Improving The Safety And Quality Of Eggs And Egg Products Egg Safety And Nutritional Quality Woodhead Publishing Series In Food Science Technology And Nutrition

Medical residents in hospitals are often required to be on duty for long hours. In 2003 the organization overseeing graduate medical education adopted common program requirements to restrict resident workweeks, including limits to an average of 80 hours over 4 weeks and the longest consecutive period of work to 30 hours in order to protect patients and residents from unsafe conditions resulting from excessive fatigue. Resident Duty Hours provides a timely examination of how those requirements were implemented and their impact on safety, education, and the training institutions. An in-depth review of the evidence on sleep and human performance indicated a need to increase opportunities for sleep during residency training to prevent acute and chronic sleep deprivation and minimize the risk of fatigue-related errors. In addition to recommending opportunities for on-duty sleep during long duty periods and breaks for sleep of appropriate lengths between work periods, the committee also recommends enhancements of supervision, appropriate workload, and changes in the work environment to improve conditions for safety and learning. All residents, medical educators, those involved with academic training institutions, specialty societies, professional groups, and consumer/patient safety organizations will find this book useful to advocate for an improved culture of safety.

Each year, hospital-acquired infections, prescribing and treatment errors, lost documents and test reports, communication failures, and other problems have caused thousands of deaths in the United States, added millions of days to patients' hospital stays, and cost Americans tens of billions of dollars. Despite (and sometimes because of) new medical information technology and numerous well-intentioned initiatives to address these problems, threats to patient safety remain and in some areas are on the rise. In First, Do Less Harm, twelve health care professionals and researchers plus two former patients look at patient safety from a variety of perspectives, finding many of the proposed solutions to be inadequate or impractical. Several contributors to this book attribute the failure to confront patient safety concerns to the influence of the "market model" on medicine and emphasize the need for hospital-wide teamwork and greater involvement from frontline workers (from janitors and aides to nurses and physicians) in planning, implementing, and evaluating effective safety initiatives. Several chapters in First, Do Less Harm focus on the critical role of interprofessional and occupational practice in patient safety. Rather than focusing on the usual suspects—physicians, safety champions, or high level management—these chapters expand the list of "stakeholders" and patient safety advocates to include nurses, patient care assistants, and other staff, as well as the health care unions that may represent them. First, Do Less Harm also highlights workplace issues that negatively affect safety: including sleeplessness, excessive workloads, outsourcing of hospital cleaning, and lack of teamwork between physicians and other health care staff. In two chapters, experts explain why the promise of health care information technology to fix safety problems remains unrealized, with examples that are at once humorous and frightening. A book that will be required reading for physicians, nurses, hospital administrators, public health officers, quality and risk managers, healthcare educators, economists, and policymakers, First, Do Less Harm concludes with a list of twenty-seven paradoxes and challenges facing everyone interested in making care safe for both patients and those who care for them.

The guidance you need to protect your pediatric patients from medical error From front-line treatment to critical policy issues, Pediatric Patient Safety and Quality Improvement provides all the knowledge and insight you need to ensure your pediatric patients are treated safely and effectively. This unique guide addresses the specific challenges of medical professionals treating young patients. Packed with the newest research findings and best practices from top figures in the patient safety community, Pediatric Patient Safety and Quality Improvement will ensure that you provide optimum child care free of the oversights and errors for better patient outcomes. Pediatric Patient Safety and Quality Improvement offers the scientific information and current perspectives you need to: Build your expertise on the latest quality improvement methods Deepen your understanding of the human factors in medical mistakes Improve team efficacy for better care and outcomes in any setting

This volume, developed by the Observatory together with OECD, provides an overall conceptual framework for understanding and applying strategies aimed at improving quality of care. Crucially, it summarizes available evidence on different quality strategies and provides recommendations for their implementation. This book is intended to help policy-makers to understand concepts of quality and to support them to evaluate single strategies and combinations of strategies.

Organizations around the world are using Lean to redesign care and improve processes in a way that achieves and sustains meaningful results for patients, staff, physicians, and health systems. Lean Hospitals, Third Edition explains how to use the Lean methodology and mindsets to improve safety, quality, access, and morale while reducing costs, increasing capacity, and strengthening the long-term bottom line. This updated edition of a Shingo Research Award recipient begins with an overview of Lean methods. It explains how Lean practices can help reduce various frustrations for caregivers, prevent delays and harm for patients, and improve the long-term health of your organization. The second edition of this book presented new material on identifying waste, A3 problem solving, engaging employees in continuous improvement, and strategy deployment. This third edition adds new sections on structured Lean problem solving methods (including Toyota Kata), Lean Design, and other topics. Additional examples, case studies, and explanations are also included throughout the book. Mark Graban is also the co-author, with Joe Swartz, of the book Healthcare Kaizen: Engaging Frontline Staff in Sustainable Continuous Improvements, which is also a Shingo Research Award recipient. Mark and Joe also wrote The Executive’s Guide to Healthcare Kaizen.

The authors of this book set out a system of safety strategies and interventions for managing patient safety on a day-to-day basis and improving safety over the long term. These strategies are applicable at all levels of the healthcare system from the frontline to the regulation and governance of the system. There have been many advances in patient safety, but we now need a new and broader vision that encompasses care throughout the patient’s journey. The authors argue that we need to see safety through the patient’s eyes, to consider how safety is managed in different contexts and to develop a wider strategic and practical vision in which patient safety is recast as the management of risk over time. Most safety improvement strategies aim to improve reliability and move closer toward optimal care. However, healthcare will always be under pressure and we also require ways of managing safety when conditions are difficult. We need to make more use of strategies concerned with detecting, controlling, managing and responding to risk. Strategies for managing safety in highly standardised and controlled environments are necessarily different from those in which clinicians constantly have to adapt and respond to changing circumstances. This work is supported by the Health Foundation. The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK. The charity’s aim is a healthier population in the UK, supported by high quality health care that can be equitably accessed. The Foundation carries out policy analysis and makes grants to front-line teams to try

ideas in practice and supports research into what works to make people's lives healthier and improve the health care system, with a particular emphasis on how to make successful change happen. A key part of the work is to make links between the knowledge of those working to deliver health and health care with research evidence and analysis. The aspiration is to create a virtuous circle, using what works on the ground to inform effective policymaking and vice versa. Good health and health care are vital for a flourishing society. Through sharing what is known, collaboration and building people's skills and knowledge, the Foundation aims to make a difference and contribute to a healthier population.

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.

Based on the IOM's estimate of 44,000 deaths annually, medical errors rank as the eighth leading cause of death in the U.S. Clearly medical errors are an epidemic that needs to be contained. Despite these numbers, patient safety and medical errors remain an issue for physicians and other clinicians. This book bridges the issues related to patient safety by providing clinically relevant, vignette-based description of the areas where most problems occur. Each vignette highlights a particular issue such as communication, human facturs, E.H.R., etc. and provides tools and strategies for improving quality in these areas and creating a safer environment for patients.

Americans should be able to count on receiving health care that is safe. To achieve this, a new health care delivery system is needed â€" a system that both prevents errors from occurring, and learns from them when they do occur. The development of such a system requires a commitment by all stakeholders to a culture of safety and to the development of improved information systems for the delivery of health care. This national health information infrastructure is needed to provide immediate access to complete patient information and decision-support tools for clinicians and their patients. In addition, this infrastructure must capture patient safety information as a by-product of care and use this information to design even safer delivery systems. Health data standards are both a critical and time-sensitive building block of the national health information infrastructure. Building on the Institute of Medicine reports To Err Is Human and Crossing the Quality Chasm, Patient Safety puts forward a road map for the development and adoption of key health care data standards to support both information exchange and the reporting and analysis of patient safety data.

Winner of the 2009 ACHE James A. Hamilton Book of the Year Award! "This book is a tour de force, and no one but John Nance could have written it. Only he could have made sophisticated, scientifically disciplined instruction about the nature and roots of safety into a page-turner. Medical care has a ton yet to learn from the decades of progress that have brought aviation to unprecedented levels of safety, and, in instructing us all about those lessons, John Nance is not just a bridge-builder he is the bridge." --Donald M. Berwick, MD, MPP, President and

CEO, Institute for Healthcare Improvement (IHI)

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.

Learn why ergonomics is a business solution and not a businessproblem The Ergonomics Edge Improving Safety, Quality, andProductivity Dan MacLeod It is time for ergonomics to be seen inits true light. Too often, the subject of ergonomics appears to becomplicated, expensive, and a burden on industry. It has gainedvisibility because of hefty regulatory fines and product liabilitylaw-suits. As a result, many managers consider ergonomics to bejust another business headache. In The Ergonomics Edge, Dan MacLeoddemonstrates why ergonomics is really good news for managers,revealing how it can actually be a formidable weapon in a company'squest to gain competitive advantage. MacLeod is one of the leadingpractitioners of workplace ergonomics in the U.S., and hassuccessfully applied ergonomics in many manufacturing and serviceindustries. He shows how improving the user-friendliness of boththe workplace and a company's end-product can lead to reducedworkers' comp, turnover, absenteeism, and other cost savings.Moreover, he reveals how ergonomics can lead to higher earningsthrough greater worker productivity and increased sales. Highlyillustrated and written in a conversational style, The ErgonomicsEdge provides a non-technical approach designed to demystify thissubject that many find daunting. Section 1 presents basic ergonomicprinciples and discusses how these serve to enhance the functioningof any business, and goes on to show how businesses can respond tonew and impending OSHA and ANSI standards in a way that promotesefficient business operation. Section 2 explores a number ofspecific issues, offering insight into: * Ergonomics as an aspect of your firm's Total Quality Managementeffort * The causes and costs of cumulative trauma disorders (CTDs) andhow these may be prevented * The role of ergonomics in improving quality, productivity, andwork organization * The capacity of ergonomics to address vital human resource issuessuch as today's aging work force and the rights of employees withdisabilities Section 3 offers numerous case studies of practical applications ofergonomic solutions. In addition, it outlines the elements of aneffective workplace ergonomics program, with coverage of key issuessuch as organization, training, communication, job analysis and jobimprovements, medical management, and program monitoring. TheErgonomics Edge is the first working resource to offer convincingevidence that ergonomics can be a blessing and not a burden to U.S.business. This book will be indispensable in helping your firm

meetits long-range strategic goals. In addition, it will be importantreading for ergonomists, industrial hygienists, physicaltherapists, and other safety and medical professionals, to helpeveryone make the case for ergonomics.

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

Quality and Safety in Neurosurgery covers recent improvements and presents solutions for problems that impact patient care. This book is written for anyone who works at the intersection of quality, safety and neurosurgery, including neurosurgeons, neurologists, clinical researchers looking to improve outcomes in neurosurgery, hospital quality and safety officers, department leaders, fellows and residents. Edited by neurosurgeons who helped build the culture of quality and safety in the Department of Neurosurgery at UMN, this work emphasizes quality and safety, whether through ‘value based purchasing’, finding specialty specific quality and safety metrics, or just the professional desire to provide quality care. Presents an overview of quality and safety in neurosurgical settings and discusses solutions for problems that impact patient care Gives readers the tools they need to improve quality and safety in neurosurgery Provides examples on how to implement new tactics Includes coverage on teams, competence, safety, hospital incentives, quality, the physician handoff, medication compliance and operating room efficiency, and more

Consumers demand quality milk with a reasonable shelf-life, a requirement that can be met more successfully by the milk industry through use of improved processes and technologies. Guaranteeing the production of safe milk also remains of paramount importance. Improving the safety and quality of milk provides a comprehensive and timely reference to best practice and research advances in these areas. Volume 1 focuses on milk production and processing. Volume 2 covers the sensory and nutritional quality of cow’s milk and addresses quality improvement of a range of other milk-based products. The opening section of Volume 1: Milk production and processing introduces milk biochemistry and raw milk microbiology. Part two then reviews major milk contaminants, such as bacterial pathogens, pesticides and veterinary residues. The significance of milk production on the farm for product quality and safety is the focus of Part three. Chapters cover the effects of cows’ diet and mastitis, among other topics. Part four then reviews the state-of-the-art in milk processing. Improving the quality of pasteurised milk and UHT milk and novel non-thermal processing methods are among the subjects treated. With its distinguished editor and international team of contributors, volume 1 of Improving the safety and quality of milk is an essential reference for researchers and those in industry responsible for milk safety and quality. Addresses consumer demand for improved processes and technologies in the production, safety and quality of milk and milk products Reviews the major milk contaminants including bacterial pathogens, pesticides and vetinary residues as well as the routes of contamination, analytical techniques and methods of control Examines the latest advances in milk processing methods to improve the quality and safety of milk such as modelling heat processing, removal of bacteria and microfiltration techniques

From the nation’s leading experts in healthcare safety—the first comprehensive guide to delivering care that ensures the safety of patients and staff alike. One of the primary tenets among healthcare professionals is, “First, do no harm.” Achieving this goal means ensuring the safety of both patient and caregiver. Every year in the United States alone, an estimated 4.8 million hospital patients suffer serious harm that is preventable. To address this industry-wide problem—and provide evidence-based solutions—a team of award-winning safety specialists from Press Ganey/Healthcare Performance Improvement have applied their decades of experience and research to the subject of patient and workforce safety. Their mission is to achieve zero harm in the healthcare industry, a lofty goal that some hospitals have already accomplished—which you can, too. Combining the latest advances in safety science, data technology, and high reliability solutions, this step-

by-step guide shows you how to implement 6 simple principles in your workplace. 1. Commit to the goal of zero harm.2. Become more patient-centric.3. Recognize the interdependency of safety, quality, and patient-centricity.4. Adopt good data and analytics.5. Transform culture and leadership.6. Focus on accountability and execution. In Zero Harm, the world's leading safety experts share practical, day-to-day solutions that combine the latest tools and technologies in healthcare today with the best safety practices from high-risk, yet high-reliability industries, such as aviation, nuclear power, and the United States military. Using these field-tested methods, you can develop new leadership initiatives, educate workers on the universal skills that can save lives, organize and train safety action teams, implement reliability management systems, and create long-term, transformational change. You'll read case studies and success stories from your industry colleagues—and discover the most effective ways to utilize patient data, information sharing, and other up-to-the-minute technologies. It's a complete workplace-ready program that's proven to reduce preventable errors and produce measurable results—by putting the patient, and safety, first. The maxim "Primum non nocere" is almost as old as the practice of medicine. In combination with the principles of beneficence, autonomy and justice, and whilst keeping in mind the confidence and dignity of the patient, it should constitute the basis of our behaviours as physicians and nurses. Since diagnostic and therapeutic interventions have become more complex and their risk/benefit ratios more difficult to assess, the importance of safety and quality of care rises. Avoiding the infliction of harm on our patients has moved into the focus of clinical medicine. Patient safety is now viewed as a priority even by the Presidency of the European Union. Physicians in intensive care medicine deal with the most fragile and dependent human beings, often struggling with multiple co-morbid diseases and physiological derangements at the limits of survival. These patients are often reliant on numerous invasive technologies for their survival. Moreover, the almost universal need for multiple pharmacological interventions – combinations of which have often never been rigorously tested before – places the critically ill patients at a very high risk of being harmed by the physician's interventions. More than 120 internationally known experts introduce their current knowledge of patient safety and quality of care in intensive care medicine in over 50 chapters covering the following fields: - Safety in intensive care medicine - Decision making - Culture and behaviour - Structure and processes - Protocolised medicine - First, do no harm - Safety during technical support - Training, teaching and education - Risk management - Ethical issues - Future approaches This book should be read by every manager who has responsibility for the acutely ill. It is an invaluable educational and reference tool for physicians and nurses in intensive care medicine and will help to improve the safety and overall care for critically ill patients. with contributions from: LM Aitken, R Alvisi, R Amerling, PJD Andrews, A Artigas, D De Backer, N Badjatia, M Bauer, G Bertolini, A Biasi Cavalcanti, JF Bion, BW Böttiger, CSC Bouman, A Boumendil, FA Bozza, J Braithwaite, G Brattebø, FM Brunkhorst, DDG Bugano, M Capuzzo, M Cecconi, W Chaboyer, J Chen, E Coiera, K Colpaert, CR Cooke, JR Curtis, BH Cuthbertson, AL Cuvello Neto, KJ Deans, J Decruyenaere, J-M Dominguez-Roldan, Y Donchin, C Druml, G Dubreuil, R Endacott, A Esteban, R Ferrer, H Flaatten, J Fragata, F Frutos-Vivar, C Garcia-Alfaro, M Garrouste-Orgeas, TD Girard, ARJ Girbes, J Graf, D Grimaldi, ABJ Groeneveld, B Guidet, U Günther, N Harbord, DA Harrison, C Hartog, N Heming, F Hernandez-Hazañas, K Hillman, P Holder, MH Hooper, M Imhoff, U Janssens, JM Kahn, E Knobel, M Knobel, J Lipman, T Lisboa, Y Livne, S Lorent, M Makdisse, A Marques, GD Martich, ML Martinez, SA Mayer, DK Menon, PC Minneci, J-P Mira, X Monnet, RP Moreno, T Muders, C Natanson, A Navas, G Ntoumenopoulos, SA Nurmohamed, HM Oudemans-van Straaten, R Paterson, O Peñuelas, JG Pereira, C Pierrakos, LF Poli-de-Figueiredo, CE Pompilio, D Poole, A Pronovost, C Putensen, K Reinhart, J Rello, A Rhodes, Z Ricci, C Richard, F Rincon, JA Roberts, E Roeb, C Ronco, GD Rubenfeld, D Salgado, JIF Salluh, G Satkurunath, A Schneider, C Schwebel, E Silva, M Singer, EGM Smit, M Soares, L Soufir, A Tabah, J-L Teboul, P Teschendorf, N Theuerkauf, J-F Timsit, M Ulldemolins, A Valentin, JM

Varghese, J-L Vincent, B Volpe, CS Waldmann, RR West, S West, JF Winchester, H Wrigge

As tree nuts and peanuts become increasingly recognised for their health-promoting properties, the provision of safe, high quality nuts is a growing concern. Improving the safety and quality of nuts reviews key aspects of nut safety and quality management. Part one explores production and processing practices and their influence on nut contaminants. Chapters discuss agricultural practices to reduce microbial contamination of nuts, pest control in postharvest nuts, and the impact of nut postharvest handling, de-shelling, drying and storage on quality. Further chapters review the validation of processes for reducing the microbial load on nuts and integrating Hazard Analysis Critical Control Point (HACCP) and Statistical Process Control (SPC) for safer nut processing. Chapters in part two focus on improving nut quality and safety and highlight oxidative rancidity in nuts, the impact of roasting on nut quality, and advances in automated nut sorting. Final chapters explore the safety and quality of a variety of nuts including almonds, macadamia nuts, pecans, peanuts, pistachios and walnuts. Improving the safety and quality of nuts is a comprehensive resource for food safety, product development and QA professionals using nuts in foods, those involved in nut growing, nut handling and nut processing, and researchers in food science and horticulture departments interested in the area. Reviews key aspects of nut safety and quality management and addresses the influences of production and processing practices on nut safety Analyses particular nut contaminants, safety management in nut processing and significant nut quality issues, such as oxidative rancidity Places focus on quality and safety in the production and processing of selected types of nuts

Concise, portable, and user-friendly, The Washington Manual® of Patient Safety and Quality Improvement covers essential information in every area of this complex field. With a focus on improving systems and processes, preventing errors, and promoting transparency, this practical reference provides an overview of PS/QI fundamentals, as well as insight into how these principles apply to a variety of clinical settings. Part of the popular Washington Manual® series, this unique volume provides the knowledge and skills necessary for an effective, proactive approach to patient safety and quality improvement.

Eggs are economical and of high nutritional value, yet can also be a source of foodborne disease. Understanding of the factors influencing egg quality has increased in recent years and new technologies to assure egg safety have been developed. Improving the safety and quality of eggs and egg products reviews recent research in these areas Volume 2 focuses on egg safety and nutritional quality. Part one provides an overview of egg contaminants, covering both microbial pathogens and chemical residues. Salmonella control in laying hens is the focus of part two. Chapters cover essential topics such as monitoring and control procedures in laying flocks and egg decontamination methods. Finally, part three looks at the role of eggs in nutrition and other health applications. Chapters cover dietary cholesterol, egg allergy, egg enrichment and bioactive fractions of eggs, among other topics. With its distinguished editors and international team of contributors, Volume 2 of Improving the safety and quality of eggs and egg products is an essential reference for managers in the egg industry, professionals in the food industry using eggs as ingredients and all those with a research interest in the subject. Focuses on egg safety and nutritional quality with reference to egg contaminants such as Salmonella Enteritidis Chapters discuss essential topics such as monitoring and control procedures in laying flocks and egg decontamination methods Presents a comprehensive overview of the role of eggs in nutrition and other health applications including dietary cholesterol, egg allergy, egg enrichment and bioactive fractions of eggs

Learning Teams from Dr Todd Conklin, PhD, are part of a way of looking at safety, quality and operational excellence differently by a facilitated approach to worker engagement and supporting the empowerment of people to own safety, quality or operational excellence. A Learning Team is notable because it encourages organizations to obtain and consider different perspectives and angles of functional diversity

to define a problem in a group context. The different perspectives that emerge from a Learning Team group demonstrate that no one person holds all the knowledge needed to solve complex problems.A Learning Team involves facilitated engagement (using a facilitator) with workers to understand and then learn from the opportunities that are presented by:1) Everyday successful and safe work (Everyday Learning Teams)2) Events or incidents that could have or did harm workers (Event Learning Teams)3) Introduction of changes (Management of change) that could affect worker safety (Periodic Learning Teams).Learning Teams support both worker learning and organizational learning by allowing the different stakeholders groups to understand better what, when, how, and why, people do things differently rather than following formal, written procedures or systems. By understanding what is necessary to make sure things go right, it is possible to focus on ensuring that factors which make things go right are present in the workplace every day. In the book Dr Todd Conklin states: "The Practice of Learning Teams will become a powerful resource in changing the way organizations learn and improve their operations. This book is easy to read and full of great concepts that can be used as soon as you read them. I love a book where you read an idea in the morning and try the same idea that very afternoon."This book has been written to act as a guide on how to:1) Integrate Learning Teams into your organization2) Improve worker learning and build critical thinking skills for workers in their everyday work3) Improve organizational learning using Learning Teams4) Become an effective Learning Teams facilitator by understanding what core capabilities and competencies are neededThroughout this book, we will explore examples of applications of Learning Teams in safety, quality and operational excellence.As the reader, you will gain additional knowledge and understanding about Learning Teams in the context of:1) The expected outcomes of a Learning Team2) Where you are at and how you become an effective Learning Team facilitator3) Learning about what makes a successful Learning Team4) When you can use a Learning Team to build and improve worker knowledge5) When you can use a Learning Team to build and improve organizational knowledge6) An opportunity to see the different contexts in which a Learning Team can add value7) Reflecting and learning from real-life experiences where Learning Teams have been successful, and considering the pitfalls that make them less effective.

"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.

Medical and health activities can greatly benefit from the effective use of health informatics. By capturing, processing, and disseminating information to the correct systems and processes, decision-making can be more successful and quality care and patient safety would see significant improvements. The Handbook of Research on Patient Safety and Quality Care through Health Informatics highlights current research and trends from both professionals and researchers on health informatics as applied to the needs of patient safety and quality care. Bringing together theory and practical approaches for patient needs, this book is essential for educators and trainers at multiple experience levels in the fields of medicine and medical informatics.

Influencing the Quality, Risk and Safety Movement in Healthcare explores the inner workings of some of the most influential minds in healthcare quality, risk and safety. The book was created in cooperation with the Master of Science in Healthcare Quality graduate program, developed and delivered by Queen’s University, Canada. This is the only standalone interdisciplinary Master of Science graduate degree in

Healthcare Quality in North America that focuses on creating tomorrow's healthcare leaders. Following a one-to-one collaboration between each leader in healthcare with a dedicated learner of the MSc(HQ), readers are presented with a synopsis of the leader's work followed by an in-depth interview with him or her. Interviews center around the leaders' contributions to and thoughts on quality, risk and safety in healthcare, dealing with topics such as the development of their body of work, their greatest achievements, what they wish they could change, and future direction of quality, risk and safety, etc. The book provides a unique and highly accessible view into how and why the science of healthcare quality has developed, as well as giving a first-hand account of the founders and key players in the movement. It will offer valuable insights to any undergraduate/graduate class with an interest in healthcare, as well as professionals working within any of the many disciplines that can influence the healthcare system.

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 AIDS--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 consequence--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 agenda--with state and local implications--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 errors--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 care--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 advocates--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

This text uses a case-based approach to share knowledge and techniques on how to operationalize much of the theoretical underpinnings of hospital quality and safety. Written and edited by leaders in healthcare, education, and engineering, these 22 chapters provide insights as to where the field of improvement and safety science is with regards to the views and aspirations of healthcare advocates and patients. Each chapter also includes vignettes to further solidify the theoretical underpinnings and drive home learning. End of chapter commentary by the editors highlight important concepts and connections between various chapters in the text. Patient Safety and Quality Improvement in Healthcare: A Case-Based Approach presents a novel approach towards hospital safety and quality with the goal to help healthcare providers

reach zero harm within their organizations.

Responding to the public concern caused by recent hospital scandals and accounts of unintended harm to patients, this author draws on her experience of analysing the health care systems of over a dozen countries and examines whether greater regulation has increased patient safety and health care quality. The book adopts a new approach to mapping developments in health care systems in Europe, North America and Australia and pieces together evidence of which regulatory strategies and mechanisms work well to ensure safer patient care. It identifies the regulatory bodies, the regulatory principles and the implementation strategies adopted to improve governance in health care systems and suggests a conceptual framework for responsive regulation. The book will be of interest to government actors, health care professionals and medico-legal scholars.

This book focuses exclusively on the surgical patient and on the perioperative environment with its unique socio-technical and cultural issues. It covers preoperative, intraoperative, and postoperative processes and decision making and explores both sharp-end and latent factors contributing to harm and poor quality outcomes. It is intended to be a resource for all healthcare practitioners that interact with the surgical patient. This book provides a framework for understanding and addressing many of the organizational, technical, and cultural aspects of care to one of the most vulnerable patients in the system, the surgical patient. The first section presents foundational principles of safety science and related social science. The second exposes barriers to achieving optimal surgical outcomes and details the various errors and events that occur in the perioperative environment. The third section contains prescriptive and proactive tools and ways to eliminate errors and harm. The final section focuses on developing continuous quality improvement programs with an emphasis on safety and reliability. Surgical Patient Care: Improving Safety, Quality and Value targets an international audience which includes all hospital, ambulatory and clinic-based operating room personnel as well as healthcare administrators and managers, directors of risk management and patient safety, health services researchers, and individuals in higher education in the health professions. It is intended to provide both fundamental knowledge and practical information for those at the front line of patient care. The increasing interest in patient safety worldwide makes this a timely global topic. As such, the content is written for an international audience and contains materials from leading international authors who have implemented many successful programs.

Researching Patient Safety and Quality in Health Care: A Nordic Perspective is an anthology based on contributions from leading researchers on quality and safety in healthcare in the Nordic countries together with four internationally renowned patient safety authors. Research on patient safety and quality has been dominated by countries such as the USA, England, Canada, and Australia. This book addresses the current debates in research on patient safety and quality in healthcare from a Nordic perspective. What are the flavours of Nordic research within these topics? What does it add to the international research literature? This book illustrates the unique nature of researching patient safety and quality with the Nordic perspective as well as showcasing representative work. The book presents an overview of the status and evidence of international and Nordic research on quality and safety in healthcare. Four different perspectives are used to present the trends within the research field: a patient perspective, a methodological perspective, a theoretical perspective, and a clinical perspective. The book then presents the status of Nordic research in the field and displays a set of illustrative work and current research topics within the Nordic context, concluding with a discussion of the characteristic features of Nordic research on patient safety and quality in healthcare. The anthology presents an inter-professional perspective and researchers from disciplines such as medical and nursing sciences, humanities, social sciences and engineering. It is written to contribute to the patient safety cause with translational knowledge that will be

useful to researchers, policy makers and healthcare managers within Nordic countries and internationally.

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 nursesâ€™ 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.

Americans are accustomed to anecdotal evidence of the health care crisis. Yet, personal or local stories do not provide a comprehensive nationwide picture of our access to health care. Now, this book offers the long-awaited health equivalent of national economic indicators. This useful volume defines a set of national objectives and identifies indicators--measures of utilization and outcome--that can "sense" when and where problems occur in accessing specific health care services. Using the indicators, the committee presents significant conclusions about the situation today, examining the relationships between access to care and factors such as income, race, ethnic origin, and location. The committee offers recommendations to federal, state, and local agencies for improving data collection and monitoring. This highly readable and well-organized volume will be essential for policymakers, public health officials, insurance companies, hospitals, physicians and nurses, and interested individuals.

The Washington Manual of Patient Safety and Quality Improvement provides a basic framework of many common principles in patient safety and quality improvement to a broad market of medical students and residents, nurses, patient safety officers and pharmacists. Chapters address a practical and multidisciplinary overview of patient safety in complex health care systems, and each concept is introduced using a clinical vignette. The text introduces models, measurements and tools to assess patient safety and quality improvement, and it discusses types of medical errors, how to respond to adverse events, and potential solutions. Addresses PS/QI in specific clinical settings (radiology, emergency room, surgery, ambulatory) Templated chapters, beginning with clinical vignettes, introduce PS/QI concepts in a relatable manner Written by advocates in patient safety/quality improvement Now with the print edition, enjoy the bundled interactive eBook edition, which can be downloaded to your tablet and smartphone or accessed online and includes features like: Complete content with enhanced navigation Powerful search tools and smart navigation cross-links that pull results from content in the book, your notes, and even the web Cross-linked pages, references, and more for easy navigation Highlighting tool for easier reference of key content throughout the text Ability to take and share notes with friends and colleagues Quick reference tabbing to save your favorite content for future use The Washington Manual® is a registered mark belonging to Washington University in St. Louis to which international legal protection applies. The mark is used in this publication by Wolters Kluwer under license from Washington University.

Global aquaculture production has grown rapidly over the last 50 years. It is generally accepted that there is limited potential to increase

traditional fisheries since most fish stocks are well or fully exploited. Consequently increased aquaculture production is required in order to maintain global per capita fish consumption at the present level. Fish farming enables greater control of product quality and safety, and presents the possibility of tailoring products according to consumer demands. This important collection reviews safety and quality issues in farmed fish and presents methods to improve product characteristics. The first part of the book focuses on chemical contaminants, chemical use in aquaculture and farmed fish safety. After an opening chapter discussing the risks and benefits of consumption of farmed fish, subsequent contributions consider environmental contaminants, pesticides, drug use and antibiotic resistance in aquaculture. Part two addresses important quality issues, such as selective breeding to improve flesh quality, the effects of dietary factors including alternative lipids and proteins sources on eating quality, microbial safety of farmed products, parasites, flesh colouration and off-flavours. Welfare issues and the ethical quality of farmed products are also covered. The final part discusses ways of managing of product quality, with chapters on HACCP, monitoring and surveillance, authenticity and product labelling. With its distinguished editor and international team of contributors, Improving farmed fish quality and safety is a standard reference for aquaculture industry professionals and academics in the field. Reviews safety and quality issues in farmed fish and presents methods to improve product characteristics Discusses contaminants, persistent organic pollutants and veterinary drug residues and methods for their reduction and control Addresses important quality issues, genetic control of flesh characteristics and the effects of feed on product nutritional and sensory quality

Patient safety and quality are an ever-increasing concern to consumers, payers, providers, organizations, and governments. However, high reliability methods and science that can provide efficient and effective care have still not been totally implemented into our healthcare culture. Nurses, representing the majority of healthcare workers, are on the front line of the delivery and provision of safe and effective care and are ideally situated to drive the mission to achieve high reliability in healthcare. High Reliability Organizations: A Healthcare Handbook for Patient Safety & Quality presents practical examples of HRO principles in order to establish a system that detects and prevents errors from happening even in the most difficult, high risk conditions. Authors Cynthia Oster and Jane Braaten provide healthcare professionals with tools and best practices that will improve and enhance patient safety and quality outcomes. This book provides: An overview of HRO science as an organizing framework for quality and patient safety, practical applications of HRO science, focusing on quality and patient safety, knowledge and tools that can be applied to current quality and safety practices and real-world examples of HRO principles employed in a variety of patient care areas.

Drawing on the universal values in health care, the second edition of Quality and Safety in Nursing continues to devote itself to the nursing community and explores their role in improving quality of care and patient safety. Edited by key members of the Quality and Safety Education for Nursing (QSEN) steering team, Quality and Safety in Nursing is divided into three sections. Itfirst looks at the national initiative for quality and safety and links it to its origins in the IOM report. The second section defines each of the six QSEN competencies as well as providing teaching and clinical application strategies, resources and current references. The final section now features redesigned chapters on implementing quality and safety across settings. New to this edition includes: Instructional and practice approaches including narrative pedagogy and integrating the competencies in simulation A new chapter exploring the application of clinical learning and the critical nature of inter-professional teamwork A revised chapter on the mirror of education and practice to better understand teaching approaches This ground-breaking unique text addresses the challenges of preparing future nurses with the knowledge, skills, and attitudes (KSAs) necessary to continuously improve the health care system in which they practice.

Improving the Safety and Quality of NutsElsevier

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.

This Handbook provides an authoritative overview of current issues and debates in the field of health care management. It contains over twenty chapters from well-known and eminent academic authors, who were carefully selected for their expertise and asked to provide a broad and critical overview of developments in their particular topic area. The development of an international perspective and body of knowledge is a key feature of the book. The Handbook secondly makes a case for bringing back a social science perspective into the study of the field of health care management. It therefore contains a number of contrasting and theoretically orientated chapters (e.g. on institutionalism; critical management studies). This social science based approach is a refreshing alternative to much existing work in this domain and offers a good way into current academic debates in this field. The Handbook thirdly explores a variety of important policy and organizational developments apparent within the current health care field (e.g. new organizational forms; growth of management consulting in health care organizations). It therefore explores and comments on major contemporary trends apparent in the practice field.