

CHMEGH29: Patient Safety and Clinical Risk

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1.
Vincent, Charles. Patient safety. 2nd ed. Oxford: Wiley-Blackwell; 2010.
 2.
Vincent, Charles. Clinical risk management: enhancing patient safety. 2nd ed. London: BMJ Books; 2001.
 3.
Rhona H. Flin, O'Connor P, Crichton M. Safety at the sharp end. Aldershot, Hants, England: Ashgate; 2007.
 4.
Reynard, John, Stevenson, Peter, Reynolds, John. Practical patient safety. Oxford: Oxford University Press; 2009.
 5.
Department of Health Expert Group (Chairman, CMO). An Organisation with a Memory (OWAM). The Stationery Office Limited; 13AD.
 6.
Department of Health-a Safer Place for Patients. Stationery Office;

7.

Manchester Patient Safety Framework (MaPSaF). 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') [Internet]. UK Department of Health; 2013. Available from: <https://www.gov.uk/government/publications/berwick-review-into-patient-safety>

9.

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

10.

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

11.

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

12.

Walsh K, Boaden K. Patient Safety: Research into Practice. Maidenhead, England: 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: Oxford University Press; 2009.

15.

Dekker S. Just culture: balancing safety and accountability. Farnham: 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 Jun 1;17(3):216–23.

17.

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

18.

Brennan TA, Leape LL, Laird NM, Hebert L, Localio AR, Lawthers AG, 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 Apr 1;13(2):145–51.

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 Sep;35(5):20–31.

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 Jan 13;334(7584):79–79.

21.

Vincent C, Neale G, Woloshynowych M. Adverse events in British hospitals: preliminary retrospective record review. *BMJ*. 2001 Mar 3;322(7285):517–9.

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 May 25;170(11):1678-86.

23.

Thomas EJ, Studdert DM, Burstin HR, Orav EJ, Zeena T, Williams EJ, 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, Wu AW, Bates DW, Runciman WB, et al. Measures of patient safety in developing and emerging countries: a review of the literature. *Quality and Safety in Health Care*. 2010 Feb 19;19(1):48-54.

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, Verzier NR, Meehan TP, Pandolfi MM, et al. National Trends in Patient Safety for Four Common Conditions, 2005-2011. *New England Journal of Medicine*. 2014 Jan 23;370(4):341-51.

27.

Kuehn BM. IT Vulnerabilities Highlighted by Errors, Malfunctions at Veterans' Medical Centers. *JAMA*. 2009 Mar 4;301(9).

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 Mar 1;6(1):7-13.

29.

Wu AW, Folkman S, McPhee S, Lo B. Do house officers learn from their mistakes? *Quality and Safety in Health Care*. 2003 Jun 1;12(>3):221-6.

30.

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

31.

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

32.

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

33.

Leape LL. Errors in medicine. *Clinica Chimica Acta*. 2009 Jun;404(1):2-5.

34.

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

35.

Power M, Fogarty M, Madsen J, Fenton K, Stewart K, Brotherton A, et al. Learning from the design and development of the NHS Safety Thermometer. *International Journal for Quality in Health Care*. 2014 Apr 30;

36.

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

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

37.

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

38.

Vincent, Charles. Chapter of 6 Patient safety. In: Patient safety. 2nd ed. Oxford: 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. Aldershot: Ashgate; 1997.

41.

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

42.

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

43.

Vincent, Charles. Chapter 14. In: Patient safety. 2nd ed. Oxford: 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).

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).

46.

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

47.

Pham JC, Colantuoni E, Dominici F, Shore A, Macrae C, Scobie S, et al. The harm susceptibility model: a method to prioritise risks identified in patient safety reporting systems. Quality and Safety in Health Care. 2010 Apr 28;19(5):440-5.

48.

Evans SM, Smith BJ, Esterman A, Runciman WB, Maddern G, Stead K, et al. Evaluation of an intervention aimed at improving voluntary incident reporting in hospitals. Quality and Safety in Health Care. 2007 Jun 1;16(3):169-75.

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 Dec 1;15(suppl_1):i82-90.

50.

Runciman, Bill, Merry, Alan, Walton, Marilyn. 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; 2007.

51.

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

52.

Vincent, Charles. Chapter 8. In: Patient safety. 2nd ed. Oxford: 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 Apr 1;16(Supplement 1):34-41.

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):248-67.

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).

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*. Boca Raton: Taylor & Francis; 1992.

59.

Dimond B. Legal aspects of nursing. Harlow, England: Pearson; 2011.

60.

Stauch M, Wheat K. Text, cases and materials on medical law and ethics. New York: 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 [Internet]. London: Profile; 2010. Available from: <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. 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: Oxford University Press; 2009.

66.

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

67.

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

68.

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

69.

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

70.

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

71.

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

72.

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

73.

Runciman WB, Baker GR, Michel P, Dovey S, Lilford RJ, Jensen N, et al. Tracing the foundations of a conceptual framework for a patient safety ontology. Quality and Safety in

Health Care. 2010 Aug 10;19(6):1-5.

74.

Huckvale C, Car J, Akiyama M, Jaafar S, Khoja T, Bin Khalid A, et al. Information technology for patient safety. *Quality and Safety in Health Care*. 2010 Aug 6;19(Suppl 2):i25-33.

75.

Karsh BT. Beyond usability: designing effective technology implementation systems to promote patient safety. *Quality and Safety in Health Care*. 2004 Oct 1;13(5):388-94.

76.

Vincent, Charles. Chapter 13. In: *Patient safety*. 2nd ed. Oxford: 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;1:20-5.

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 Feb 1;16(1):28-33.

79.

Chung K, Choi YB, Moon S. *Journal of Medical Systems*, Volume 27, Number 6 - SpringerLink. *Journal of Medical Systems*. 2003;27(6):553-60.

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 Nov 21;11(2):104-12.

81.

Black AD, Car J, Cresswell K, Hemmi A, Majeed A, McLean S, et al. The Impact of eHealth on the Quality and Safety of Healthcare. 2011.

82.

Kuehn BM. IT Vulnerabilities Highlighted by Errors, Malfunctions at Veterans' Medical Centers. JAMA: The Journal of the American Medical Association. 2009 Mar 4;301(9):919-20.

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).

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).

85.

Isaac T, Weissman JS, Davis RB, Massagli M, Cyrulik A, Sands DZ, et al. Overrides of Medication Alerts in Ambulatory Care. Archives of Internal Medicine. 2009 Feb 9;169(3):305-11.

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).

87.

Sweidan M, Williamson M, Reeve JF, Harvey K, O'Neill JA, Schattner P, et al. Evaluation of

features to support safety and quality in general practice clinical software. BMC Medical Informatics and Decision Making. 2011;11(1).

88.

Wears RL. "Just a Few Seconds of Your Time..." at Least 130 Million Times a Year. Annals of Emergency Medicine. 2015 Jun;65(6):687-9.

89.

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