2018, the 8 full papers presented at CLIP 2018, and the 10 full papers presented at ISIC 2018 were carefully reviewed and selected. The OR 2.0 papers cover a wide range of topics such as machine vision and perception, robotics, surgical simulation and modeling, multi-modal data fusion and visualization, image analysis, advanced imaging, advanced display technologies, human-computer interfaces, sensors. The CARE papers cover topics to advance the field of computer-assisted and robotic endoscopy. The CLIP papers cover topics to fill gaps between basic science and clinical applications. The ISIC papers cover topics to facilitate knowledge dissemination in the field of skin image analysis, as well as to host a melanoma detection challenge, raising awareness and interest for these valuable tasks.

Gain the knowledge and skills you need to provide safe, effective perioperative nursing care! Alexander's Care of the Patient in Surgery, 17th Edition is the definitive resource for nurses and surgical technologists training for a career in the operating room. Illustrated, step-by-step instructions cover patient care in more than 400 surgical interventions, including patient positioning, instrument management, and postoperative care. Along with the latest on robotic surgery and a review of evidence-based guidelines, this edition includes new coverage of COVID-19 and gender affirmation surgery. From well-known educator Jane C. Rothrock — and with every chapter authored by an expert nurse — Alexander's gives you the tools you need to pass the CNOR® certification exam and succeed in the surgical suite. 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 at 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.

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 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

Author Joseph Dyro has been awarded the Association for the Advancement of Medical Instrumentation (AAMI) Clinical/Biomedical Engineering Achievement Award which recognizes individual excellence and achievement in the clinical engineering and biomedical engineering fields. He has also been awarded the American College of Clinical Engineering 2005 Tom O'Dea Advocacy Award. As the biomedical engineering field expands throughout the world, clinical engineers play an evermore important role as the translator between the worlds of the medical, engineering, and business professionals. Their influence procedure and policy at research facilities, universities and private and government agencies including the Food and Drug Administration and the World Health Organization. Clinical Engineers are key players in calming the hysteria over electrical safety in the 1970's and Y2K at the turn of the century and continue to work for medical safety. This title brings together all the important aspects of Clinical Engineering. It provides the reader with prospects for the future of clinical engineering as well as guidelines and standards for best practice around the world. * Clinical Engineers are the safety and quality facilitators in all medical facilities.

Surgical Patient Care

A Path Forward

Mohs Micrographic Surgery

The SAGES Manual of Quality, Outcomes and Patient Safety

OR 2.0 Context-Aware Operating Theaters, Computer Assisted Robotic Endoscopy, Clinical Image-Based Procedures, and Skin Image Analysis

Improving Safety, Quality and Value

A brilliant and courageous doctor reveals, in gripping accounts of true cases, the power and limits of modern medicine. Sometimes in medicine the only way to know what is truly going on in a patient is to operate, to look inside with one's own eyes. This book is exploratory surgery on medicine itself, laying bare a science not in its idealized form but as it actually is -- complicated, perplexing, and profoundly human. Atul Gawande offers an unflinching view from the scalpel's edge, where science is ambiguous, information is limited, the stakes are high, yet decisions must be made. In dramatic and revealing stories of patients and doctors, he explores how deadly mistakes occur and why good surgeons go bad. He also shows us what happens when medicine comes up against the inexplicable: an architect with incapacitating back pain for which there is no physical cause; a young woman with nausea that won't go away; a television newscaster whose blushing is so severe that she cannot do her job. Gawande offers a richly detailed portrait of the people and the science, even as he tackles the paradoxes and imperfections inherent in caring for human lives. At once tough-minded and humane, *Complications* is a new kind of medical writing, nuanced and lucid, unafraid to confront the conflicts and uncertainties that lie at the heart of modern medicine, yet always alive to the possibilities of wisdom in this extraordinary endeavor. *Complications* is a 2002 National Book Award Finalist for Nonfiction.

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--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--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--with state and local implications--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--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--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--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

This new addition to the acclaimed *Mastery of Surgery* series guides readers step by step through all vascular surgical procedures, both open and endovascular. In the tradition of the series, this text/atlas is written by the world's master surgeons and richly illustrated throughout with detailed drawings, photographs, and imaging scans. Coverage of each procedure begins with indications, contraindications, preoperative preparation, anatomy, and patient management, followed by step-by-step descriptions of operative technique and pitfalls. For diseases in which open and endovascular approaches are used for different indications, both approaches are presented with discussions of when and why each is preferable. Each chapter ends with an editor's comment.

Patient Safety in Surgery Springer

Clinical Engineering Handbook

Root Cause Analysis in Health Care

Alexander's Care of the Patient in Surgery - E-Book

An Evidence-based Handbook for Nurses

A Surgeon's Notes on an Imperfect Science

Root Cause Analysis

The first textbook on the subject, this is a practical, clinically comprehensive guide to ethical issues in surgical practice, research, and education written by some of the most prominent figures in the fields of surgery and bioethics. Discussions of informed consent, confidentiality, and advance directives--core concepts integral to every surgeon-patient relationship--open the volume. Seven chapters tackle the ethical issues in surgical practice, covering the full range of surgical patients--from emergency, acute, high-risk, and elective patients, to poor surgical risk and dying patients. The book even considers the special relationship between the surgeon and patients who are family members or friends. Chapters on surgical research and education address innovation, self-regulation in practice and research, and the prevention of unwarranted bias. Two chapters focus on the multidisciplinary nature of surgery, including the relationships between surgery and other medical specialties and the obligations of the surgeon to other members of the surgical team. The economic dimensions of surgery, especially within managed care, are addressed in chapters on the surgeons financial relationships with patients, conflicts of interest, and relationships with payers and institutions. The authors do not engage in abstract discussions of ethical theory; instead, their discussions are always directly relevant to the everyday concerns of practicing surgeons. This well-integrated volume is intended for practicing surgeons, medical educators, surgical residents, bioethicists, and medical students.

Guest Editor Juan Sanchez reviews articles in Safe Surgery for the general surgeon. Articles include iatrogenesis: the nature, frequency, and science of medical errors, risk management and the regulatory framework for safer surgery medication, lab, and blood banking errors, surgeons' non-technical skills, creating safe and effective surgical teams, human factors and operating room safety, systemic analysis of adverse events: identifying root causes and latent errors, information technologies and patient safety, patient safety and the surgical workforce, measuring and preventing healthcare associated infections, the surgeon's four-phase reaction to error, universal protocols and wrong-site/wrong-patient events, unconscious biases and patient safety, and much more!

This book focuses exclusively on the surgical patient and on the perioperative environment with its unique socio-technical and cultural issues. It covers preoperative, intraoperative, and postoperative processes and decision making and explores both sharp-end and latent factors contributing to harm and poor quality outcomes. It is intended to be a resource for all healthcare practitioners that interact with the surgical patient. This book provides a framework for understanding and addressing many of the organizational, technical, and cultural aspects of care to one of the most vulnerable patients in the system, the surgical patient. The first section presents foundational principles of safety science and related social science. The second exposes barriers to achieving optimal surgical outcomes and details the various errors and events that occur in the perioperative environment. The third section contains prescriptive and proactive tools and ways to eliminate errors and harm. The final section focuses on developing continuous quality improvement programs with an emphasis on safety and reliability. Surgical Patient Care: Improving Safety, Quality and Value targets an international audience which includes all hospital, ambulatory and clinic-based operating room personnel as well as healthcare administrators and managers, directors of risk management and patient safety, health services researchers, and individuals in higher education in the health professions. It is intended to provide both fundamental knowledge and practical information for those at the front line of patient care. The increasing interest in patient safety worldwide makes this a timely global topic. As such, the content is written for an international audience and contains materials from leading international authors who have implemented many successful programs.

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.

Patient Safety in Surgery

Error Reduction in Health Care

Textbook of Patient Safety and Clinical Risk Management

Error Reduction and Prevention in Surgical Pathology

Complications in Gynecological Surgery

Medical Device Use Error

In general, surgeons strive to achieve excellent results and ideal patient outcomes, however, this noble task is frequently failed. For patients, surgical complications are analogous to “friendly fire” in wartime. Both scenarios imply that harm is unintentionally done by somebody whose aim was to help. Interestingly, adverse events resulting from surgical interventions are more frequently related to system errors and a communication breakdown among providers, rather than to the imminent threat of the surgical blade “gone wrong”. Patient Safety in Surgery aims to increase the safety and quality of care for patients undergoing surgical procedures in all fields of surgery. Patient Safety in Surgery, covers all aspects related to patient safety in surgery, including pertinent issues of interest to surgeons, medical trainees (students, residents, and fellows), nurses, anaesthesiologists, patients, patient families, advocacy groups, and medicolegal experts.??

Americans should be able to count on receiving health care that is safe. To achieve this, a new health care delivery system is needed – 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.

Scores of talented and dedicated people serve the forensic science community, performing vitally important work. However, they are often constrained by lack of adequate resources, sound policies, and national support. It is clear that change and advancements, both systematic and scientific, are needed in a number of forensic science disciplines to ensure the reliability of work, establish enforceable standards, and promote best practices with consistent application. Strengthening Forensic Science in the United States: A Path Forward provides a detailed plan for addressing these needs and suggests the creation of a new government entity, the National Institute of Forensic Science, to establish and enforce standards within the forensic science community. The benefits of improving and regulating the forensic science disciplines are clear: assisting law enforcement officials, enhancing homeland security, and reducing the risk of wrongful conviction and exoneration. Strengthening Forensic Science in the United States gives a full account of what is needed to advance the forensic science disciplines, including upgrading of systems and organizational structures, better training, widespread adoption of uniform and enforceable best practices, and mandatory certification and accreditation programs. While this book provides an essential call-to-action for congress and policy makers, it also serves as a vital tool for law enforcement agencies, criminal prosecutors and attorneys, and forensic science educators.

Simulation in Surgical Training and Practice is reviewed extensively in this important Surgical Clinics of North America issue. Articles include: Applying Educational Theory to Simulation Based Training and Assessment in Surgery; Figuring out Team Simulation Training; Faculty Development for Simulation Training; The Evolving Role of Simulation in Teaching Surgery in Undergraduate Medical Education; Using Simulation in Inter-Professional Education; Current Status of Simulation Based Training in Graduate Medical Education; National Simulation-based Training of Fellows: The Vascular Surgery Exam? Paying For it: Funding Models for Simulation Centers; Surgical Simulation Centers as Educational Homes for Practicing Surgeons; Better Assessment: Advanced Engineering Technology for Measuring Performance In and Out of the Simulation Lab; Moving the Needle - Simulation's Impact on Patient Outcomes; Human Factors Engineering and Effective Simulation - Partners for Improved Patient Safety; Simulation for the Assessment and Improvement of Teamwork and Communication in the Operating Room; Using Simulation to Improve Systems; Simulation for Maintenance of Certification; and more!

Achieving a New Standard for Care

Simulation in Surgical Training and Practice

Basics of Anesthesia, 6/e

Understanding, Prevention, and Control

A Root Cause Analysis of Medical Decision Making

Complications

Recent debate over healthcare and its spiraling costs has brought medical error into the spotlight as an indicator of everything that is ineffective, inhumane, and wasteful about modern medicine. But while the tendency is to blame it all on human error, it is a much more

complex problem that involves overburdened systems, constantly changing technology, increasing specialization, and a cycle of continual funding shortfalls made even more acute by resource-wasting inefficiencies. Medical Error and Harm: Understanding, Prevention and Control, presents the work of long time physician and teacher Milos Jenicek, a pioneering expert on epidemiology, evidence-based medicine, and critical thinking and decision making in the health sciences. Providing an extraordinarily comprehensive overview of the subject that is as thorough and scientifically organized as it is accessible and free of rhetoric, Dr. Jenicek – Presents a short history of error in general across various domains of human activity and endeavor, including concepts, methodologies of study, and management applications Provides semantic and taxonomic classifications of challenges in medical error and harm, two distinct domains Explores approaches used to investigate and ameliorate challenges in medicine and other health sciences Explains why, when, and how studies and decisions regarding errors should be carried out, such as whether risk assessment should be undertaken in the diagnosis, treatment, or prognosis stage Covers essential strategies for mitigating errors in the broader framework of medical care, specifically in community medicine and public health Considers the ever-growing role of physicians in tort law and litigation The book also discusses whether dealing with errors is a learned skill and looks at how much of the problem with medical error is caused by the medical community's failure to teach, learn, and understand everything there is to know about medical error, including the often neglected importance of critical thinking skills. Understanding and correcting this shortfall is a primary responsibility of every health professional, one they can begin to realize with the study of these pages. Getting the right diagnosis is a key aspect of health care - it provides an explanation of a patient's health problem and informs subsequent health care decisions. The diagnostic process is a complex, collaborative activity that involves clinical reasoning and information gathering to determine a patient's health problem. According to Improving Diagnosis in Health Care, diagnostic errors-inaccurate or delayed diagnoses-persist throughout all settings of care and continue to harm an unacceptable number of patients. It is likely that most people will experience at least one diagnostic error in their lifetime, sometimes with devastating consequences. Diagnostic errors may cause harm to patients by preventing or delaying appropriate treatment, providing unnecessary or harmful treatment, or resulting in psychological or financial repercussions. The committee concluded that improving the diagnostic process is not only possible, but also represents a moral, professional, and public health imperative. Improving Diagnosis in Health Care a continuation of the landmark Institute of Medicine reports To Err Is Human (2000) and Crossing the Quality Chasm (2001) finds that diagnosis-and, in particular, the occurrence of diagnostic errors"has been largely unappreciated in efforts to improve the quality and safety of health care. Without a dedicated focus on improving diagnosis, diagnostic errors will likely worsen as the delivery of health care and the diagnostic process continue to increase in complexity. Just as the diagnostic process is a collaborative activity, improving diagnosis will require collaboration and a widespread commitment to change among health care professionals, health care organizations, patients and their families, researchers, and policy makers. The recommendations of Improving Diagnosis in Health Care contribute to the growing momentum for change in this crucial area of health care quality and safety.

Whether you are a student or a working professional, you can benefit from being better at solving the complex problems that come up in your life. Strategic Thinking in Complex Problem Solving provides a general framework and the necessary tools to help you do so. Based on his groundbreaking course at Rice University, engineer and former strategy consultant Arnaud Chevallier provides practical ways to develop problem solving skills, such as investigating complex questions with issue maps, using logic to promote creativity, leveraging analogical thinking to approach unfamiliar problems, and managing diverse groups to foster innovation. This book breaks down the resolution process into four steps: 1) frame the problem (identifying what needs to be done), 2) diagnose it (identifying why there is a problem, or why it hasn't been solved yet), 3) identify and select potential solutions (identifying how to solve the problem), and 4) implement and monitor the solution (resolving the problem, the 'do'). For each of these four steps - the what, why, how, and do - this book explains techniques that promotes success and demonstrates how to apply them on a case study and in additional examples. The featured case study guides you through the resolution process, illustrates how these concepts apply, and creates a concrete image to facilitate recollection. Strategic Thinking in Complex Problem Solving is a tool kit that integrates knowledge based on both theoretical and empirical evidence from many disciplines, and explains it in accessible terms. As the book guides you through the various stages of solving complex problems, it also provides useful templates so that you can easily apply these approaches to your own personal projects. With this book, you don't just learn about problem solving, but how to actually do it.

Error Reduction in Health Care Completely revised and updated, this second edition of Error Reduction in Health Care offers a step-by-step guide for implementing the recommendations of the Institute of Medicine to reduce the frequency of errors in health care services and to mitigate the impact of errors when they do occur. With contributions from noted leaders in health safety, Error Reduction in Health Care

provides information on analyzing accidents and shows how systematic methods can be used to understand hazards before accidents occur. In the chapters, authors explore how to prioritize risks to accurately focus efforts in a systems redesign, including performance measures and human factors. This expanded edition covers contemporary material on innovative patient safety topics such as applying Lean principles to reduce mistakes, opportunity analysis, deductive adverse event investigation, improving safety through collaboration with patients and families, using technology for patient safety improvements, medication safety, and high reliability organizations. The Editor

Crossing the Quality Chasm

Patient Safety

Management and Leadership – A Guide for Clinical Professionals

Building a Safer Health System

Strategic Thinking in Complex Problem Solving

Mastery of Vascular and Endovascular Surgery

Behind heart disease and cancer, medical error is now listed as one of the leading causes of death. Of the many medical errors that may lead to injury and death, diagnostic failure is regarded as the most significant. Generally, the majority of diagnostic failures are attributed to the clinicians directly involved with the patient, and to a lesser extent, the system in which they work. In turn, the majority of errors made by clinicians are due to decision making failures manifested by various departures from rationality. Of all the medical environments in which patients are seen and diagnosed, the emergency department is the most challenging. It has been described as a "wicked" environment where illness and disease may range from minor ailments and complaints to severe, life-threatening disorders. The Cognitive Autopsy is a novel strategy towards understanding medical error and diagnostic failure in 42 clinical cases with which the author was directly involved or became aware of at the time. Essentially, it describes a cognitive approach towards root cause analysis of medical adverse events or near misses. Whereas root cause analysis typically focuses on the observable and measurable aspects of adverse events, the cognitive autopsy attempts to identify covert cognitive processes that may have contributed to outcomes. In this clinical setting, no cognitive process is directly observable but must be inferred from the behavior of the individual clinician. The book illustrates unequivocally that chief among these cognitive processes are cognitive biases and other flaws in decision making, rather than knowledge deficits.

"Nurses play a vital role in improving the safety and quality of patient care -- 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/nursesfdbk>.

Second in a series of publications from the Institute of Medicine's Quality of Health Care in America project Today's health care providers have more research findings and more technology available to them than ever before. Yet recent reports have raised serious doubts about the quality of health care in America. Crossing the Quality Chasm makes an urgent call for fundamental change to close the quality gap. This book recommends a sweeping redesign of the American health care system and provides overarching principles for specific direction for policymakers, health care leaders, clinicians, regulators, purchasers, and others. In this comprehensive volume the committee offers: A set of performance expectations for the 21st century health care system. A set of 10 new rules to guide patient-clinician relationships. A suggested organizing framework to better align the incentives inherent in payment and accountability with improvements in quality. Key steps to promote evidence-based practice and strengthen clinical information systems. Analyzing health care organizations as complex systems, Crossing the Quality Chasm also documents the causes of the quality gap, identifies current practices that impede quality care, and explores how systems approaches can be used to implement change.

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.

The Story of the Patient Safety Movement

A New Health System for the 21st Century

A Systems Approach to Improving Patient Safety

Disease Control Priorities, Third Edition (Volume 1)

First International Workshop, OR 2.0 2018, 5th International Workshop, CARE 2018, 7th International Workshop, CLIP 2018, Third International Workshop, ISIC 2018, Held in Conjunction with MICCAI 2018, Granada, Spain, September 16 and 20, 2018, Proceedings

A Step-by-step Guide

Radiology has been transformed by new imaging advances and a greater demand for imaging, along with a much lower tolerance for error as part of the Quality & Safety revolution in healthcare. With a greater emphasis on patient safety and quality in imaging practice, imaging specialists are increasingly charged with ensuring patient safety and demonstrating that everything done for patients in their care meets the highest quality and safety standards. This book offers practical guidance on understanding, creating, and implementing quality management programs in Radiology. Chapters are comprehensive, detailed, and organized into three sections: Core Concepts, Management Concepts, and Educational & Special Concepts. Discussions are applicable to all practice settings: community hospitals, private practice, academic radiology, and government/military practice, as well as to those preparing for the quality and safety questions on the American Board of Radiology's "Maintenance of Certification" or initial Board Certification Examinations. Bringing together the various elements that comprise the quality and safety agenda for Radiology, this book serves as a thorough roadmap and resource for radiologists, technicians, and radiology managers and administrators.

The book follows a proven training outline, including real-life examples and exercises, to teach healthcare professionals and students how to lead effective and successful Root Cause Analysis (RCA) to eliminate patient harm. This book discusses the need for RCA in the healthcare sector, providing practical advice for its facilitation. It addresses when to use RCA, how to create effective RCA action plans, and how to prevent common RCA failures. An RCA training curriculum is also included. This book is intended for those leading RCAs of patient harm events, leaders, students, and patient safety advocates who are interested in gaining more knowledge about RCA in healthcare.

This issue of Hand Clinics, guest edited by series consulting editor Dr. Kevin Chung, will cover Global Hand Surgery, with a focus on learning and contributing in the developing world. Topics discussed in the volume include: Economic Evaluations of Hand Surgery in the Developing World, Developing a Sustaining Program of Surgery Care in the Developing World, Overcoming Barriers to Hand Surgical Care in Low-Resource Settings, Postoperative Management for Hand Surgery in the Developing World, Interdisciplinary Teams and Global Hand Surgery, Guidelines for Ideal Short-Term Hand Surgery Outreach Trips, Cultural Sensitivity and Surgical Outreach, Treating Upper Extremity Burns in the Developing World, Treating Congenital Hand Anomalies in Low-Resource Settings, Treating Hand Traumas in Low-Resource Setting, Ethics in Global Hand Surgery, Hand Surgery in Underserved Populations in the United States, and Initiatives and Future Directions, among others.

Medical Device Use Error: Root Cause Analysis offers practical guidance on how to methodically discover and explain the root cause of a use error-a mistake-that occurs when someone uses a medical device. Covering medical devices used in the home and those used in clinical environments, the book presents informative case studies about the use errors

Making Healthcare Safe

Patient Safety, An Issue of Surgical Clinics - E-Book

Improving Diagnosis in Health Care

The Cognitive Autopsy

Practical Healthcare Epidemiology

With the most authoritative and complete overview of anesthesia theory and practice, the latest edition of Basic Anesthesia, edited by noted anesthesiologist Ronald D. Miller, MD and Manuel C. Pardo, Jr., MD, continues to serve as an excellent primer on the scope and practice of anesthesiology. Widely acknowledged as the foremost introductory text, the new edition-now presented in full color throughout-has been thoroughly updated to reflect new and rapidly changing areas in anesthesia practice including new chapters on awareness under anesthesia, quality and patient safety, orthopedics, and expanded coverage of new ultrasound techniques in regional anesthesiology with detailed illustrated guidance. You can access the full text and image library online at www.expertconsult.com. Obtain a clear overview of everything you need to know about the fundamentals of anesthesia, including basic science and emerging clinical topics. Efficiently retain and synthesize information more easily thanks to a concise, at-a-glance format with numerous illustrations and tables throughout the book that condense complex concepts, and 'Questions of the Day' to assist you in understanding key material presented in each chapter.

Risk management is a relatively new process that can sometimes evoke feelings of suspicion among clinicians. However, when used proactively, it offers the opportunity to act at the root cause of an incident to expose deficiencies in the system rather than in individuals. This process encourages a supportive approach to patients, relatives, and

staff. The overall aim should be to learn lessons rather than to attribute blame. References 1. Vincent C, Neale G, Woloshynowych M. Adverse events in British hospitals: a preliminary retrospective record review. *Br Med J*. 2001;322:517-519. 2. Neale G, Woloshynowych M, Vincent C. Exploring the causes of adverse events in NHS hospital practice. *J R Soc Med*. 2001;94:322-330. 3. Walshe K. The development of clinical risk management. In: Vincent C, ed. *Clinical Risk Management*. London: BMJ Publishing Group; 2001, p. 45-60. 4. Department of Health. *An Organization with a Memory*. London: HMSO; 2000. 5. National Patient Safety Agency. *Reporting incidents*. Available at: <http://www.npsa.nhs.uk/health/reporting>. Assessed June 25, 2007. 6. National Confidential Enquiry into Perioperative Deaths. *Changing the way we operate. The 2001 Report of the National Confidential Enquiry into Perioperative Deaths*. London: National Confidential Enquiry into Perioperative Deaths; 2001. Available at: <http://www.ncepod.org.uk>. Assessed June 25, 2007. 7. General Medical Council. *Good Medical Practice*. London: General Medical Council; 2006. Available at: http://www.gmc-uk.org/guidance/good_medical_practice/index.asp.

Essential Surgery is part of a nine volume series for *Disease Control Priorities* which focuses on health interventions intended to reduce morbidity and mortality. The *Essential Surgery* volume focuses on four key aspects including global financial responsibility, emergency procedures, essential services organization and cost analysis. Air embolism is one of the serious causes of morbidity and mortality in medicine and surgery, especially in cardiac surgery. Various medical and surgical procedures have been associated with the risk of air embolism. In the chapter, all procedures and pathologic conditions will be described, paying special attention to the root cause analysis of the events in any given circumstance. Special attention is to be paid to techniques of risk minimization of this serious complication. The chapter will give an in-depth insight to the anatomical, physiological and other preconditions of air embolism, thus helping the reader to implement preventive measures and to increase patient safety.

2012 Standards for Ambulatory Surgery Centers

Root Cause Analysis (RCA) for the Improvement of Healthcare Systems and Patient Safety

Strengthening Forensic Science in the United States

Root Cause Analysis and Improvement in the Healthcare Sector

Essential Surgery

Medical Error and Harm