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Preventing Medication Errors Patient Safety and Quality The Nurse's Role in Medication Safety To Err Is Human Medication Errors Errors of Omission Drug Safety in Developing Countries Error Reduction in Health Care Human Reliability and Error in Medical System Medication Errors Advances in Patient Safety Error and Reporting in Surgery Medication Reconciliation When We Do Harm Preventing Errors and Pitfalls in Nursing with Infectious Patients Annual Review of Nursing Research, Volume 24, 2006 Crossing the Quality Chasm Vignettes in Patient Safety Information Technology in Health Care 2007 Contemporary Educational Researches: Theory and Practice in Education Learning from Error in Policing Safeguards to Prevent Medication Administration Errors in The National Health Service Breaching Safe Nursing Practice Impact of Medical Errors and Malpractice on Health Economics, Quality, and Patient Safety Nursing Pharmacology for Nurses Evidence-Based Practice for Nurses Health Literacy: Breakthroughs in Research and Practice Doing a Literature Review in Nursing, Health and Social Care First, Do Less Harm Adverse Drug Effects Medical Error and Patient Safety Healthcare Ethics and Training: Concepts, Methodologies, Tools, and Applications Issues in Nursing Research, Training, and Practice: 2013 Edition Second Victim Johns Hopkins Nursing Evidence-based Practice Contemporary Consumer Health Informatics Exploring Rituals in Nursing Detecting Reference Errors Before Publication Routledge International Handbook of Advanced Quantitative Methods in Nursing Research

Medical mistakes are more pervasive than we think. How can we improve outcomes? An acclaimed MD’s rich stories and research explore patient safety. Patients enter the medical system with faith that they will receive the best care possible, so when things go wrong, it’s a profound and painful breach. Medical science has made enormous strides in decreasing mortality and suffering, but there’s no doubt that treatment can also cause harm, a significant portion of which is preventable. In When We Do Harm, practicing physician and acclaimed author Danielle Ofri places the issues of medical error and patient safety front and center in our national healthcare conversation. Drawing on current research, professional experience, and extensive interviews with nurses, physicians, administrators, researchers, patients, and families, Dr. Ofri explores the diagnostic, systemic, and cognitive causes of medical error. She advocates for strategic use of concrete safety interventions such as checklists and improvements to the electronic medical record, but focuses on the full-scale cultural and cognitive shifts required to make a meaningful dent in medical error. Woven throughout the book are the powerfully human stories that Dr. Ofri is renowned for. The errors she dissects range from the hardly noticeable missteps to the harrowing medical cataclysms. While our healthcare system is—and always will be—imperfect, Dr. Ofri argues that it is possible to minimize preventable harms, and that this should be the galvanizing issue of current medical discourse. Academic Paper from the year 2019 in the subject Health - Nursing Science - Miscellaneous, grade: A, University of Nairobi (College of Medicine and Applied Sciences), course: International Nursing Practice, language: English, abstract: This text deals with safeguards to prevent medication administration errors in general and the Automated Dispensing Cabinets (ACD) in particular. They are a decentralised medication distribution system that offers a computer controlled dispensing, storage as well as the tracking of medication at the care point in the patient care units. The author will also look at the benefits and challenges for the nurse, care delivery, and implications for patient care. Medication errors, particularly the administration of wrong drugs is a common error type in the health care services. However, to ensure the safety of the patients, it is important to develop a system that can verify that the right drug is delivered to the correct patient; such a system is essential and basic for ensuring the improvement of care quality and the patient safety. Although errors associated with drug identity checking – cases where the health care professionals administer the wrong drug – have been put under the same category with the errors of wrong dose, such a categorisation should be reconsidered as part of quality improvement in clinical practice. Clinical research has indicated that the implications of wrong drug errors are significantly different in terms of corrective action for the errors of wrong dose errors. Wrong drug errors entail the checking errors by the nurses and pharmacists that lead to patients nearly receiving (near misses) or receiving the wrong medication. The wrong drug errors are different from the cases of wrong dosage errors where there is a failure by the pharmacists or the nurses to ensure that the proper dosage is administered or dispensed. The wrong drug errors can lead to significant adverse effects when the psychiatrist patient receives a drug that is inappropriate for their condition. When the disorder that the patient has is not treated properly, such a patient is exposed to medication that is not only unnecessary but can also attendant adverse and side effects. 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 A difficult and recalcitrant phenomenon, medical error causes pervasive and expensive problems in terms of patient injury, ineffective treatment, and rising healthcare costs. Simple heightened awareness can help, but it requires organized, effective remedies and countermeasures that are reasonable, acceptable, and adaptable to see a truly significant drop in the intolerable rate of medical mistakes. Only with better understanding, knowledge, and directed techniques can there be rapid and marked improvement in medical error management discipline. Since medical error is situation specific and involves diverse variables in equipment, environment, and human performance, the correct choice of preventive and corrective techniques is critical. Providing a wealth of useful ideas, concepts, and techniques, Medical Error and Patient Safety: Human Factors in Medicine uses abroad perspective to present more than 500 remedies that can be applied and tailored to your unique circumstances. This detailed review of so many measures enables you to correctly identify needs and undertake appropriate actions to achieve a success that can be measured in avoided injuries, improved healthcare, and reduced cost. Thought provoking and useful, this book considers the potential for error and the possibility for improvement in every aspect of healthcare. After an introduction to general concepts and approaches, it examines vulnerabilities in medical services, including emergency services, healthcare facilities, and infection control. It covers risks in medical devices and product design; human factors such as fatigue and stress; management errors; errors in communication at all levels of the healthcare hierarchy; as well as mistakes in drug delivery including faulty labels and warnings. The authors also compare and contrast several analytical methods, their interpretation, and their translation into a plan of action. Pharmacology for Nurses, Second Edition teaches undergraduate nursing students the basic concepts of pharmacology. 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. In this expanded 600+ page edition, Dr. Cohen brings together some 30 experts from pharmacy, medicine, nursing, and risk management to provide the most current thinking about the causes of medication errors and strategies to prevent them. While the proximate cause of any accident is usually someone’s immediate action— or omission (failure to act)—there is often a trail of underlying latent conditions that facilitated their error: the person has, in effect, been unwittingly “set up” for failure by the organization. This Brief explores an accident in policing, as a framework for examining existing police practices. Learning from Error in Policing describes a case of wrongful arrest from the perspective of organizational accident theory, which suggests a single unsafe act—in this case a wrongful arrest—is facilitated by several underlying latent conditions that triggered the event and failed to stop the harm once in motion. The analysis demonstrates that the risk of errors committed by omission (failing to act) were significantly more likely to occur than errors committed by acts of commission. By examining this case, policy implications and directions for future research are discussed. The analysis of this case, and the underlying lessons learned from it will have important implications for researchers and practitioners in the policing field. Human reliability and error have become a very important issue in health care, owing to the vast number of associated deaths each year. For example, according to the findings of the Institute of Medicine in 1999, around 100000 Americans die each year because of human error. This makes human error in health care the eighth leading cause of deaths in the US. Moreover, the total annual national cost of the medical errors is estimated at between $17 billion and $37.6 billion. There are very few books on this subject, and none of them covers it at a significant depth. The need for a book presenting the basics of human reliability, human factors and comprehensive information on error in medical systems is essential. This book meets that need. Contents: Human Reliability and Error Mathematics; Human Factors Basics; Human Reliability and Error Basics; Methods for Performing Human Reliability and Error Analysis in Health Care System; Human Error in Medication; Human Error in Anesthesia; Human Error in Miscellaneous Health Care Areas and Health Care Human Error Cost; Human Factors in Medical Devices; Mathematical Models for Predicting Human Reliability and Error in Medical System; Health Care Human Error Reporting Systems and Data; Appendix: Bibliography: Literature on Human Reliability and Error in Health Care. Readership: Health care and safety professionals, administrators, students, human-factors/psychology specialists, biomedical engineers and health care researchers. This book addresses selected violations of professional nursing conduct and practices that take place in shadows or on the margins of clinical practice--incidents that represent "dark" or "gray" areas of nursing. Chapters identify threats to patient and nurse well-being that are antithetical to nurses' principles; sensitize nurses and other stakeholders to gray and dark sides of nursing through case examples; and pose evidence-based solutions for eliminating, mitigating, and addressing examples representing the gray or dark side of nursing. The book encourages organizations to promote a culture of ethical responsibility for nursing practices. The 140 articles in the 4-volume set represent the efforts of AHRQ-funded patient safety researchers as well as the patient safety initiatives of other parts of the Federal Government. The articles cover a wide range of research paradigms, clinical settings, and patient populations, and they cover various stages of the research process. The volumes include the articles research that is complete and from research still in process, as well as a series of articles that address implementation issues and provide useful tools and products that can be used to improve patient safety. This book informs nurses about the most common and the more serious errors made in caring for patients with infectious diseases. It provides learnings about a variety of infectious diseases, including COVID-19, methicillin-resistant Staphylococcus aureus (MRSA), Vancomycin-resistant Enterococcus (VRE), Clostridium difficile (C-diff.), and tuberculosis (TB), amongst others. Factors that are predisposing and contributing factors for nursing errors are reviewed. The types of errors, consequences, detection, and monitoring for nursing errors are included. This book examines how errors can be avoided with necessary precautions, and managed appropriately based on current evidence-based practice. Recommendations for further study are also provided. This book is a useful tool for nurse educators/ leaders/mentors to educate and guide their students and professional nurses. In 1996 the Institute of Medicine launched the Quality Chasm Series, a series of reports focused on assessing and improving the nation's quality of health care. Preventing Medication Errors is the newest volume in the series. Responding to the key messages in earlier volumes of the seriesâ€"To Err Is Human (2000), Crossing the Quality Chasm (2001), and Patient Safety (2004)â€"this book sets forth an agenda for improving the safety of medication use. It begins by providing an overview of the system for drug development, regulation, distribution, and use. Preventing Medication Errors also examines the peer-reviewed literature on the incidence and the cost of medication errors and the effectiveness of error prevention strategies. Presenting data that will foster the reduction of medication errors, the book provides action agendas detailing the measures needed to improve the safety of medication use in both the short- and long-term. Patients, primary health care providers, health care organizations, purchasers of group health care, legislators, and those affiliated with providing medications and medication- related products and services will benefit from this guide to reducing medication errors. Print+CourseSmart "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/ Given the large number of new drugs approved over the past 25 years--many highly potent and complex--it's no surprise that medication errors occur. Although most are not serious, some cause irreparable harm and fatalities. Medication Errors takes an in-depth look at factors that contribute to medication errors and recommends steps for preventing them at the micro and macro levels. Issues in Nursing Research, Training, and Practice: 2013 Edition is a ScholarlyEditions™ book that delivers timely, authoritative, and comprehensive information about Nurse Practitioners. The editors have built Issues in Nursing Research, Training, and Practice: 2013 Edition on the vast information databases of ScholarlyNews.™ You can expect the information about Nurse Practitioners in this book to be deeper than what you can access anywhere else, as well as consistently reliable, authoritative, informed, and relevant. The content of Issues in Nursing Research, Training, and Practice: 2013 Edition has been produced by the world’s leading scientists, engineers, analysts, research institutions, and companies. All of the content is from peer-reviewed sources, and all of it is written, assembled, and edited by the editors at ScholarlyEditions™ and available exclusively from us. You now have a source you can cite with authority, confidence, and credibility. More information is available at http://www.ScholarlyEditions.com/. 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 The development of better processes to relay medical information has enhanced the healthcare field. By implementing effective collaborative strategies, this ensures proper quality and instruction for both the patient and medical practitioners. Health Literacy: Breakthroughs in Research and Practice examines the latest advances in providing and helping patients and medical professionals to understand basic health information and the services that are most appropriate. Including innovative studies on interactive health information, health communication, and health education, this multi-volume book is an ideal source for professionals, researchers, academics, practitioners, and students interested in the improvement of health literacy. This text on the application of best practices to improve nursing patient care covers the fundamentals of evidence-based practice, identifying research questions and evidence, methods for collecting evidence, evaluation of evidence and decision-making, and evaluating applications. Designated a Doody's Core Title! Supporting the urgent need for new patient safety guidelines and practices, Focus on Patient Safety, provides the most current and authoritative research and review to help decision makers develop new and much-needed standards and practices in nursing. With contributions from experts in the field, this new up-to-date reference focuses on key disciplines and topics that are critical to patient safety today including: Patient safety indicators Medication errors Falls and injury prevention Hospital-acquired infections Patient safety in acute-care units in hospitals Medications in the perioperative environment Home visit programs for the elderly Nursing homes Informatics issues Organizational, climate, and culture factors From new and emerging issues in patient safety to a review of research methods and measurement, this new 24th volume in the Annual Review of Nursing Research (ARNR) series continues to provide the highest standards of content and authoritative review of research for students, researchers, and clinicians. This thesis presents a research study, conducted for my PhD. This research used mixed qualitative and quantitative methods to address four central questions: How do interdisciplinary team members perceive error and error reporting? How do patients perceive error and error reporting? What are the areas of congruence and conflict between different healthcare professionals' approaches to error and patients' needs and perspectives? Why are certain events not described as errors and not addressed in a systematic fashion that would improve patient safety? This study was conducted in the grounded theory tradition and included two phases. The first phase investigated the perceptions of OR team members and patients regarding error definition and error reporting; the second phase sought to elaborate two of the dominant themes from the first phase. The first three chapters of this thesis provide background information about the context, theoretical foundation, and design of the research. The following three chapters present the results of the study in the form of three self-contained articles that have been published or submitted to academic journals. The first of these articles describes and compares surgical team members' and patients' perceptions of error, its reporting, and its disclosure from the first phase of the study. It is published in the journal Surgery. The second article explores operating room (OR) nurses' error reporting preferences from the second phase of the study. This article has been submitted to an applied nursing research journal. The third article sought to probe the factors influencing whether team members saw error events in everyday work as problematic or whether they rationalized such occurrences to support the status quo. The analysis draws on three concepts from organizational and psychological theory to explore team members' responses to these error scenarios. This article has been submitted to the journal Quality and Safety in Healthcare. The final chapter draws the three papers together into an extended discussion about the significance and future implications of this work. Written especially for nurses in all disciplines and health care settings, this second edition of The Nurses's Role in Medication Safety focuses on the hands-on role nurses play in the delivery of care and their unique opportunity and responsibility to identify potential medication safety issues. Reflecting the contributions of several dozen nurses who provided new and updated content, this book includes strategies, examples, and advice on how to: * Develop effective medication reconciliation processes * Identify and address causes of medication errors * Encourage the reporting of medication errors in a safe and just culture * Apply human factors solutions to medication management issues and the implementation of programs to reduce medication errors * Use technology (such as smart pumps and computerized provider order entry) to improve medication safety * Recognize the special issues of medication safety in disciplines such as obstetrics, pediatrics, geriatrics, and oncology and within program settings beyond large urban hospitals, including long term care, behavioral health care, critical access hospitals, and ambulatory care and office-based surgery How do people cope with having "caused" a terrible accident? How do they cope when they survive and have to live with the consequences ever after? We tend to blame and forget professionals who cause incidents and accidents, but they are victims too. They are second victims whose experiences of an incident or adverse event can be as traumatic as that of the first victims’. Yet information on second victimhood and its relationship to safety, about what is known and what organizations might need to do, is difficult to find. Thoroughly exploring an emerging topic with great relevance to safety culture, Second Victim: Error, Guilt, Trauma, and Resilience examines the lived experience of second victims. It goes through what we know about trauma, guilt, forgiveness, and injustice and how these might be felt by the second victim. The author discusses how to conduct investigations of incidents that do not alienate second victims or make them feel even worse. It explores the importance support and resilience and where the responsibilities for creating it may lie. Drawing on his unique background as psychologist, airline pilot, and safety specialist, and his own experiences with helping second victims from a variety of backgrounds, Sidney Dekker has written a powerful, moving account of the experience of the second victim. It forms compelling reading for practitioners, risk managers, human resources managers, safety experts, mental health workers, regulators, the judiciary, and many other professionals. Dekker provides a strong theoretical background to promote understanding of the situation of the second victim and solid practical advice about how to deal with trauma that continues after an event leading to preventable harm or even avoidable death of a patient, consumer, or colleague. Listen to Sidney Dekker speak about his book Drug Safety in Developing Countries: Achievements and Challenges provides comprehensive information on drug safety issues in developing countries. Drug safety practice in developing countries varies substantially from country to country. This can lead to a rise in adverse reactions and a lack of reporting can exasperate the situation and lead to negative medical outcomes. This book documents the history and development of drug safety systems, pharmacovigilance centers and activities in developing countries, describing their current situation and achievements of drug safety practice. Further, using extensive case studies, the book addresses the challenges of drug safety in developing countries. Provides a single resource for educators, professionals, researchers, policymakers, organizations and other readers with comprehensive information and a guide on drug safety related issues Describes current achievements of drug safety practice in developing countries Addresses the challenges of drug safety in developing countries Provides recommendations, including practical ways to implement strategies and overcome challenges surrounding drug safety The application of proper ethical systems and education programs is a vital concern in the medical industry. When healthcare professionals are held to the highest moral and training standards, patient care is improved. Healthcare Ethics and Training: Concepts, Methodologies, Tools, and Applications is a comprehensive source of academic research material on methods and techniques for implementing ethical standards and effective education initiatives in clinical settings. Highlighting pivotal perspectives on topics such as e-health, organizational behavior, and patient rights, this multi-volume work is ideally designed for practitioners, upper-level students, professionals, researchers, and academics interested in the latest developments within the healthcare industry. Contemporary Educational Researches: Theory and Practice in Education. How do I start my literature review? What sources can I go to for information? How do I analyse the work of others? This clear, practical book guides readers undertaking their own literature review through the process, giving them the skills and knowledge they need for success. The chapters address: - Different types of literature reviews - Critically analysing material - Presenting the final piece of work - Best practice in referencing and plagiarism - Systematic approaches to literature reviews It will be an essential guide for all nursing and all

allied healthcare students, as well as professionals working in practice. The Nursing - New Perspectives book covers nursing services and related topics of interest. The book includes innovative nursing services that will positively affect patient safety such as leadership in nursing, patient-nurse conflict, patient safety and medical errors, nurses' perspective, simulation, collaboration, communication and quality in care. Various experts from around the world have made valuable contributions to the book. I especially thank them. With these broad advanced topics covered in this particular book, no doubt the clinician, researcher, or any reader will find this book valuable in guiding them to grasp a new understanding and to keep up-to-date with information on nursing services. When conducting research, the author has become increasingly frustrated by citation and quotation errors. In a recently published book chapter, its author summarized a research study but cited a paper from a completely different study. This same author made citation errors within the reference list and obviously gleaned data from a secondary source without reading the original paper. As a result, the author questioned the accuracy of the entire chapter. Reference errors are not innocuous. Reference and quotation errors prolong the time needed to find a reference, damage an author's reputation, weaken a journal's credibility, disrespect the primary paper's author(s), and undermine clinical and research nursing literature. Furthermore, authors promulgate errors when they copy an inaccurate citation without verifying its content with the primary source. Investigators have confirmed the author's observations that reference errors are prevalent in nursing literature. Foreman and Kirchhoff (1987) were the first nurses to study the accuracy of reference citations. Using the lead article from the final 1983 issue of 65 clinical journal and 47 non-clinical journals, these investigators evaluated randomly selected references for accuracy. Reference errors occurred in 38.4% of the clinical journals and in 21.3% of the non-clinical journals. Schulmeister (1998) evaluated 60 published papers from three nursing journals and reported that 32% of 180 references contained citation errors. In a similar study of 262 references that were cited in three nursing research journals, Taylor (1998) reported an overall citation error rate of 45.8%. More recently, Lok, Chan, and Martinson (2001) reported that 43% of 550 references from 11 nursing journals contained citation errors. As a manuscript reviewer, the author now uses databases such as CINAHL or MEDLINE to check references. Seven strategies are presented to help nurse editors and reviewers detect errors before publication. This volume presents the papers from the 3rd International Conference on Technology in Health Care: Socio-technical Approaches held in Sydney, Australia in 2007. 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. This innovative reference examines how consumer health informatics (CHI) can transform healthcare systems stressed by staffing shortages and budget constraints and challenged by patients taking a more active role in their care. It situates CHI as vital to upgrading healthcare service delivery, detailing the relationship between health information technologies and quality healthcare, and outlining what stakeholders need to learn for health IT systems to function effectively. Wide-ranging content identifies critical issues and answers key questions at the consumer, practitioner, administration, and staff levels, using examples from diverse conditions, countries, technologies, and specialties. In this framework, the benefits of CHI are seen across service domains, from individual patients and consumers to healthcare systems and global health entities. Included in the coverage: Use of video technology in an aged care environment A context-aware remote health monitoring service for improved patient care Accessibility issues in interoperable sharing of electronic health records: physician's perspective Managing gestational diabetes with mobile web-based reporting of glucose readings An organizing vision perspective for developing and adopting e-health solutions An ontology of consumer health informatics Contemporary Consumer Health Informatics combines blueprint and idea book for public health and health informatics students, healthcare professionals, physicians, medical administrators, managers, and IT practitioners. Medical errors contribute significantly to morbidity and mortality across our healthcare institutions. Due to the increasing complexity of the modern medical practice, a perfect storm of regulatory, market, social, and technical factors, and other competing priorities, created an environment that is primed for patient safety lapses. The spectrum of contributing variables - ranging from minor errors that subsequently escalate, poor communication, and protocol/process non-compliance (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 on best practices and evidence-based medical principles - for healthcare organizations to develop, implement, and embrace. Based on the tremendous interest in the initial three volumes of our Vignettes in Patient Safety series, this fourth volume follows a similar model of outlining a patient safety case based on experiences that many clinicians can relate to, and then discusses various factors that may have contributed to a medical error, complication, and/or poor outcome. Building on a problem-based clinical vignette, each chapter then outlines an evidence-based approach to present any related literature, pertinent evidence, and potential contributing factors and solutions to common patient safety occurrences. By focusing on some of the best practices, structured experiences, and objective approaches to medical error genesis, the authors and editors hopefully can lend some insights into how we can make healthcare encounters for all patients, across all settings, better and safer. Precise and flawless medical practice is imperative due to the delicate nature of patient lives and health. Without methods and technologies to detect medical mistakes, many lives would be compromised. Impact of Medical Errors and Malpractice on Health Economics, Quality, and Patient Safety is an essential reference source for the latest research on the detection and analysis of the various implications of medical errors and addresses the hidden malpractices that exist in healthcare systems globally. Featuring extensive coverage on a broad range of topics such as clinical pathways, decision-making techniques, and health information technology, this book is ideally designed for practitioners, professionals, and researchers seeking current research on various issues in healthcare provision. "Appendix F_Nonresearch Evidence Appraisal Tool"--"Appendix G_Individual Evidence Summary Tool"--"Appendix H_Synthesis Process and Recommendations Tool" -- "Appendix I_Action Planning Tool" -- "Appendix J_Dissemination Tool Designed to support global development of nursing science, the Routledge International Handbook of Advanced Quantitative Methods in Nursing Research provides a new, comprehensive, and authoritative treatment of advanced quantitative methods for nursing research. Incorporating past approaches that have served as the foundation for the science, this cutting edge book also explores emerging approaches that will shape its future. Divided into six parts, it covers: -the domain of nursing science - measurement—classical test theory, IRT, clinimetrics, behavioral observation, biophysical measurement -models for prediction and explanation—SEM, general growth mixture models, hierarchical models, analysis of dynamic systems -intervention research—theory-based interventions, causality, third variables, pilot studies, quasi-experimental design, joint models for longitudinal data and time to event -e-science—DIKW paradigm, big data, data mining, omics, FMRI -special topics—comparative effectiveness and meta-analysis, patient safety, economics research in nursing, mixed methods, global research dissemination Written by a distinguished group of international nursing scientists,

scientists from related fields, and methodologists, the Handbook is the ideal reference for everyone involved in nursing science, whether they are graduate students, academics, editors and reviewers, or clinical investigators. This practical guide to pharmacology is unusual in its approach. Instead of examining the normal effects of drugs this book looks at the adverse effects. With the advent of nurse prescribing it is essential that nurses are familiar with the common adverse effects, how to recognise them and how to deal with them. The book is divided into three sections. The first examines the pharmacology of drugs i.e. what the body does to drugs (pharmocokinetics), what the drugs do to the body (pharmocodynamics), and how adverse reactions can result from these two processes. Section two looks at putting the scientific knowledge into action through an examination of nurse administration and prescribing, drug development and the issue of patient compliance and empowerment. Section three consists of twelve case studies which describe various scenarios in which there have been adverse drug effects. Throughout the book concepts are explained using examples so that the nurse can relate the concept of adverse effect to the drugs she is familiar with. Tired of medication reconciliation headaches? Your remedy is here! Inadequate reconciliation is a significant source of preventable medication errors nationwide. Most hospitals have implemented medication reconciliation plans, but are still struggling with obstacles such as lack of communication, resistance to change, and evolving standards and regulations. Is medication reconciliation a headache for your organization? It's been several years since The Joint Commission made medication reconciliation a National Patient Safety Goal, but it's not getting any easier, as facilities adopt electronic forms and The NPSG continues to evolve. Furthermore, since that time, they have made significant changes to the scoring and the goal itself. Medication Reconciliation: Practical Strategies and Tools for Joint Commission Compliance, Second Edition, gives you best practices, step-by-step guidance, forms, and advice to: - Reduce medication errors - Streamline the process - Boost compliance - Fine tune policies and tools - Address problem areas - Comply with the latest Joint Commission and CAMH standards With the help of this book and bonus CD-ROM, you will: - Learn from the best practices of your peers - Obtain buy-in from physicians and directors - Train staff in all areas - Build an effective team approach - Improve documentation - Gather quality data Who will benefit from this helpful resource? Hospitals Healthcare systems Pharmacies Quality improvement Patient Safety Survey Committee Chief Nursing Officer Director/VP of Nursing Quality Manager/Director Pharmacy staff/director Risk Manager Survey Committee leader/team member