FREE KEEPING PATIENTS SAFE TRANSFORMING THE WORK ENVIRONMENT OF NURSES 1ST FIRST EDITION BY COMMITTEE ON THE WORK ENVIRONMENT FOR NURSES AND PATIENT SAF PUBLISHED BY NATIONAL ACADEMIES PRESS 2004

Keeping Patients Safe

Building on the revolutionary Institute of Medicine reports To Err is Human and Crossing the Quality Chasm, Keeping Patients Safe lays out guidelines for improving patient safety by changing nurses' working conditions and demands. Licensed nurses and unlicensed nursing assistants are critical participants in our national effort to protect patients from health care errors. The nature of the activities nurses typically perform â€\" monitoring patients, educating home caretakers, performing treatments, and rescuing patients who are in crisis â€\" provides an indispensable resource in detecting and remedying error-producing defects in the U.S. health care system. During the past two decades, substantial changes have been made in the organization and delivery of health care â€\" and consequently in the job description and work environment of nurses. As patients are increasingly cared for as outpatients, nurses in hospitals and nursing homes deal with greater severity of illness. Problems in management practices, employee deployment, work and workspace design, and the basic safety culture of health care organizations place patients at further risk. This newest edition in the groundbreaking Institute of Medicine Quality Chasm series discusses the key aspects of the work environment for nurses and reviews the potential improvements in working conditions that are likely to have an impact on patient safety.

Making Health Care Safer

\"This project aimed to collect and critically review the existing evidence on practices relevant to improving patient safety\"--P. v.

Shaping Health Policy Through Nursing Research

Named a 2013 Doody's Core Title! 2011 AJN Book of the Year Winner in Nursing Research! \"This is a much needed addition to nursing's arsenal of policy books. It is the first to really examine the need for scientific evidence to underpin policy. The two editors are pioneers in research and have led nursing research to new levels. It is fitting they do the same in underscoring the important role nurses have in using their programs of research to develop policy agendas.\"Score: 94, 4 stars --Doody's A must-read for health care policy makers, as well as nursing students, faculty, and professionals, this groundbreaking text provides actual strategies for translating nursing research to health policy at all levels of policy-making. The editors, both leaders in nursing research, provide key findings from research programs that have positively influenced health policy decisions and programs at community, state, national, and international levels. The first

compilation of information linking health policy and nursing research, this text presents perspectives and frameworks for understanding the processes bridging research and health policy; multiple factors influencing the processes; and actual examples of National Institute of Nursing Research (NINR)-funded research that has influenced health policy programs. Key Features: Examples of NINR-funded research that has been used at all levels to influence health policy, including settings, populations, and age spectrums Models and strategies for linking research and health policy Lessons learned from pioneer nurse scientists who have shaped health policy with nursing research Recommendations for improving nurses' work environments for better patient outcomes

Handbook of Human Factors and Ergonomics in Health Care and Patient Safety, Second Edition

The first edition of Handbook of Human Factors and Ergonomics in Health Care and Patient Safety took the medical and ergonomics communities by storm with in-depth coverage of human factors and ergonomics research, concepts, theories, models, methods, and interventions and how they can be applied in health care. Other books focus on particular human factors and ergonomics issues such as human error or design of medical devices or a specific application such as emergency medicine. This book draws on both areas to provide a compendium of human factors and ergonomics issues relevant to health care and patient safety. The second edition takes a more practical approach with coverage of methods, interventions, and applications and a greater range of domains such as medication safety, surgery, anesthesia, and infection prevention. New topics include: work schedules error recovery telemedicine workflow analysis simulation health information technology development and design patient safety management Reflecting developments and advances in the five years since the first edition, the book explores medical technology and telemedicine and puts a special emphasis on the contributions of human factors and ergonomics to the improvement of patient safety and quality of care. In order to take patient safety to the next level, collaboration between human factors professionals and health care providers must occur. This book brings both groups closer to achieving that goal.

Financial Management for Nurse Managers and Executives

Covering the financial topics all nurse managers need to know and use, this book explains how financial management fits into the healthcare organization. You'll study accounting principles, cost analysis, planning and control management of the organization's financial resources, and the use of management tools. In addition to current issues, this edition also addresses future directions in financial management. Chapter goals and an introduction begin each chapter. Each chapter ends with Implications For The Nurse Manager and Key Concepts, to reinforce understanding. Key Concepts include definitions of terms discussed in each chapter. A comprehensive glossary with all key terms is available on companion Evolve? website. Two chapter-ending appendixes offer additional samples to reinforce chapter content. Four NEW chapters are included: Quality, Costs and Financing; Revenue Budgeting; Variance Analysis: Examples, Extensions, and Caveats; and Benchmarking, Productivity, and Cost-Benefit and Cost-Effectiveness Analysis. The new Medicare prescription bill is covered, with its meaning for healthcare providers, managers, and executives. Coverage now includes the transition from the role of bedside or staff nurse to nurse manager and nurse executive. Updated information includes current nursing workforce issues and recurring nursing shortages. Updates focus on health financing and the use of computers in budgeting and finance. New practice problems are included.

Simulation Scenarios for Nursing Educators, Second Edition

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The Future of Nursing

The Future of Nursing explores how nurses' roles, responsibilities, and education should change significantly to meet the increased demand for care that will be created by health care reform and to advance improvements in America's increasingly complex health system. At more than 3 million in number, nurses make up the single largest segment of the health care work force. They also spend the greatest amount of time in delivering patient care as a profession. Nurses therefore have valuable insights and unique abilities to contribute as partners with other health care professionals in improving the quality and safety of care as envisioned in the Affordable Care Act (ACA) enacted this year. Nurses should be fully engaged with other health professionals and assume leadership roles in redesigning care in the United States. To ensure its members are well-prepared, the profession should institute residency training for nurses, increase the percentage of nurses who attain a bachelor's degree to 80 percent by 2020, and double the number who pursue doctorates. Furthermore, regulatory and institutional obstacles-including limits on nurses' scope of practice-should be removed so that the health system can reap the full benefit of nurses' training, skills, and knowledge in patient care. In this book, the Institute of Medicine makes recommendations for an action-oriented blueprint for the future of nursing.

Nursing Leadership

A single comprehensive reference for nursing leaders, leadership organizations, nursing clinicians, and educators, Nursing Leadership is the only compendium of nursing terminology in existence. Written by eminent nursing professionals, it provides descriptions of prominent individuals in nursing, information regarding nine leadership-related topics, and current trends in nurse leadership. This second edition has been expanded to encompass 80 new entries and revisions or updates to all original entries. It provides an extensive overview of current leadership issues including theories, characteristics, and skills required of nurse leaders in today's complex health care system. Highly respected contributors include Claire Fagan, Beverly Malone (NLN CEO), Polly Bednash (AACN CEO), Patricia Benner, and many others. For ease of use this new edition contains both alphabetic and thematic indexes, extensive cross-referencing, and print and web references for each entry. The new edition features: Thematic list of entries in addition to alphabetic index An extensive overview on salient nursing leadership issues, themes, characteristics, and current and future developments A \"legacies\" section on nursing luminaries throughout history Over 80 new entries and updates and revisions of original entries Extensive cross-referencing and print and web resources for each entry

Front Line of Defense

Includes examples of adverse events, medical errors, and 'near misses' within a variety of health care settings to help you identify possible root causes of adverse events and medical errors and strategies nurses can use to prevent adverse events. This title helps to create a safer, more efficient environment.

Crossing the Quality Chasm

Second in a series of publications from the Institute of Medicine's Quality of Health Care in America project Today's health care providers have more research findings and more technology available to them than ever before. Yet recent reports have raised serious doubts about the quality of health care in America. Crossing the Quality Chasm makes an urgent call for fundamental change to close the quality gap. This book recommends a sweeping redesign of the American health care system and provides overarching principles for specific direction for policymakers, health care leaders, clinicians, regulators, purchasers, and others. In this comprehensive volume the committee offers: A set of performance expectations for the 21st century health care system. A set of 10 new rules to guide patient-clinician relationships. A suggested organizing framework to better align the incentives inherent in payment and accountability with improvements in quality. Key steps to promote evidence-based practice and strengthen clinical information systems. Analyzing health care

organizations as complex systems, Crossing the Quality Chasm also documents the causes of the quality gap, identifies current practices that impede quality care, and explores how systems approaches can be used to implement change.

Patient Safety and Quality

\"Nurses play a vital role in improving the safety and quality of patient car -- not only in the hospital or ambulatory treatment facility, but also of community-based care and the care performed by family members. Nurses need know what proven techniques and interventions they can use to enhance patient outcomes. To address this need, the Agency for Healthcare Research and Quality (AHRQ), with additional funding from the Robert Wood Johnson Foundation, has prepared this comprehensive, 1,400-page, handbook for nurses on patient safety and quality -- Patient Safety and Quality: An Evidence-Based Handbook for Nurses. (AHRQ Publication No. 08-0043).\" - online AHRQ blurb, http://www.ahrq.gov/qual/nurseshdbk/

Health IT and Patient Safety

IOM's 1999 landmark study To Err is Human estimated that between 44,000 and 98,000 lives are lost every year due to medical errors. This call to action has led to a number of efforts to reduce errors and provide safe and effective health care. Information technology (IT) has been identified as a way to enhance the safety and effectiveness of care. In an effort to catalyze its implementation, the U.S. government has invested billions of dollars toward the development and meaningful use of effective health IT. Designed and properly applied, health IT can be a positive transformative force for delivering safe health care, particularly with computerized prescribing and medication safety. However, if it is designed and applied inappropriately, health IT can add an additional layer of complexity to the already complex delivery of health care. Poorly designed IT can introduce risks that may lead to unsafe conditions, serious injury, or even death. Poor human-computer interactions could result in wrong dosing decisions and wrong diagnoses. Safe implementation of health IT is a complex, dynamic process that requires a shared responsibility between vendors and health care organizations. Health IT and Patient Safety makes recommendations for developing a framework for patient safety and health IT. This book focuses on finding ways to mitigate the risks of health IT-assisted care and identifies areas of concern so that the nation is in a better position to realize the potential benefits of health IT. Health IT and Patient Safety is both comprehensive and specific in terms of recommended options and opportunities for public and private interventions that may improve the safety of care that incorporates the use of health IT. This book will be of interest to the health IT industry, the federal government, healthcare providers and other users of health IT, and patient advocacy groups.

The Future of Nursing 2020-2030

The decade ahead will test the nation's nearly 4 million nurses in new and complex ways. Nurses live and work at the intersection of health, education, and communities. Nurses work in a wide array of settings and practice at a range of professional levels. They are often the first and most frequent line of contact with people of all backgrounds and experiences seeking care and they represent the largest of the health care professions. A nation cannot fully thrive until everyone - no matter who they are, where they live, or how much money they make - can live their healthiest possible life, and helping people live their healthiest life is and has always been the essential role of nurses. Nurses have a critical role to play in achieving the goal of health equity, but they need robust education, supportive work environments, and autonomy. Accordingly, at the request of the Robert Wood Johnson Foundation, on behalf of the National Academy of Medicine, an ad hoc committee under the auspices of the National Academies of Sciences, Engineering, and Medicine conducted a study aimed at envisioning and charting a path forward for the nursing profession to help reduce inequities in people's ability to achieve their full health potential. The ultimate goal is the achievement of health equity in the United States built on strengthened nursing capacity and expertise. By leveraging these attributes, nursing will help to create and contribute comprehensively to equitable public health and health care systems that are designed to work for everyone. The Future of Nursing 2020-2030: Charting a Path to

Achieve Health Equity explores how nurses can work to reduce health disparities and promote equity, while keeping costs at bay, utilizing technology, and maintaining patient and family-focused care into 2030. This work builds on the foundation set out by The Future of Nursing: Leading Change, Advancing Health (2011) report.

Taking Action Against Clinician Burnout

Patient-centered, high-quality health care relies on the well-being, health, and safety of health care clinicians. However, alarmingly high rates of clinician burnout in the United States are detrimental to the quality of care being provided, harmful to individuals in the workforce, and costly. It is important to take a systemic approach to address burnout that focuses on the structure, organization, and culture of health care. Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being builds upon two groundbreaking reports from the past twenty years, To Err Is Human: Building a Safer Health System and Crossing the Quality Chasm: A New Health System for the 21st Century, which both called attention to the issues around patient safety and quality of care. This report explores the extent, consequences, and contributing factors of clinician burnout and provides a framework for a systems approach to clinician burnout and professional well-being, a research agenda to advance clinician well-being, and recommendations for the field.

Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry

This public inquiry report into serious failings in healthcare that took place at the Mid Staffordshire NHS Foundation Trust builds on the first independent report published in February 2010 (ISBN 9780102964394). It further examines the suffering of patients caused by failures by the Trust: there was a failure to listen to its patients and staff or ensure correction of deficiencies. There was also a failure to tackle the insidious negative culture involving poor standards and a disengagement from managerial and leadership responsibilities. These failures are in part a consequence of allowing a focus on reaching national access targets, achieving financial balance and seeking foundation trust status at the cost of delivering acceptable care standards. Further, the checks and balances that operate within the NHS system should have prevented the serious systemic failure that developed at Mid Staffs. The system failed in its primary duty to protect patients and maintain confidence in the healthcare system. This report identifies numerous warning signs that could and should have alerted the system to problems developing at the Trust. It also sets out 290 recommendations grouped around: (i) putting the patient first; (ii) developing a set of fundamental standards, easily understood and accepted by patients; (iii) providing professionally endorsed and evidence-based means of compliance of standards that are understood and adopted by staff; (iv) ensuring openness, transparency and candour throughout system; (v) policing of these standards by the healthcare regulator; (vi) making all those who provide care for patients , properly accountable; (vii) enhancing recruitment, education, training and support of all key contributors to the provision of healthcare; (viii) developing and sharing ever improving means of measuring and understanding the performance of individual professionals, teams, units and provider organisations for the patients, the public, and other stakeholders.

Accident Precursor Analysis and Management

In the aftermath of catastrophes, it is common to find prior indicators, missed signals, and dismissed alerts that, had they been recognized and appropriately managed before the event, could have resulted in the undesired event being averted. These indicators are typically called \"precursors.\" Accident Precursor Analysis and Management: Reducing Technological Risk Through Diligence documents various industrial and academic approaches to detecting, analyzing, and benefiting from accident precursors and examines public-sector and private-sector roles in the collection and use of precursor information. The book includes the analysis, findings and recommendations of the authoring NAE committee as well as eleven individually authored background papers on the opportunity of precursor analysis and management, risk assessment, risk management, and linking risk assessment and management.

Strengthening Forensic Science in the United States

Scores of talented and dedicated people serve the forensic science community, performing vitally important work. However, they are often constrained by lack of adequate resources, sound policies, and national support. It is clear that change and advancements, both systematic and scientific, are needed in a number of forensic science disciplines to ensure the reliability of work, establish enforceable standards, and promote best practices with consistent application. Strengthening Forensic Science in the United States: A Path Forward provides a detailed plan for addressing these needs and suggests the creation of a new government entity, the National Institute of Forensic Science, to establish and enforce standards within the forensic science community. The benefits of improving and regulating the forensic science disciplines are clear: assisting law enforcement officials, enhancing homeland security, and reducing the risk of wrongful conviction and exoneration. Strengthening Forensic Science in the United States gives a full account of what is needed to advance the forensic science disciplines, including upgrading of systems and organizational structures, better training, widespread adoption of uniform and enforceable best practices, and mandatory certification and accreditation programs. While this book provides an essential call-to-action for congress and policy makers, it also serves as a vital tool for law enforcement agencies, criminal prosecutors and attorneys, and forensic science educators.

Introduction to Quality and Safety Education for Nurses

This is the first textbook designed to introduce the six areas of nursing competencies, as developed by the Quality and Safety Education for Nurses (QSEN) initiative, which are required content in undergraduate nursing programs.

Managing Maintenance Error

Situations and systems are easier to change than the human condition - particularly when people are well-trained and well-motivated, as they usually are in maintenance organisations. This is a down-to-earth practitioner’s guide to managing maintenance error, written in Dr. Reason’s highly readable style. It deals with human risks generally and the special human performance problems arising in maintenance, as well as providing an engineer’s guide for their understanding and the solution. After reviewing the types of error and violation and the conditions that provoke them, the author sets out the broader picture, illustrated by examples of three system failures. Central to the book is a comprehensive review of error management, followed by chapters on:- managing person, the task and the team; - the workplace and the organization; - creating a safe culture; It is then rounded off and brought together, in such a way as to be readily applicable for those who can make it work, to achieve a greater and more consistent level of safety in maintenance activities. The readership will include maintenance engineering staff and safety officers and all those in responsible roles in critical and systems-reliant environments, including transportation, nuclear and conventional power, extractive and other chemical processing and manufacturing industries and medicine.

Nurses With Disabilities

Nursing with Disabilities: Professional Issues and Job Retention grapples with issues that many nurses have suffered but the profession has avoided up till now, from three perspectives: RNs with disabilities, nurse leaders and administrators, and patients. This book, written by the foremost researcher on nurses with disabilities, features the voices of actual nurse with disabilities, nurse recruiters, nurse managers and patients, to outline issues and propose solutions. The book identifies nurses with disabilities (from sensory to muscoskeletal and emotional and mental health), discusses why they leave nursing or hide their disability to sustain their position or obtain a new one, and analyzes how it may influence career choices. Feature issues include patient safety, environmental factors, and retention strategies. Nursing leaders/administrators, with the power to institute change to retain nurses with disabilities, comprise the key audience. Nurse educators

will use the book as a supplementary text in undergraduate and graduate courses in policy and leadership.

The Measurement and Monitoring of Safety

Print+CourseSmart

Nurses Making Policy

Children are already learning at birth, and they develop and learn at a rapid pace in their early years. This provides a critical foundation for lifelong progress, and the adults who provide for the care and the education of young children bear a great responsibility for their health, development, and learning. Despite the fact that they share the same objective - to nurture young children and secure their future success - the various practitioners who contribute to the care and the education of children from birth through age 8 are not acknowledged as a workforce unified by the common knowledge and competencies needed to do their jobs well. Transforming the Workforce for Children Birth Through Age 8 explores the science of child development, particularly looking at implications for the professionals who work with children. This report examines the current capacities and practices of the workforce, the settings in which they work, the policies and infrastructure that set qualifications and provide professional learning, and the government agencies and other funders who support and oversee these systems. This book then makes recommendations to improve the quality of professional practice and the practice environment for care and education professionals. These detailed recommendations create a blueprint for action that builds on a unifying foundation of child development and early learning, shared knowledge and competencies for care and education professionals, and principles for effective professional learning. Young children thrive and learn best when they have secure, positive relationships with adults who are knowledgeable about how to support their development and learning and are responsive to their individual progress. Transforming the Workforce for Children Birth Through Age 8 offers guidance on system changes to improve the quality of professional practice, specific actions to improve professional learning systems and workforce development, and research to continue to build the knowledge base in ways that will directly advance and inform future actions. The recommendations of this book provide an opportunity to improve the quality of the care and the education that children receive, and ultimately improve outcomes for children.

Transforming the Workforce for Children Birth Through Age 8

Increased concern for patient safety has put the issue at the top of the agenda of practitioners, hospitals, and even governments. The risks to patients are many and diverse, and the complexity of the healthcare system that delivers them is huge. Yet the discourse is often oversimplified and underdeveloped. Written from a scientific, human factors

Patient Safety

This review incorporates the views and visions of 2,000 clinicians and other health and social care professionals from every NHS region in England, and has been developed in discussion with patients, carers and the general public. The changes proposed are locally-led, patient-centred and clinically driven. Chapter 2 identifies the challenges facing the NHS in the 21st century: ever higher expectations; demand driven by demographics as people live longer; health in an age of information and connectivity; the changing nature of disease; advances in treatment; a changing health workplace. Chapter 3 outlines the proposals to deliver high quality care for patients and the public, with an emphasis on helping people to stay healthy, empowering patients, providing the most effective treatments, and keeping patients as safe as possible in healthcare environments. The importance of quality in all aspects of the NHS is reinforced in chapter 4, and must be understood from the perspective of the patient's safety, experience in care received and the effectiveness of that care. Best practice will be widely promoted, with a central role for the National Institute for Health and Clinical Excellence (NICE) in expanding national standards. This will bring clarity to the high standards

expected and quality performance will be measured and published. The review outlines the need to put frontline staff in control of this drive for quality (chapter 5), with greater freedom to use their expertise and skill and decision-making to find innovative ways to improve care for patients. Clinical and managerial leadership skills at the local level need further development, and all levels of staff will receive support through education and training (chapter 6). The review recommends the introduction of an NHS Constitution (chapter 7). The final chapter sets out the means of implementation.

High Quality Care for All

Equity and Excellence : Liberating the NHS: Presented to Parliament by the Secretary of State for Health by Command of Her Majesty

Equity and excellence:

Quality Assurance of Aseptic Preparation Services Standards Handbook (also known as the Yellow Guide) provides standards for unlicensed aseptic preparation in the UK, as well as practical information to aid implementation of the standards. The handbook delivers essential standards in a practical way and in a format that will be useful for pharmacy management, staff working in aseptic preparation units and those whose role it is to audit the services. The accompanying support resources help with understanding the complexities of relevant topics including microbiology, radiopharmaceuticals, advanced therapy medicinal products, technical (quality) agreements and capacity planning. All the standards have been revised and updated for this 5th edition. The text is produced on behalf of the Royal Pharmaceutical Society (RPS) and the NHS Pharmaceutical Quality Assurance Committee. New in this edition: Replaces the 4th edition standards and forms the basis for an ongoing audit program in the NHS Many new and revised standards Greater emphasis on Pharmaceutical Quality Systems; the responsibilities of pharmacy management, Chief Pharmacists (or equivalent), has been expanded in line with developments in Good Manufacturing Practice Reformatted into 2 parts: standards and support resources. This is a new collaboration between the RPS and NHS. Since the previous edition the RPS has become the professional body for pharmacists and pharmaceutical scientists. RPS launched these standards as part of a library of professional standards and a programme of work to create standards for all areas of pharmacy. The Handbook is essential for pharmacists, hospital pharmacy management and technical services teams, and auditors of unlicensed NHS hospital pharmacy aseptic preparation services in the UK, pharmacists and regulators. The text is used to inform standards used in several other countries.

Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers

From the 1920s when he watched his father, a general practitioner who made housecalls and wrote his prescriptions in Latin, to his days in medical school and beyond, Lewis Thomas saw medicine evolve from an art into a sophisticated science. The Youngest Science is Dr. Thomas's account of his life in the medical profession and an inquiry into what medicine is all about--the youngest science, but one rich in possibility and promise. He chronicles his training in Boston and New York, his war career in the South Pacific, his most impassioned research projects, his work as an administrator in hospitals and medical schools, and even his experiences as a patient. Along the way, Thomas explores the complex relationships between research and practice, between words and meanings, between human error and human accomplishment, More than a magnificent autobiography, The Youngest Science is also a celebration and a warning--about the nature of medicine and about the future life of our planet.

Quality Assurance of Aseptic Preparation Services

Hospitals and nursing homes are responding to changes in the health care system by modifying staffing

levels and the mix of nursing personnel. But do these changes endanger the quality of patient care? Do nursing staff suffer increased rates of injury, illness, or stress because of changing workplace demands? These questions are addressed in Nursing Staff in Hospitals and Nursing Homes, a thorough and authoritative look at today's health care system that also takes a long-term view of staffing needs for nursing as the nation moves into the next century. The committee draws fundamental conclusions about the evolving role of nurses in hospitals and nursing homes and presents recommendations about staffing decisions, nursing training, measurement of quality, reimbursement, and other areas. The volume also discusses work-related injuries, violence toward and abuse of nursing staffs, and stress among nursing personnelâ€\"and examines whether these problems are related to staffing levels. Included is a readable overview of the underlying trends in health care that have given rise to urgent questions about nurse staffing: population changes, budget pressures, and the introduction of new technologies. Nursing Staff in Hospitals and Nursing Homes provides a straightforward examination of complex and sensitive issues surround the role and value of nursing on our health care system.

The Youngest Science

Incorporating HC 1030-i to iii.

Nursing Staff in Hospitals and Nursing Homes

Would you like to develop some strategies to manage knowledge deficits, near misses and mistakes in practice? Are you looking to improve your reflective writing for your portfolio, essays or assignments? Reflective practice enables us to make sense of, and learn from, the experiences we have each day and if nurtured properly can provide skills that will you come to rely on throughout your nursing career. Using clear language and insightful examples, scenarios and case studies the third edition of this popular and bestselling book shows you what reflection is, why it is so important and how you can use it to improve your nursing practice. Key features: · Clear and straightforward introduction to reflection directly written for nursing students and new nurses · Full of activities designed to build confidence when using reflective practice · Each chapter is linked to relevant NMC Standards and Essential Skills Clusters

The Influence of the Pharmaceutical Industry

Take an evidence-based approach that prepares nurses to be leaders at all levels. Learn the skills you need to lead and succeed in the dynamic health care environments in which you will practice. From leadership and management theories through their application, you'll develop the core competences needed to deliver and manage the highest quality care for your patients. You'll also be prepared for the initiatives that are transforming the delivery and cost-effectiveness of health care today. New, Updated & Expanded! Content reflecting the evolution of nursing leadership and management New! Tables that highlight how the chapter content correlates with the core competencies of BSN Essentials, ANA Code of Ethics, and Standards of Practice or Specialty Standards of Practice New!10 NCLEX®-style questions at the end of each chapter with rationales in an appendix New & Expanded! Coverage of reporting incidents, clinical reasoning and judgment, communication and judgment hierarchy, quality improvement tools, leveraging diversity, security plans and disaster management, health care and hospital- and unit-based finances, and professional socialization Features an evidence-based and best practices approach to develop the skills needed to be effective nurse leaders and managers—from managing patient care to managing staff and organizations. Encompasses new quality care initiatives, including those from the Institute of Medicine (IOM) Report, AACN Essentials of Baccalaureate Education, and Quality and Safety Education for Nurses (QSEN) Report which form the foundation of the content. Discusses the essentials of critical thinking, decision-making and problem solving, including concepts such as SWOT, 2x2 matrix, root-cause analysis, plan-do-study-act, and failure mode and effects analysis. Demonstrates how to manage conflict, manage teams and personnel, utilize change theory, and budget Uses a consistent pedagogy in each chapter, including key terms, learning outcomes, learning activities, a case study, coverage of evidence, research and best practices, and a chapter

summary.

Reflective Practice in Nursing

The Essential Guide for Patient Safety Officers, Second Edition, copublished with the Institute for Healthcare Improvement (IHI), is a comprehensive and authoritative repository of essential knowledge on operationalizing patient safety. Patient safety officers must make sure their organizations create a safety culture, implement new safety practices, and improve safety-related management and operations. This updated edition of a JCR best seller, with many new chapters, will help them do that. Edited by Allan Frankel, MD; Michael Leonard, MD; Frank Federico, RPh; Karen Frush, MD; and Carol Haraden, PhD, this book provides: * Core knowledge and insights for patient safety leaders, clinicians, change agents, and other staff * Strategies and best practices for day-to-day operational issues * Patient safety strategies and initiatives * Tools, checklists, and guidelines to assess, improve, and monitor patient safety functions * Expert guidance on leadership's role, assessing and improving safety culture, designing for reliability and resilience, ensuring patient involvement, using technology to enhance safety, and building and sustaining a learning system -- and other essential topics The work described in the book reveals growing insight into the complex task of taking care of patients safely as an intrinsic, inseparable part of quality care. To do this we need to create a systematic, integrated approach, and this book shows us how to do it. -- Gary S. Kaplan, MD, Chairman and CEO, Virginia Mason Medical Center, Seattle

National Safety and Quality Health Service Standards

This unique and engaging open access title provides a compelling and ground-breaking account of the patient safety movement in the United States, told from the perspective of one of its most prominent leaders, and arguably the movement’s founder, Lucian L. Leape, MD. Covering the growth of the field from the late 1980s to 2015, Dr. Leape details the developments, actors, organizations, research, and policy-making activities that marked the evolution and major advances of patient safety in this time span. In addition, and perhaps most importantly, this book not only comprehensively details how and why human and systems errors too often occur in the process of providing health care, it also promotes an in-depth understanding of the principles and practices of patient safety, including how they were influenced by today’s modern safety sciences and systems theory and design. Indeed, the book emphasizes how the growing awareness of systems-design thinking and the self-education and commitment to improving patient safety, by not only Dr. Leape but a wide range of other clinicians and health executives from both the private and public sectors, all converged to drive forward the patient safety movement in the US. Making Healthcare Safe is divided into four parts: I. In the Beginning describes the research and theory that defined patient safety and the early initiatives to enhance it. II. Institutional Responses tells the stories of the efforts of the major organizations that began to apply the new concepts and make patient safety a reality. Most of these stories have not been previously told, so this account becomes their histories as well. III. Getting to Work provides in-depth analyses of four key issues that cut across disciplinary lines impacting patient safety which required special attention. IV. Creating a Culture of Safety looks to the future, marshalling the best thinking about what it will take to achieve the safe care we all deserve. Captivatingly written with an “insider’s” tone and a major contribution to the clinical literature, this title will be of immense value to health care professionals, to students in a range of academic disciplines, to medical trainees, to health administrators, to policymakers and even to lay readers with an interest in patient safety and in the critical quest to create safe care.

Nursing Leadership and Management for Patient Safety and Quality Care

Experts estimate that as many as 98,000 people die in any given year from medical errors that occur in hospitals. That's more than die from motor vehicle accidents, breast cancer, or AIDSâ€\"three causes that receive far more public attention. Indeed, more people die annually from medication errors than from workplace injuries. Add the financial cost to the human tragedy, and medical error easily rises to the top ranks of urgent, widespread public problems. To Err Is Human breaks the silence that has surrounded

medical errors and their consequenceâ€\"but not by pointing fingers at caring health care professionals who make honest mistakes. After all, to err is human. Instead, this book sets forth a national agendaâ€\"with state and local implicationsâ€\"for reducing medical errors and improving patient safety through the design of a safer health system. This volume reveals the often startling statistics of medical error and the disparity between the incidence of error and public perception of it, given many patients' expectations that the medical profession always performs perfectly. A careful examination is made of how the surrounding forces of legislation, regulation, and market activity influence the quality of care provided by health care organizations and then looks at their handling of medical mistakes. Using a detailed case study, the book reviews the current understanding of why these mistakes happen. A key theme is that legitimate liability concerns discourage reporting of errorsâ€\"which begs the question, \"How can we learn from our mistakes?\" Balancing regulatory versus market-based initiatives and public versus private efforts, the Institute of Medicine presents wide-ranging recommendations for improving patient safety, in the areas of leadership, improved data collection and analysis, and development of effective systems at the level of direct patient care. To Err Is Human asserts that the problem is not bad people in health careâ€\"it is that good people are working in bad systems that need to be made safer. Comprehensive and straightforward, this book offers a clear prescription for raising the level of patient safety in American health care. It also explains how patients themselves can influence the quality of care that they receive once they check into the hospital. This book will be vitally important to federal, state, and local health policy makers and regulators, health professional licensing officials, hospital administrators, medical educators and students, health caregivers, health journalists, patient advocatesâ€\"as well as patients themselves. First in a series of publications from the Quality of Health Care in America, a project initiated by the Institute of Medicine

The Essential Guide for Patient Safety Officers

These guidelines provide recommendations that outline the critical aspects of infection prevention and control. The recommendations were developed using the best available evidence and consensus methods by the Infection Control Steering Committee. They have been prioritised as key areas to prevent and control infection in a healthcare facility. It is recognised that the level of risk may differ according to the different types of facility and therefore some recommendations should be justified by risk assessment. When implementing these recommendations all healthcare facilities need to consider the risk of transmission of infection and implement according to their specific setting and circumstances.

Making Healthcare Safe

'I'm a HUGE fan of Alison Green's \"Ask a Manager\" column. This book is even better' Robert Sutton, author of The No Asshole Rule and The Asshole Survival Guide 'Ask A Manager is the book I wish I'd had in my desk drawer when I was starting out (or even, let's be honest, fifteen years in)' - Sarah Knight, New York Times bestselling author of The Life-Changing Magic of Not Giving a F*ck A witty, practical guide to navigating 200 difficult professional conversations Ten years as a workplace advice columnist has taught Alison Green that people avoid awkward conversations in the office because they don't know what to say. Thankfully, Alison does. In this incredibly helpful book, she takes on the tough discussions you may need to have during your career. You'll learn what to say when: · colleagues push their work on you - then take credit for it · you accidentally trash-talk someone in an email and hit 'reply all' · you're being micromanaged - or not being managed at all · your boss seems unhappy with your work · you got too drunk at the Christmas party With sharp, sage advice and candid letters from real-life readers, Ask a Manager will help you successfully navigate the stormy seas of office life.

To Err Is Human

Nursing Home Trends, 1987 and 1996

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