

CHMEGH29: Patient Safety and Clinical Risk

[View Online](#)

Ash, J.S., Berg, M. and Coiera, E. (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), pp. 104–112. Available at: <https://doi.org/10.1197/jamia.M1471>.

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

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), pp. 28–33. Available at: <https://doi.org/10.1136/qshc.2006.018192>.

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

Baker, G.R., Norton, P. and Flintoft, V. (2004) 'The Canadian Adverse Events Study: the incidence of adverse events among hospital patients in Canada', *Canadian Medical Association Journal*, 170(11), pp. 1678–1686. Available at: <https://doi.org/10.1503/cmaj.1040498>.

Bark, P. et al. (1997) 'Impact of litigation on senior clinicians: implications for risk management.', *Quality and Safety in Health Care*, 6(1), pp. 7–13. Available at: <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.

Beatty, P. (2006) 'Chapter of Patient safety: "Technology, informatics and patient safety"', in *Patient safety*. Maidenhead, England: Open University Press.

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

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), pp. 145–151. Available at: <https://doi.org/10.1136/qshc.2002.003822>.

'Building a safer NHS for patients - implementing an organisation with a memory' (17ADa).

'Building a safer NHS for patients - implementing an organisation with a memory' (17ADb).

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), pp. 48–54. Available at: <https://doi.org/10.1136/qshc.2008.031088>.

Chung, K., Choi, Y.B. and Moon, S. (2003) 'Journal of Medical Systems, Volume 27, Number 6 - SpringerLink', *Journal of Medical Systems*, 27(6), pp. 553–560. Available at: <https://doi.org/10.1023/A:1025937916203>.

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

Colligan, L. et al. (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). Available at: <https://doi.org/10.1186/1472-6963-10-7>.

Colligan, L. et al. (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). Available at: <https://doi.org/10.1186/1472-6963-10-7>.

'Conceptual Framework for the International Classification for Patient Safety' (2009a). WHO.

'Conceptual Framework for the International Classification for Patient Safety' (2009b). WHO.

Dekker, S. (2007a) *Just culture: balancing safety and accountability*. Farnham: Ashgate.

Dekker, S. (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 [Paperback] (no date). Stationery Office.

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), pp. 248–267.

Dimond, B. (2011) *Legal aspects of nursing*. Harlow, England: Pearson.

Dineen, M. and Bartlett, R. (no date) *Six Steps to Root Cause Analysis*: Amazon.co.uk: : Books.

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), pp. 169–175. Available at: <https://doi.org/10.1136/qshc.2006.019349>.

Finkelstein, A.; Dowell, J. (1996) 'A comedy of errors: the London Ambulance Service case study'. Available at: <http://dl.acm.org/citation.cfm?id=858287>.

Gawande, Atul (2010) *The checklist manifesto: how to get things right*. London: Profile. Available at:

<https://search-ebshost-com.libproxy.ucl.ac.uk/login.aspx?direct=true&AuthType=ip,shib&db=nlebk&AN=1369183&site=ehost-live&scope=site&custid=s8454451>.

Huckvale, C. et al. (2010) 'Information technology for patient safety', *Quality and Safety in Health Care*, 19(Suppl 2), pp. i25–i33. Available at: <https://doi.org/10.1136/qshc.2009.038497>.

Isaac, T. et al. (2009) 'Overrides of Medication Alerts in Ambulatory Care', *Archives of Internal Medicine*, 169(3), pp. 305–311. Available at: <https://doi.org/10.1001/archinternmed.2008.551>.

Joint Commission International (no date) *Failure Mode and Effects Analysis in Health Care: Proactive Risk Reduction*. 3rd edn.

Julianne M., RN, MS Morath and Joanne E., PHD Turnbull (no date) *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), pp. 388–394. Available at: <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, Bridget M. (2009) 'IT Vulnerabilities Highlighted by Errors, Malfunctions at Veterans' Medical Centers', *JAMA*, 301(9). Available at: <https://doi.org/10.1001/jama.2009.239>.

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

Leape, L.L. (2009) 'Errors in medicine', *Clinica Chimica Acta*, 404(1), pp. 2–5. Available at: <https://doi.org/10.1016/j.cca.2009.03.020>.

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

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). Available at: <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. Available at: <https://www.gov.uk/government/publications/berwick-review-into-patient-safety>.

Nicolini, D., Waring, J. and Mengis, J. (2011) 'The challenges of undertaking root cause analysis in health care: a qualitative study', *Journal of Health Services Research & Policy*, 16(Supplement 1), pp. 34–41. Available at: <https://doi.org/10.1258/jhsrp.2010.010092>.

Perla, R.J., Hohmann, S.F. and Annis, K. (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), pp. 20–31. Available at: <https://doi.org/10.1111/jhq.12027>.

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), pp. 440–445. Available at: <https://doi.org/10.1136/qshc.2009.035444>.

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). Available at: <https://doi.org/10.1186/1472-6963-14-41>.

Power, M. et al. (2014) 'Learning from the design and development of the NHS Safety Thermometer', *International Journal for Quality in Health Care* [Preprint]. Available at: <https://doi.org/10.1093/intqhc/mzu043>.

Reason, J. T. (1997) *Managing the risks of organizational accidents*. Aldershot: Ashgate.

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). Available at: <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.

Reynard, John, Stevenson, Peter, and Reynolds, John (2009b) *Practical patient safety*. Oxford: Oxford University Press.

Reynard, John, Stevenson, Peter, and Reynolds, John (2009c) *Practical patient safety*. Oxford: Oxford University Press.

Rhona H. Flin, O'Connor, P. and Crichton, M. (2007) *Safety at the sharp end*. Aldershot, Hants, England: Ashgate.

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

Robert M. Wachter (no date) *Understanding Patient Safety* [Paperback]. McGraw-Hill Professional.

Runciman, Bill, Merry, Alan, and Walton, Marilyn (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. 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), pp. i82-i90. Available at: <https://doi.org/10.1136/qshc.2005.017467>.

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), pp. 1-5. Available at: <https://doi.org/10.1136/qshc.2009.035147>.

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), pp. 79-79. Available at: <https://doi.org/10.1136/bmj.39031.507153.AE>.

Stauch, M. and Wheat, K. (2011) *Text, cases and materials on medical law and ethics*. New York: Routledge.

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). Available at: <https://doi.org/10.1186/1472-6947-11-27>.

Thomas, E.J. et al. (no date) 'Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado.', *Medical Care*, 38(3).

Tingle, J and Bark, P. (2011) 'Chapter 2', in *Patient Safety, Law Policy and Practice*.

Tingle, John and Bark, P. (2011) 'Chapter of Patient Safety, Law Policy and Practice: "Psychological Aspects of Patient Safety"', in *Patient Safety, Law Policy and Practice*.

Tingle, J. and Bark, P. (no date) 'Chapter 3', in *Patient Safety, Law Policy and Practice*.

Vincent, C., Neale, G. and Woloshynowych, M. (2001) 'Adverse events in British hospitals: preliminary retrospective record review', *BMJ*, 322(7285), pp. 517-519. Available at: <https://doi.org/10.1136/bmj.322.7285.517>.

Vincent, Charles (2001) *Clinical risk management: enhancing patient safety*. 2nd ed. London: BMJ Books.

Vincent, Charles (2010a) 'Chapter 1 of Patient Safety', in *Patient safety*. 2nd ed. Oxford: Wiley-Blackwell.

Vincent, Charles (2010b) 'Chapter 2', in *Patient safety*. 2nd ed. Oxford: Wiley-Blackwell.

Vincent, Charles (2010c) 'Chapter 4', in *Patient safety*. 2nd ed. Oxford: Wiley-Blackwell.

Vincent, Charles (2010d) 'Chapter 5', in *Patient safety*. 2nd ed. Oxford: Wiley-Blackwell.

Vincent, Charles (2010e) 'Chapter 5', in *Patient safety*. 2nd ed. Oxford: Wiley-Blackwell.

Vincent, Charles (2010f) 'Chapter 6', in *Patient safety*. 2nd ed. Oxford: Wiley-Blackwell.

- Vincent, Charles (2010g) 'Chapter 7', in Patient safety. 2nd ed. Oxford: Wiley-Blackwell.
- Vincent, Charles (2010h) 'Chapter 8', in Patient safety. 2nd ed. Oxford: Wiley-Blackwell.
- Vincent, Charles (2010i) 'Chapter 9', in Patient safety. 2nd ed. Oxford: Wiley-Blackwell.
- Vincent, Charles (2010j) 'Chapter 10', in Patient safety. 2nd ed. Oxford: Wiley-Blackwell.
- Vincent, Charles (2010k) 'Chapter 11', in Patient safety. 2nd ed. Oxford: Wiley-Blackwell.
- Vincent, Charles (2010l) 'Chapter 12', in Patient safety. 2nd ed. Oxford: Wiley-Blackwell.
- Vincent, Charles (2010m) 'Chapter 13', in Patient safety. 2nd ed. Oxford: Wiley-Blackwell.
- Vincent, Charles (2010n) 'Chapter 14', in Patient safety. 2nd ed. Oxford: Wiley-Blackwell.
- Vincent, Charles (2010o) 'Chapter 20', in Patient safety. 2nd ed. Oxford: Wiley-Blackwell.
- Vincent, Charles (2010p) 'Chapter of 6 Patient safety', in Patient safety. 2nd ed. Oxford: Wiley-Blackwell.
- Vincent, Charles (2010q) Patient safety [electronic book]. 2nd ed. Oxford: Wiley-Blackwell.
- 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), pp. 216–223. Available at: <https://doi.org/10.1136/qshc.2007.023622>.
- Walsh, K. and Boaden, K. (2006) *Patient Safety: Research into Practice*. Maidenhead, England: Open University Press.
- Wang, Y. et al. (2014) 'National Trends in Patient Safety for Four Common Conditions, 2005–2011', *New England Journal of Medicine*, 370(4), pp. 341–351. Available at: <https://doi.org/10.1056/NEJMsa1300991>.
- Wears, R.L. (2015) '"Just a Few Seconds of Your Time..." at Least 130 Million Times a Year', *Annals of Emergency Medicine*, 65(6), pp. 687–689. Available at: <https://doi.org/10.1016/j.annemergmed.2015.02.006>.
- Wu, A.W. et al. (2003) 'Do house officers learn from their mistakes?', *Quality and Safety in Health Care*, 12(>3), pp. 221–226. Available at: <https://doi.org/10.1136/qhc.12.3.221>.