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Patient Safety Culture Theory Methods And Application [PDF]
Find many great new & used options and get the best deals for Patient Safety Culture: Theory, Methods and Application by Taylor & Francis Ltd (Hardback, 2014) at the best online prices at eBay! Free delivery for many products!

How safe are hospitals? Why do some hospitals have higher rates of accident and errors involving patients? How can we accurately measure and assess staff attitudes towards safety? How can hospitals and other healthcare environments improve their safety culture and minimize harm to patients? These and other questions have been the focus of research within the area of Patient Safety Culture (PSC) in the last decade. More and more hospitals and healthcare managers are trying to understand the nature of the culture within their organisations and implement strategies for improving patient safety. The main purpose of this book is to provide researchers, healthcare managers and human factors practitioners with details of the latest developments within the theory and application of PSC within healthcare. It brings together contributions from the most prominent researchers and practitioners in the field of PSC and covers the background to work on safety culture (e.g. measuring safety culture in industries such as aviation and the nuclear industry), the dominant theories and concepts within PSC, examples of PSC tools, methods of assessment and their application, and details of the most prominent challenges for the future in the area. Patient Safety Culture: Theory, Methods and Application is essential reading for all of the professional groups involved in patient safety and healthcare quality improvement, filling an important gap in the current market.

Building on the revolutionary Institute of Medicine reports To Err is Human and Crossing the Quality Chasm, Keeping Patients Safe lays out guidelines for improving patient safety by changing nursesâ€™ working conditions and demands. Licensed nurses and unlicensed nursing assistants are critical participants in our national effort to protect patients from health care errors. The nature of the activities nurses typically perform â€" monitoring patients, educating home caretakers, performing treatments, and rescuing patients who are in crisis â€" provides an indispensable resource in detecting and remedying error-producing defects in the U.S. health care system. During the past two decades, substantial changes have been made in the organization and delivery of health care â€" and consequently in the job description and work environment of nurses. As patients are increasingly cared for as outpatients, nurses in hospitals and nursing homes deal with greater severity of illness. Problems in management practices, employee deployment, work and workspace design, and the basic safety culture of health care organizations place patients at further risk. This newest edition in the groundbreaking Institute of Medicine Quality Chasm series discusses the key aspects of the work environment for nurses and reviews the potential improvements in working conditions that are likely to have an impact on patient safety.

Background: Shared values, norms and beliefs of relevance for safety in health care can be described in terms of patient safety culture. This concept overlaps with patient safety climate, but culture represents the deeprooted values, norms and beliefs, whereas climate refers to attitudes and more

superficial manifestations of culture. There may be numerous subcultures within an organization, including different professional cultures. In recent years, increased attention has been paid to patient safety culture in Sweden, and the patient safety culture/climate in health care is regularly measured based on the assumption that patient safety culture/climate can influence various patient safety outcomes. Aim: The overall aim of the thesis is to contribute to an improved understanding of patient safety culture and subcultures in Swedish health care. Design and methods: The thesis is based on four studies applying different methods. Study 1 was a survey that included 23,781 respondents. Data were analysed with quantitative methods, with primarily descriptive results. Studies 2 and 3 were qualitative studies, involving interviews with a total of 28 registered nurses, 24 nurse assistants and 28 physicians. Interview data were analysed using content analysis. Study 4 evaluated an intervention intended to influence patient safety culture and included data from a questionnaire with both fixed and open-ended questions, which was answered by 200 respondents. Results: A key result from Study 1 was that professional groups differed in terms of their views and statements about patient safety culture/ climate. Registered nurses and nurse assistants in Study 2 were found to have partially overlapping norms, values and beliefs concerning patient safety, which were identified at individual, interpersonal and organizational level. Study 3 found four categories of values and norms among physicians of potential relevance for patient safety. Predominantly positive perceptions were found in Study 4 concerning the Walk Rounds intervention among frontline staff members, local managers and top-level managers who participated in the intervention. However, there were also reflections on disadvantages and some suggestions for improvement. Conclusions: According to the results of the patient safety culture/ climate questionnaire, perceptions about safety culture/climate dimensions contribute more to the rating of overall patient safety than background characteristics (e.g. profession and years of experience). There are differences in the patient safety culture between registered nurses and nurse assistants, which imply that efforts for improved patient safety must be tailored to their respective values, norms and beliefs. Several aspects of physicians' professional culture may have relevance for patient safety. Expectations of being infallible reduce their willingness to talk about errors they make, thus limiting opportunities for learning from errors. Walk Rounds are perceived to contribute to increased learning concerning patient safety and could potentially have a positive influence on patient safety culture.

How safe are hospitals? Why do some hospitals have higher rates of accident and errors involving patients? How can we accurately measure and assess staff attitudes towards safety? How can hospitals and other healthcare environments improve their safety culture and minimize harm to patients? These and other questions have been the focus of research within the area of Patient Safety Culture (PSC) in the last decade. More and more hospitals and healthcare managers are trying to understand the nature of the culture within their organisations and implement strategies for improving patient safety. The main purpose of this book is to provide researchers, healthcare managers and human factors practitioners with details of the latest developments within the theory and application of PSC within healthcare. It brings together contributions from the most prominent researchers and practitioners in the field of PSC and covers the background to work on safety culture (e.g. measuring safety culture in industries such as aviation and the nuclear industry), the dominant theories and concepts within PSC, examples of PSC tools, methods of assessment and their application, and details of the most prominent challenges for the future in the area. Patient Safety Culture: Theory, Methods and Application is essential reading for all of the professional groups involved in patient safety and healthcare quality improvement, filling an important gap in the current market.

This volume, developed by the Observatory together with OECD, provides an overall conceptual framework for understanding and applying strategies aimed at improving quality of care. Crucially, it summarizes available evidence on different quality strategies and provides recommendations for their implementation. This book is intended to help policy-makers to understand concepts of quality and to support them to evaluate single strategies and combinations of strategies.

Ergonomics and human factors is the discipline concerned with the application of scientifc knowledge to improve people‘s interaction with products, systems and environments. This book presents the proceedings of the international conference, Ergonomics and Human Factors 2015, the 29th year in which a volume in the Contemporary Ergonomics series has

A Wiley Blackwell Handbook of Organizational Psychology focusing on occupational safety and workplace health. The editors draw on their collective experience to present thematically structured material from leading thinkers and practitioners in the USA, Europe, and Asia Pacific Provides comprehensive coverage of the major contributions that psychology can make toward the improvement of workplace safety and employee health Equips those who need it most with cutting-edge research on key topics including wellbeing, safety culture, safety leadership, stress, bullying, workplace health promotion and proactivity

The objective of this book is to help at-risk organizations to decipher the “safety cloud”, and to position themselves in terms of operational decisions and improvement strategies in safety, considering the path already travelled, their context, objectives and constraints. What link can be established between safety culture and safety models in order to increase safety within companies carrying out dangerous activities? First, while the term “safety culture” is widely shared among the academic and industrial world, it leads to various interpretations and therefore different positioning when it comes to assess, improve or change it. Many safety theories, concepts, and models coexist today, being more or less appealing and/or directly useful to the industry. How, and based on which criteria, to choose from the available options? These are some of the questions addressed in this book, which benefits from the

expertise of its worldwide famous authors in several industrial sectors.

Leading Reliable Healthcare describes ‘state of the art’ healthcare management systems. The key focus of the publication is ‘reliable’; describing how leadership can ensure never less than reliable standards of care for patients and how excellence can be achieved. The focus throughout is on ensuring that patients and their families can depend on a reliable healthcare system for their needs, fulfilling their expectations that hospitals are trustworthy, stable and capable of dealing with their health, from the simplest to the most complex illnesses. Each of the chapters focuses on a different aspect of building a reliable healthcare system, concentrating on the leadership necessary to deliver and manage the different component elements of the healthcare system. The nominated contributors for this book are recognized leaders from various healthcare systems around the globe, including the UK, USA, Canada and South Korea/Singapore. The contributors have been selected to ensure a wide perspective of healthcare management, building on diverse approaches, practices and experiences, and are currently practicing healthcare management in their respective systems. The book aims to focus on the pragmatic rather than theoretical and will provide a series of practical methodologies and case studies to help improve decision making in healthcare management. With contributions by: Sallie J. Weaver, PhD, MHS, Associate Professor, Armstrong Institute for Patient Safety and Quality and Dept. of Anesthesiology & Critical Care Medicine, John Hopkins University School of Medicine Susan Mascitelli, Senior Vice President, Patient Services & Liaison to the Board of Trustees, New York-Presbyterian Hospital Dr. Sandra Fenwick, Chief Executive Officer, Boston Children’s Hospital Martin A. Makary, MD, MPH, Professor of Surgery, Johns Hopkins University School of Medicine; Professor of Health Policy and Management, John Hopkins Bloomberg School of Public Health Frank Federico, RPh, Vice President, Institute for Healthcare Improvement Dr. Hanan Edrees, Manager, Quality Management, KAMC-Riyadh Dr. Hee Hwang, CIO and Associate Professor; Seoul National University Bundang Hospital, Department of Pediatrics, Division of pediatric Neurology, Center of Medical Informatics Dr. M. Andrew Padmos, Chief Executive Officer, The Royal College of Physicians and Surgeons of Canada Professor Richard Hobbs, Professor of Primary Care Health Sciences, Director, NIHR English School for Primary Care Research, Nuffield Department of Primary Care Health Sciences, University of Oxford Ms. Jules Martin, Managing Director, Central London Clinical Commissioning Group Dr. Bruno Holthof, Chief Executive Officer, Oxford University Hospitals Tara Donnelly, Chief Executive, Health Innovation Network, South London Göran Henriks, Chief Executive of Learning and Innovation, Qulturum, County Council of Jönköping, Sweden

This volume delves into the potential that design thinking can have when applied to organizational systems and structures in health care environments to mitigate risks, reduce medical errors and ultimately improve patient safety, the quality of care, provider well-being, and the overall patient experience.