CHMEGH29: Patient Safety and Clinical Risk

Ash, J. S., M Berg, and E Coiera. 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): 104–12. https://doi.org/10.1197/jamia.M1471.

Åstrand, Bengt, Emelie Montelius, Göran Petersson, and Anders Ekedahl. 2009. 'Assessment of ePrescription Quality: An Observational Study at Three Mail-Order Pharmacies'. BMC Medical Informatics and Decision Making 9 (1). https://doi.org/10.1186/1472-6947-9-8.

Avery, A. J, B. S P Savelyich, A. Sheikh, C. J Morris, I. Bowler, and S. Teasdale. 2007. 'Improving General Practice Computer Systems for Patient Safety: Qualitative Study of Key Stakeholders'. Quality and Safety in Health Care 16 (1): 28–33. https://doi.org/10.1136/qshc.2006.018192.

Baker, David P. , Sigrid Gustafson, Jeff Beaubien, Eduardo Salas, and Paul Barach. 2003. 'Literature Review: Medical Teamwork and Patient Safety: The Evidence-Based Relation'. Baker, G. R., PG Norton, and V Flintoft . 2004. 'The Canadian Adverse Events Study: The Incidence of Adverse Events among Hospital Patients in Canada'. Canadian Medical Association Journal 170 (11): 1678–86. https://doi.org/10.1503/cmaj.1040498.

Bark, P, C Vincent, L Olivieri, and A Jones. 1997. 'Impact of Litigation on Senior Clinicians: Implications for Risk Management.' Quality and Safety in Health Care 6 (1): 7–13. https://doi.org/10.1136/qshc.6.1.7.

Beatty, P. 2005. 'Chapter of PATIENT SAFETY: RESEARCH INTO PRACTICE: "Technology, Informatics and Patient Safety"'. In PATIENT SAFETY: RESEARCH INTO PRACTICE. BUCKINGHAM: OPEN UNIVERSITY.

———. 2006. 'Chapter of Patient Safety: "Technology, Informatics and Patient Safety"'. In Patient Safety. Maidenhead, England: Open University Press.

Black, Ashly D. , Josip Car, Kathrin Cresswell, Akiko Hemmi, Azeem Majeed, Susannah McLean, Brian McKinstry, et al. 2011. 'The Impact of eHealth on the Quality and Safety of Healthcare'.

Brennan, T A, L L Leape, N M Laird, L Hebert, A R Localio, A G Lawthers, J P Newhouse, P C Weiler, and H H Hiatt. 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): 145–51. https://doi.org/10.1136/qshc.2002.003822.

'Building a Safer NHS for Patients - Implementing an Organisation with a Memory'. 17ADa.

'———'. 17ADb.

Carpenter, K B, M A Duevel, P W Lee, A W Wu, D W Bates, W B Runciman, G R Baker, I Larizgoitia, and W B Weeks. 2010. 'Measures of Patient Safety in Developing and Emerging Countries: A Review of the Literature'. Quality and Safety in Health Care 19 (1): 48–54. https://doi.org/10.1136/qshc.2008.031088.

Chung, Kyusuk, Young B. Choi, and Sangho Moon. 2003. 'Journal of Medical Systems, Volume 27, Number 6 - SpringerLink'. Journal of Medical Systems 27 (6): 553–60. https://doi.org/10.1023/A:1025937916203.

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

Colligan, Lacey, Janet E Anderson, Henry W W Potts, and Jonathan Berman. 2010a. '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). https://doi.org/10.1186/1472-6963-10-7.

———. 2010b. '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). https://doi.org/10.1186/1472-6963-10-7. 'Conceptual Framework for the International Classification for Patient Safety'. 2009a. WHO.

'———'. 2009b. WHO.

Dekker, Sidney. 2007a. Just Culture: Balancing Safety and Accountability. Farnham: Ashgate.

———. 2007b. Just Culture: Balancing Safety and Accountability. Farnham: Ashgate.

Department of Health. 16AD. 'Coding for Success: Simple Technology for Safer Patient Care'.

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

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

DeRosier, Joseph , Erik Stalhandske, James P. Bagian, and Tina Nudell. 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): 248–67.

Dimond, Bridgit . 2011. Legal Aspects of Nursing. Harlow, England: Pearson.

Dineen, Maria , and Richard Bartlett. n.d. Six Steps to Root Cause Analysis:

Amazon.Co.Uk: : Books.

Evans, S. M, B. J Smith, A. Esterman, W. B Runciman, G. Maddern, K. Stead, P. Selim, J. O'Shaughnessy, S. Muecke, and S. Jones. 2007. 'Evaluation of an Intervention Aimed at Improving Voluntary Incident Reporting in Hospitals'. Quality and Safety in Health Care 16 (3): 169–75. https://doi.org/10.1136/qshc.2006.019349.

Finkelstein, A.; Dowell, J. 1996. 'A Comedy of Errors: The London Ambulance Service Case Study', Summer. http://dl.acm.org/citation.cfm?id=858287.

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

Huckvale, C., J. Car, M. Akiyama, S. Jaafar, T. Khoja, A. Bin Khalid, A. Sheikh, and A. Majeed. 2010. 'Information Technology for Patient Safety'. Quality and Safety in Health Care 19 (Suppl 2): i25–33. https://doi.org/10.1136/qshc.2009.038497.

Isaac, T., J. S. Weissman, R. B. Davis, M. Massagli, A. Cyrulik, D. Z. Sands, and S. N. Weingart. 2009. 'Overrides of Medication Alerts in Ambulatory Care'. Archives of Internal Medicine 169 (3): 305–11. https://doi.org/10.1001/archinternmed.2008.551.

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

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

Karsh, B-T. 2004. 'Beyond Usability: Designing Effective Technology Implementation Systems to Promote Patient Safety'. Quality and Safety in Health Care 13 (5): 388–94. https://doi.org/10.1136/qshc.2004.010322.

Kirwan, B. and Ainsworth, L. K. 1992. A Guide to Task Analysis. Boca Raton: Taylor & Francis.

Kuehn, B. M. 2009. 'IT Vulnerabilities Highlighted by Errors, Malfunctions at Veterans' Medical Centers'. JAMA: The Journal of the American Medical Association 301 (9): 919–20. https://doi.org/10.1001/jama.2009.239.

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

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

'Manchester Patient Safety Framework (MaPSaF)'. 2006.

Mollon, Brent, Jaron JR Chong, Anne M Holbrook, Melani Sung, Lehana Thabane, and Gary Foster. 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). https://doi.org/10.1186/1472-6947-9-11.

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. https://www.gov.uk/government/publications/berwick-review-into-patient-safety.

Nicolini, D., J. Waring, and J. Mengis. 2011. 'The Challenges of Undertaking Root Cause Analysis in Health Care: A Qualitative Study'. Journal of Health Services Research & Policy 16 (Supplement 1): 34–41. https://doi.org/10.1258/jhsrp.2010.010092.

Perla, Rocco J., Samuel F. Hohmann, and Karen Annis. 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): 20–31. https://doi.org/10.1111/jhq.12027.

Pham, J. C., E. Colantuoni, F. Dominici, A. Shore, C. Macrae, S. Scobie, M. Fletcher, K. Cleary, C. A. Goeschel, and P. J. Pronovost. 2010. 'The Harm Susceptibility Model: A Method to Prioritise Risks Identified in Patient Safety Reporting Systems'. Quality and Safety in Health Care 19 (5): 440–45. https://doi.org/10.1136/qshc.2009.035444.

Potts, Henry WW, Janet E Anderson, Lacey Colligan, Paul Leach, Sheena Davis, and Jon Berman. 2014. 'Assessing the Validity of Prospective Hazard Analysis Methods: A Comparison of Two Techniques'. BMC Health Services Research 14 (1). https://doi.org/10.1186/1472-6963-14-41.

Power, M., M. Fogarty, J. Madsen, K. Fenton, K. Stewart, A. Brotherton, K. Cheema, A. Harrison, and L. Provost. 2014. 'Learning from the Design and Development of the NHS Safety Thermometer'. International Journal for Quality in Health Care, April. https://doi.org/10.1093/intqhc/mzu043.

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

Redwood, Sabi, Anna Rajakumar, James Hodson, and Jamie J Coleman. 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). https://doi.org/10.1186/1472-6947-11-29.

Reynard, John, Stevenson, Peter, and Reynolds, John. 2009a. 'Chapter 3 of Practical Patient Safety: "Safety Culture in High Reliability Organizations"'. In Practical Patient Safety. Oxford: Oxford University Press.

———. 2009b. Practical Patient Safety. Oxford: Oxford University Press.

———. 2009c. Practical Patient Safety. Oxford: Oxford University Press.

Rhona H. Flin, Paul O'Connor, and Margaret Crichton . 2007. Safety at the Sharp End. Aldershot, Hants, England: Ashgate.

'Right Patient, Right Blood: Advice for Safer Blood Transfusions'. 9AD.

Robert M. Wachter. n.d. Understanding Patient Safety. Paperback. McGraw-Hill Professional.

Runciman, Bill, Merry, Alan, and Walton, Merrilyn. 2007. '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. Aldershot: Ashgate.

Runciman, W. B., G. R. Baker, P. Michel, S. Dovey, R. J. Lilford, N. Jensen, R. Flin, et al. 2010. 'Tracing the Foundations of a Conceptual Framework for a Patient Safety Ontology'. Quality and Safety in Health Care 19 (6): 1–5. https://doi.org/10.1136/qshc.2009.035147. Runciman, W B, J A H Williamson, A Deakin, K A Benveniste, K Bannon, and P D Hibbert. 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): i82–90. https://doi.org/10.1136/qshc.2005.017467.

Sari, A. B.-A., T. A Sheldon, A. Cracknell, and A. Turnbull. 2007. 'Sensitivity of Routine System for Reporting Patient Safety Incidents in an NHS Hospital: Retrospective Patient Case Note Review'. BMJ 334 (7584): 79–79. https://doi.org/10.1136/bmj.39031.507153.AE.

Stauch, Marc , and K Wheat. 2011. Text, Cases and Materials on Medical Law and Ethics. New York: Routledge.

Sweidan, Michelle, Margaret Williamson, James F Reeve, Ken Harvey, Jennifer A O'Neill, Peter Schattner, and Teri Snowdon. 2011. 'Evaluation of Features to Support Safety and Quality in General Practice Clinical Software'. BMC Medical Informatics and Decision Making 11 (1). https://doi.org/10.1186/1472-6947-11-27.

Thomas, Eric J., David M. Studdert, Helen R. Burstin, E John Orav, Timothy Zeena, Elliott J. Williams, Howard Mason K., Paul C. Weiler, and Troyen A. Brennan. n.d. 'Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado.' Medical Care 38 (3).

Tingle, J , and P Bark. n.d. 'Chapter 3'. In Patient Safety, Law Policy and Practice.

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

Tingle, John , and Pippa Bark. 2011. 'Chapter of Patient Safety, Law Policy and Practice: "Psychological Aspects of Patient Safety"'. In Patient Safety, Law Policy and Practice.

Vincent, C., Graham Neale, and Maria Woloshynowych. 2001. 'Adverse Events in British Hospitals: Preliminary Retrospective Record Review'. BMJ 322 (7285): 517–19. https://doi.org/10.1136/bmj.322.7285.517.

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

———. 2010a. 'Chapter 1 of Patient Safety'. Electronic book. In Patient Safety, 2nd ed. Oxford: Wiley-Blackwell.

———. 2010b. 'Chapter 2'. Electronic book. In Patient Safety, 2nd ed. Oxford: Wiley-Blackwell.

———. 2010c. 'Chapter 4'. Electronic book. In Patient Safety, 2nd ed. Oxford: Wiley-Blackwell.

———. 2010d. 'Chapter 5'. Electronic book. In Patient Safety, 2nd ed. Oxford: Wiley-Blackwell.

———. 2010e. 'Chapter 5'. Electronic book. In Patient Safety, 2nd ed. Oxford: Wiley-Blackwell.

———. 2010f. 'Chapter 6'. Electronic book. In Patient Safety, 2nd ed. Oxford: Wiley-Blackwell.

———. 2010g. 'Chapter 7'. Electronic book. In Patient Safety, 2nd ed. Oxford: Wiley-Blackwell.

———. 2010h. 'Chapter 8'. Electronic book. In Patient Safety, 2nd ed. Oxford: Wiley-Blackwell.

———. 2010i. 'Chapter 9'. Electronic book. In Patient Safety, 2nd ed. Oxford: Wiley-Blackwell.

———. 2010j. 'Chapter 10'. Electronic book. In Patient Safety, 2nd ed. Oxford: Wiley-Blackwell.

———. 2010k. 'Chapter 11'. Electronic book. In Patient Safety, 2nd ed. Oxford: Wiley-Blackwell.

———. 2010l. 'Chapter 12'. Electronic book. In Patient Safety, 2nd ed. Oxford: Wiley-Blackwell.

———. 2010m. 'Chapter 13'. Electronic book. In Patient Safety, 2nd ed. Oxford: Wiley-Blackwell.

———. 2010n. 'Chapter 14'. Electronic book. In Patient Safety, 2nd ed. Oxford: Wiley-Blackwell.

———. 2010o. 'Chapter 20'. Electronic book. In Patient Safety, 2nd ed. Oxford: Wiley-Blackwell.

———. 2010p. 'Chapter of 6 Patient Safety'. Electronic book. In Patient Safety, 2nd ed. Oxford: Wiley-Blackwell.

———. 2010q. Patient Safety. Electronic book. 2nd ed. Oxford: Wiley-Blackwell.

Vries, E N de, M A Ramrattan, S M Smorenburg, D J Gouma, and M A Boermeester. 2008. 'The Incidence and Nature of In-Hospital Adverse Events: A Systematic Review'. Quality and Safety in Health Care 17 (3): 216–23. https://doi.org/10.1136/qshc.2007.023622.

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

Wang, Yun, Noel Eldridge, Mark L. Metersky, Nancy R. Verzier, Thomas P. Meehan, Michelle M. Pandolfi, JoAnne M. Foody, et al. 2014. 'National Trends in Patient Safety for Four Common Conditions, 2005–2011'. New England Journal of Medicine 370 (4): 341–51. https://doi.org/10.1056/NEJMsa1300991.

Wears, Robert L. 2015. '"Just a Few Seconds of Your Time…" at Least 130 Million Times a Year'. Annals of Emergency Medicine 65 (6): 687–89. https://doi.org/10.1016/j.annemergmed.2015.02.006.

Wu, A W, S Folkman, S McPhee, and B Lo. 2003. 'Do House Officers Learn from Their Mistakes?' Quality and Safety in Health Care 12 (>3): 221–26. https://doi.org/10.1136/qhc.12.3.221.