CHMEGH29: Patient Safety and Clinical Risk

View Online

1.

Vincent, Charles. Patient Safety. 2nd ed. Wiley-Blackwell; 2010.

2.

Vincent, Charles. Clinical Risk Management: Enhancing Patient Safety. 2nd ed. BMJ Books; 2001.

3.

Rhona H. Flin, O'Connor P, Crichton M. Safety at the Sharp End. Ashgate; 2007.

4.

Reynard, John, Stevenson, Peter, Reynolds, John. Practical Patient Safety. Oxford University Press; 2009.

5.

Department of Health Expert Group (Chairman, CMO). An Organisation with a Memory (OWAM). Published online 13AD.

6.

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

7.

Manchester Patient Safety Framework (MaPSaF). Published online 1 January 2006.

8.

National Advisory Group on the Safety of Patients in England. A promise to learn – a commitment to act: improving the safety of patients in England ('the Berwick review into patient safety'). Published online 6 August 2013. https://www.gov.uk/government/publications/berwick-review-into-patient-safety

9.

Vincent, Charles. Chapter 1 of Patient Safety. In: Patient Safety. 2nd ed. Wiley-Blackwell; 2010.

10.

Vincent, Charles. Chapter 2. In: Patient Safety. 2nd ed. Wiley-Blackwell; 2010.

11.

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

12.

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

13.

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

14.

Reynard, John, Stevenson, Peter, Reynolds, John. Practical Patient Safety. Oxford University Press; 2009.

15.

Dekker S. Just Culture: Balancing Safety and Accountability. Ashgate; 2007.

16.

de Vries EN, Ramrattan MA, Smorenburg SM, Gouma DJ, Boermeester MA. The incidence and nature of in-hospital adverse events: a systematic review. Quality and Safety in Health Care. 2008;17(3):216-223. doi:10.1136/qshc.2007.023622

17.

Conceptual Framework for the International Classification for Patient Safety. Published online 2009.

18.

Brennan TA, Leape LL, Laird NM, et al. Incidence of adverse events and negligence in hospitalized patients: results of the Harvard Medical Practice Study I. Quality and Safety in Health Care. 2004;13(2):145-151. doi:10.1136/qshc.2002.003822

19.

Perla RJ, Hohmann SF, Annis K. Whole-Patient Measure of Safety: Using Administrative Data to Assess the Probability of Highly Undesirable Events During Hospitalization. Journal for Healthcare Quality. 2013;35(5):20-31. doi:10.1111/jhq.12027

20.

Sari ABA, Sheldon TA, Cracknell A, Turnbull A. Sensitivity of routine system for reporting patient safety incidents in an NHS hospital: retrospective patient case note review. BMJ. 2007;334(7584):79-79. doi:10.1136/bmj.39031.507153.AE

21.

Vincent C, Neale G, Woloshynowych M. Adverse events in British hospitals: preliminary retrospective record review. BMJ. 2001;322(7285):517-519. doi:10.1136/bmj.322.7285.517

22.

Baker GR, Norton P, Flintoft V. The Canadian Adverse Events Study: the incidence of adverse events among hospital patients in Canada. Canadian Medical Association Journal. 2004;170(11):1678-1686. doi:10.1503/cmaj.1040498

23.

Thomas EJ, Studdert DM, Burstin HR, et al. Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado. Medical Care. 38(3).

24.

Carpenter KB, Duevel MA, Lee PW, et al. Measures of patient safety in developing and emerging countries: a review of the literature. Quality and Safety in Health Care. 2010;19(1):48-54. doi:10.1136/qshc.2008.031088

25.

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

26.

Wang Y, Eldridge N, Metersky ML, et al. National Trends in Patient Safety for Four Common Conditions, 2005–2011. New England Journal of Medicine. 2014;370(4):341-351. doi:10.1056/NEJMsa1300991

27.

Kuehn BM. IT Vulnerabilities Highlighted by Errors, Malfunctions at Veterans' Medical Centers. JAMA. 2009;301(9). doi:10.1001/jama.2009.239

28.

Bark P, Vincent C, Olivieri L, Jones A. Impact of litigation on senior clinicians: implications for risk management. Quality and Safety in Health Care. 1997;6(1):7-13. doi:10.1136/qshc.6.1.7

29.

Wu AW, Folkman S, McPhee S, Lo B. Do house officers learn from their mistakes? Quality and Safety in Health Care. 2003;12(>3):221-226. doi:10.1136/qhc.12.3.221

30.

Vincent, Charles. Chapter 4. In: Patient Safety. 2nd ed. Wiley-Blackwell; 2010.

31.

Vincent, Charles. Chapter 9. In: Patient Safety. 2nd ed. Wiley-Blackwell; 2010.

32.

Vincent, Charles. Chapter 10. In: Patient Safety. 2nd ed. Wiley-Blackwell; 2010.

33.

Leape LL. Errors in medicine. Clinica Chimica Acta. 2009;404(1):2-5. doi:10.1016/j.cca.2009.03.020

34.

Conceptual Framework for the International Classification for Patient Safety. Published online 2009.

35.

Power M, Fogarty M, Madsen J, et al. Learning from the design and development of the NHS Safety Thermometer. International Journal for Quality in Health Care. Published online 30 April 2014. doi:10.1093/intqhc/mzu043

36.

Beatty P. Chapter of PATIENT SAFETY: RESEARCH INTO PRACTICE: 'Technology,

informatics and patient safety'. In: PATIENT SAFETY: RESEARCH INTO PRACTICE. OPEN UNIVERSITY; 2005.

37.

Vincent, Charles. Chapter 5. In: Patient Safety. 2nd ed. Wiley-Blackwell; 2010.

38.

Vincent, Charles. Chapter of 6 Patient safety. In: Patient Safety. 2nd ed. Wiley-Blackwell; 2010.

39.

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

40.

Reason, J. T. Managing the Risks of Organizational Accidents. Ashgate; 1997.

41.

Vincent, Charles. Chapter 6. In: Patient Safety. 2nd ed. Wiley-Blackwell; 2010.

42.

Vincent, Charles. Chapter 7. In: Patient Safety. 2nd ed. Wiley-Blackwell; 2010.

43.

Vincent, Charles. Chapter 14. In: Patient Safety. 2nd ed. Wiley-Blackwell; 2010.

44.

Potts HW, Anderson JE, Colligan L, Leach P, Davis S, Berman J. Assessing the validity of prospective hazard analysis methods: a comparison of two techniques. BMC Health

Services Research. 2014;14(1). doi:10.1186/1472-6963-14-41

45.

Colligan L, Anderson JE, Potts HWW, Berman J. 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. 2010;10(1). doi:10.1186/1472-6963-10-7

46.

Dekker S. Just Culture: Balancing Safety and Accountability. Ashgate; 2007.

47.

Pham JC, Colantuoni E, Dominici F, et al. The harm susceptibility model: a method to prioritise risks identified in patient safety reporting systems. Quality and Safety in Health Care. 2010;19(5):440-445. doi:10.1136/qshc.2009.035444

48.

Evans SM, Smith BJ, Esterman A, et al. Evaluation of an intervention aimed at improving voluntary incident reporting in hospitals. Quality and Safety in Health Care. 2007;16(3):169-175. doi:10.1136/qshc.2006.019349

49.

Runciman WB, Williamson JAH, Deakin A, Benveniste KA, Bannon K, Hibbert PD. 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. 2006;15(suppl_1):i82-i90. doi:10.1136/qshc.2005.017467

50.

Runciman, Bill, Merry, Alan, Walton, Merrilyn. Chapter of Safety and ethics in healthcare: a guide to getting it right: 'Naming, blaming and shaming'. In: Safety and Ethics in Healthcare: A Guide to Getting It Right. Ashgate; 2007.

51.

Vincent, Charles. Chapter 5. In: Patient Safety. 2nd ed. Wiley-Blackwell; 2010.

52.

Vincent, Charles. Chapter 8. In: Patient Safety. 2nd ed. Wiley-Blackwell; 2010.

53.

Nicolini D, Waring J, Mengis J. The challenges of undertaking root cause analysis in health care: a qualitative study. Journal of Health Services Research & Policy. 2011;16(Supplement 1):34-41. doi:10.1258/jhsrp.2010.010092

54.

DeRosier J, Stalhandske E, Bagian JP, Nudell T. 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. 2002;27(5):248-267.

55.

Colligan L, Anderson JE, Potts HWW, Berman J. 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. 2010;10(1). doi:10.1186/1472-6963-10-7

56.

Dineen M, Bartlett R. Six Steps to Root Cause Analysis: Amazon.Co.Uk: : Books.

57.

Joint Commission International. Failure Mode and Effects Analysis in Health Care: Proactive Risk Reduction. 3rd ed.

58.

Kirwan, B., Ainsworth, L. K. A Guide to Task Analysis. Taylor & Francis; 1992.

59.

Dimond B. Legal Aspects of Nursing. Pearson; 2011.

60.

Stauch M, Wheat K. Text, Cases and Materials on Medical Law and Ethics. Routledge; 2011.

61.

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

62.

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

63.

Gawande, Atul. The Checklist Manifesto: How to Get Things Right. Profile; 2010. https://search-ebscohost-com.libproxy.ucl.ac.uk/login.aspx?direct=true&AuthType=ip,shib&db=nlebk&AN=1369183&site=ehost-live&scope=site&custid=s8454451

64.

Baker DP, Gustafson S, Beaubien J, Salas E, Barach P. Literature Review: Medical Teamwork and Patient Safety: The Evidence-based Relation. Published online 2003.

65.

Reynard, John, Stevenson, Peter, Reynolds, John. Chapter 3 of Practical patient safety: ‘Safety Culture in high reliability organizations’. In: Practical Patient Safety. Oxford University Press; 2009.

66.

Vincent, Charles. Chapter 11. In: Patient Safety. 2nd ed. Wiley-Blackwell; 2010.

67.

Vincent, Charles. Chapter 12. In: Patient Safety. 2nd ed. Wiley-Blackwell; 2010.

68.

Vincent, Charles. Chapter 20. In: Patient Safety. 2nd ed. Wiley-Blackwell; 2010.

69.

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

70.

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

71.

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

72.

Beatty P. Chapter of Patient safety: ‘Technology, informatics and patient safety’. In: Patient Safety. Open University Press; 2006.

73.

Runciman WB, Baker GR, Michel P, et al. Tracing the foundations of a conceptual framework for a patient safety ontology. Quality and Safety in Health Care. 2010;19(6):1-5. doi:10.1136/qshc.2009.035147

74.

Huckvale C, Car J, Akiyama M, et al. Information technology for patient safety. Quality and Safety in Health Care. 2010;19(Suppl 2):i25-i33. doi:10.1136/qshc.2009.038497

75.

Karsh BT. Beyond usability: designing effective technology implementation systems to promote patient safety. Quality and Safety in Health Care. 2004;13(5):388-394. doi:10.1136/qshc.2004.010322

76.

Vincent, Charles. Chapter 13. In: Patient Safety. 2nd ed. Wiley-Blackwell; 2010.

77.

Coiera E, Westbrook J. I. , Wyatt JC. The Safety and Quality of Decision Support Systems. IMIA Yearbook 2006: Assessing Information - Technologies for Health . 2006;1:20-25.

78.

Avery AJ, Savelyich BSP, Sheikh A, Morris CJ, Bowler I, Teasdale S. Improving general practice computer systems for patient safety: qualitative study of key stakeholders. Quality and Safety in Health Care. 2007;16(1):28-33. doi:10.1136/qshc.2006.018192

79.

Chung K, Choi YB, Moon S. Journal of Medical Systems, Volume 27, Number 6 - SpringerLink. Journal of Medical Systems. 2003;27(6):553-560. doi:10.1023/A:1025937916203

80.

Ash JS, Berg M, Coiera E. 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. 2003;11(2):104-112. doi:10.1197/jamia.M1471

81.

Black AD, Car J, Cresswell K, et al. The Impact of eHealth on the Quality and Safety of Healthcare. Published online 2011.

82.

Kuehn BM. IT Vulnerabilities Highlighted by Errors, Malfunctions at Veterans' Medical Centers. JAMA: The Journal of the American Medical Association. 2009;301(9):919-920. doi:10.1001/jama.2009.239

83.

Mollon B, Chong JJ, Holbrook AM, Sung M, Thabane L, Foster G. Features predicting the success of computerized decision support for prescribing: a systematic review of randomized controlled trials. BMC Medical Informatics and Decision Making. 2009;9(1). doi:10.1186/1472-6947-9-11

84.

Åstrand B, Montelius E, Petersson G, Ekedahl A. Assessment of ePrescription quality: an observational study at three mail-order pharmacies. BMC Medical Informatics and Decision Making. 2009;9(1). doi:10.1186/1472-6947-9-8

85.

Isaac T, Weissman JS, Davis RB, et al. Overrides of Medication Alerts in Ambulatory Care. Archives of Internal Medicine. 2009;169(3):305-311. doi:10.1001/archinternmed.2008.551

86.

Redwood S, Rajakumar A, Hodson J, Coleman JJ. 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. 2011;11(1). doi:10.1186/1472-6947-11-29

87.

Sweidan M, Williamson M, Reeve JF, et al. Evaluation of features to support safety and

quality in general practice clinical software. BMC Medical Informatics and Decision Making. 2011;11(1). doi:10.1186/1472-6947-11-27

88.

Wears RL. "Just a Few Seconds of Your Time..." at Least 130 Million Times a Year. Annals of Emergency Medicine. 2015;65(6):687-689. doi:10.1016/j.annemergmed.2015.02.006

89.

Finkelstein, A.; Dowell, J. A comedy of errors: the London Ambulance Service case study. Published online 3 Summer 1996. http://dl.acm.org/citation.cfm?id=858287