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[1]

Ash, J.S. et al. 2003. Some Unintended Consequences of Information Technology in Health Care: The Nature of Patient Care Information System-related Errors. Journal of the American Medical Informatics Association. 11, 2 (Nov. 2003), 104–112. DOI:https://doi.org/10.1197/jamia.M1471.

[2]

Astrand, B. et al. 2009. Assessment of ePrescription quality: an observational study at three mail-order pharmacies. BMC Medical Informatics and Decision Making. 9, 1 (2009). DOI:https://doi.org/10.1186/1472-6947-9-8.

[3]

Avery, A.J. et al. 2007. Improving general practice computer systems for patient safety: qualitative study of key stakeholders. Quality and Safety in Health Care. 16, 1 (Feb. 2007), 28–33. DOI:https://doi.org/10.1136/qshc.2006.018192.

[4]

Baker, D.P. et al. 2003. Literature Review: Medical Teamwork and Patient Safety: The Evidence-based Relation.

[5]

Baker, G.R. et al. 2004. The Canadian Adverse Events Study: the incidence of adverse events among hospital patients in Canada. Canadian Medical Association Journal. 170, 11 (May 2004), 1678–1686. DOI:https://doi.org/10.1503/cmaj.1040498.

[6]

Bark, P. et al. 1997. Impact of litigation on senior clinicians: implications for risk management. Quality and Safety in Health Care. 6, 1 (Mar. 1997), 7–13. DOI:https://doi.org/10.1136/qshc.6.1.7.

[7]

Beatty, P. 2005. Chapter of PATIENT SAFETY: RESEARCH INTO PRACTICE: 'Technology, informatics and patient safety'. PATIENT SAFETY: RESEARCH INTO PRACTICE. OPEN UNIVERSITY.

[8]

Beatty, P. 2006. Chapter of Patient safety: 'Technology, informatics and patient safety'. Patient safety. Open University Press.

[9]

Black, A.D. et al. 2011. The Impact of eHealth on the Quality and Safety of Healthcare.

[10]

Brennan, T.A. et al. 2004. Incidence of adverse events and negligence in hospitalized patients: results of the Harvard Medical Practice Study I. Quality and Safety in Health Care. 13, 2 (Apr. 2004), 145–151. DOI:https://doi.org/10.1136/qshc.2002.003822.

[11]

Carpenter, K.B. et al. 2010. Measures of patient safety in developing and emerging countries: a review of the literature. Quality and Safety in Health Care. 19, 1 (Feb. 2010), 48–54. DOI:https://doi.org/10.1136/qshc.2008.031088.

[12]

Chung, K. et al. 2003. Journal of Medical Systems, Volume 27, Number 6 - SpringerLink. Journal of Medical Systems. 27, 6 (2003), 553–560. DOI:https://doi.org/10.1023/A:1025937916203.

[13]

Coiera, E. et al. 2006. The Safety and Quality of Decision Support Systems. IMIA Yearbook 2006: Assessing Information - Technologies for Health . 1, (2006), 20–25.

[14]

Colligan, L. et al. 2010. Does the process map influence the outcome of quality improvement work? A comparison of a sequential flow diagram and a hierarchical task analysis diagram. BMC Health Services Research. 10, 1 (2010). DOI:https://doi.org/10.1186/1472-6963-10-7.

[15]

Colligan, L. et al. 2010. Does the process map influence the outcome of quality improvement work? A comparison of a sequential flow diagram and a hierarchical task analysis diagram. BMC Health Services Research. 10, 1 (2010). DOI:https://doi.org/10.1186/1472-6963-10-7.

[16]

Dekker, S. 2007. Just culture: balancing safety and accountability. Ashgate.

[17]

Dekker, S. 2007. Just culture: balancing safety and accountability. Ashgate.

[18]

Department of Health 16AD. Coding for Success: Simple technology for safer patient care.

[19]

Department of Health Expert Group (Chairman, CMO) 13AD. An Organisation with a Memory (OWAM). The Stationery Office Limited.

[20]

DeRosier, J. et al. 2002. Using Healthcare Failure Modes and Effects AnalysisSM: The VA National Center for Patient Safety's Prospective Risk Analysis System. The Joint Commission Journal on Quality Improvement. 27, 5 (2002), 248–267.

[21]

Dimond, B. 2011. Legal aspects of nursing. Pearson.

[22]

Dineen, M. and Bartlett, R. Six Steps to Root Cause Analysis: Amazon.co.uk:: Books.

[23]

Evans, S.M. et al. 2007. Evaluation of an intervention aimed at improving voluntary incident reporting in hospitals. Quality and Safety in Health Care. 16, 3 (Jun. 2007), 169–175. DOI:https://doi.org/10.1136/qshc.2006.019349.

[24]

Finkelstein, A.; Dowell, J. 1996. A comedy of errors: the London Ambulance Service case study. (Summer 1996).

[25]

Gawande, Atul 2010. The checklist manifesto: how to get things right. Profile.

[26]

Huckvale, C. et al. 2010. Information technology for patient safety. Quality and Safety in Health Care. 19, Suppl 2 (Aug. 2010), i25-i33. DOI:https://doi.org/10.1136/qshc.2009.038497.

[27]

Isaac, T. et al. 2009. Overrides of Medication Alerts in Ambulatory Care. Archives of Internal Medicine. 169, 3 (Feb. 2009), 305–311. DOI:https://doi.org/10.1001/archinternmed.2008.551.

[28]

Joint Commission International Failure Mode and Effects Analysis in Health Care: Proactive Risk Reduction.

[29]

Julianne M., RN, MS Morath and Joanne E., PHD Turnbull To Do No Harm. Jossey-Bass.

[30]

Karsh, B.-T. 2004. Beyond usability: designing effective technology implementation systems to promote patient safety. Quality and Safety in Health Care. 13, 5 (Oct. 2004), 388–394. DOI:https://doi.org/10.1136/qshc.2004.010322.

[31]

Kirwan, B. and Ainsworth, L. K. 1992. A guide to task analysis. Taylor & Francis.

[32]

Kuehn, B.M. 2009. IT Vulnerabilities Highlighted by Errors, Malfunctions at Veterans' Medical Centers. JAMA. 301, 9 (Mar. 2009). DOI:https://doi.org/10.1001/jama.2009.239.

[33]

Kuehn, B.M. 2009. IT Vulnerabilities Highlighted by Errors, Malfunctions at Veterans' Medical Centers. JAMA: The Journal of the American Medical Association. 301, 9 (Mar. 2009), 919–920. DOI:https://doi.org/10.1001/jama.2009.239.

[34]

Leape, L.L. 2009. Errors in medicine. Clinica Chimica Acta. 404, 1 (Jun. 2009), 2–5. DOI:https://doi.org/10.1016/j.cca.2009.03.020.

[35]

Mollon, B. et al. 2009. Features predicting the success of computerized decision support for prescribing: a systematic review of randomized controlled trials. BMC Medical Informatics and Decision Making. 9, 1 (2009). DOI:https://doi.org/10.1186/1472-6947-9-11.

[36]

National Advisory Group on the Safety of Patients in England 2013. A promise to learn – a commitment to act: improving the safety of patients in England ('the Berwick review into patient safety'). UK Department of Health.

[37]

Nicolini, D. et al. 2011. The challenges of undertaking root cause analysis in health care: a qualitative study. Journal of Health Services Research & Policy. 16, Supplement 1 (Apr. 2011), 34–41. DOI:https://doi.org/10.1258/jhsrp.2010.010092.

[38]

Perla, R.J. et al. 2013. Whole-Patient Measure of Safety: Using Administrative Data to Assess the Probability of Highly Undesirable Events During Hospitalization. Journal for Healthcare Quality. 35, 5 (Sep. 2013), 20–31. DOI:https://doi.org/10.1111/jhq.12027.

[39]

Pham, J.C. et al. 2010. The harm susceptibility model: a method to prioritise risks identified in patient safety reporting systems. Quality and Safety in Health Care. 19, 5 (Apr. 2010), 440–445. DOI:https://doi.org/10.1136/qshc.2009.035444.

[40]

Potts, H.W. et al. 2014. Assessing the validity of prospective hazard analysis methods: a comparison of two techniques. BMC Health Services Research. 14, 1 (2014). DOI:https://doi.org/10.1186/1472-6963-14-41.

[41]

Power, M. et al. 2014. Learning from the design and development of the NHS Safety Thermometer. International Journal for Quality in Health Care. (Apr. 2014). DOI:https://doi.org/10.1093/intqhc/mzu043.

[42]

Reason, J. T. 1997. Managing the risks of organizational accidents. Ashgate.

[43]

Redwood, S. et al. 2011. Does the implementation of an electronic prescribing system create unintended medication errors? A study of the sociotechnical context through the analysis of reported medication incidents. BMC Medical Informatics and Decision Making. 11, 1 (2011). DOI:https://doi.org/10.1186/1472-6947-11-29.

[44]

Reynard, John et al. 2009. Chapter 3 of Practical patient safety: 'Safety Culture in high reliability organizations'. Practical patient safety. Oxford University Press.

[45]

Reynard, John et al. 2009. Practical patient safety. Oxford University Press.

[46]

Reynard, John et al. 2009. Practical patient safety. Oxford University Press.

[47]

Rhona H. Flin et al. 2007. Safety at the sharp end. Ashgate.

[48]

Robert M. Wachter Understanding Patient Safety. McGraw-Hill Professional.

[49]

Runciman, Bill et al. 2007. Chapter of Safety and ethics in healthcare: a guide to getting it right: 'Naming, blaming and shaming'. Safety and ethics in healthcare: a guide to getting it

right. Ashgate.

[50]

Runciman, W.B. et al. 2006. An integrated framework for safety, quality and risk management: an information and incident management system based on a universal patient safety classification. Quality and Safety in Health Care. 15, suppl_1 (Dec. 2006), i82-i90. DOI:https://doi.org/10.1136/gshc.2005.017467.

[51]

Runciman, W.B. et al. 2010. Tracing the foundations of a conceptual framework for a patient safety ontology. Quality and Safety in Health Care. 19, 6 (Aug. 2010), 1–5. DOI:https://doi.org/10.1136/qshc.2009.035147.

[52]

Sari, A.B.-A. et al. 2007. Sensitivity of routine system for reporting patient safety incidents in an NHS hospital: retrospective patient case note review. BMJ. 334, 7584 (Jan. 2007), 79–79. DOI:https://doi.org/10.1136/bmj.39031.507153.AE.

[53]

Stauch, M. and Wheat, K. 2011. Text, cases and materials on medical law and ethics. Routledge.

[54]

Sweidan, M. et al. 2011. Evaluation of features to support safety and quality in general practice clinical software. BMC Medical Informatics and Decision Making. 11, 1 (2011). DOI:https://doi.org/10.1186/1472-6947-11-27.

[55]

Thomas, E.J. et al. Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado. Medical Care. 38, 3.

[56]

Tingle, J. and Bark, P. 2011. Chapter 2. Patient Safety, Law Policy and Practice.

[57]

Tingle, J. and Bark, P. Chapter 3. Patient Safety, Law Policy and Practice.

[58]

Tingle, J. and Bark, P. 2011. Chapter of Patient Safety, Law Policy and Practice: 'Psychological Aspects of Patient Safety'. Patient Safety, Law Policy and Practice.

[59]

Vincent, C. et al. 2001. Adverse events in British hospitals: preliminary retrospective record review. BMJ. 322, 7285 (Mar. 2001), 517–519. DOI:https://doi.org/10.1136/bmj.322.7285.517.

[60]

Vincent, Charles 2010. Chapter 1 of Patient Safety. Patient safety. Wiley-Blackwell.

[61]

Vincent, Charles 2010. Chapter 2. Patient safety. Wiley-Blackwell.

[62]

Vincent, Charles 2010. Chapter 4. Patient safety. Wiley-Blackwell.

[63]

Vincent, Charles 2010. Chapter 5. Patient safety. Wiley-Blackwell.

[64]

Vincent, Charles 2010. Chapter 5. Patient safety. Wiley-Blackwell.

[65] Vincent, Charles 2010. Chapter 6. Patient safety. Wiley-Blackwell. [66] Vincent, Charles 2010. Chapter 7. Patient safety. Wiley-Blackwell. [67] Vincent, Charles 2010. Chapter 8. Patient safety. Wiley-Blackwell. [68] Vincent, Charles 2010. Chapter 9. Patient safety. Wiley-Blackwell. [69] Vincent, Charles 2010. Chapter 10. Patient safety. Wiley-Blackwell. [70] Vincent, Charles 2010. Chapter 11. Patient safety. Wiley-Blackwell. [71] Vincent, Charles 2010. Chapter 12. Patient safety. Wiley-Blackwell. [72] Vincent, Charles 2010. Chapter 13. Patient safety. Wiley-Blackwell.

[73]

Vincent, Charles 2010. Chapter 14. Patient safety. Wiley-Blackwell.

[74]

Vincent, Charles 2010. Chapter 20. Patient safety. Wiley-Blackwell.

[75]

Vincent, Charles 2010. Chapter of 6 Patient safety. Patient safety. Wiley-Blackwell.

[76]

Vincent, Charles 2001. Clinical risk management: enhancing patient safety. BMJ Books.

[77]

Vincent, Charles 2010. Patient safety. Wiley-Blackwell.

[78]

de Vries, E.N. et al. 2008. The incidence and nature of in-hospital adverse events: a systematic review. Quality and Safety in Health Care. 17, 3 (Jun. 2008), 216–223. DOI:https://doi.org/10.1136/qshc.2007.023622.

[79]

Walsh, K. and Boaden, K. 2006. Patient Safety: Research into Practice. Open University Press.

[80]

Wang, Y. et al. 2014. National Trends in Patient Safety for Four Common Conditions, 2005–2011. New England Journal of Medicine. 370, 4 (Jan. 2014), 341–351. DOI:https://doi.org/10.1056/NEJMsa1300991.

[81]

Wears, R.L. 2015. "Just a Few Seconds of Your Time..." at Least 130 Million Times a Year. Annals of Emergency Medicine. 65, 6 (Jun. 2015), 687–689. DOI:https://doi.org/10.1016/j.annemergmed.2015.02.006.

[82]

Wu, A.W. et al. 2003. Do house officers learn from their mistakes? Quality and Safety in Health Care. 12, >3 (Jun. 2003), 221–226. DOI:https://doi.org/10.1136/qhc.12.3.221.

[83]

17AD. Building a safer NHS for patients - implementing an organisation with a memory.

[84]

17AD. Building a safer NHS for patients - implementing an organisation with a memory.

[85]

2009. Conceptual Framework for the International Classification for Patient Safety. WHO.

[86]

2009. Conceptual Framework for the International Classification for Patient Safety. WHO.

[87]

Department of Health-a Safer Place for Patients. Stationery Office.

[88]

2006. Manchester Patient Safety Framework (MaPSaF).

[89]

9AD. Right patient, right blood: advice for safer blood transfusions.