Patient Safety Handbook

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 perspective, Patient Safety: A Human Factors Approach delineates a method that can enlighten and clarify this discourse as well as put us on a better path to correcting the issues. People often think, understandably, that safety lies mainly in the hands through which care ultimately flows to the patient—those who are closest to the patient, whose decisions can mean the difference between life and death, between health and morbidity. The human factors approach refuses to lay the responsibility for safety and risk solely at the feet of people at the sharp end. That is where we should intervene to make things safer, to tighten practice, to focus attention, to remind people to be careful, to impose rules and guidelines. The book defines an approach that looks relentlessly for sources of safety and risk everywhere in the system—the designs of devices; the teamwork and coordination between different practitioners; their communication across hierarchical and gender boundaries; the cognitive processes of individuals; the organization that surrounds, constrains, and empowers them; the economic and human resources offered; the technology available; the political landscape; and even the culture of the place. The breadth of the human factors approach is itself testimony to the realization that there are no easy answers or silver bullets for resolving the issues in patient safety. A user-friendly introduction to the approach, this book takes the complexity of health care seriously and doesn't over simplify the problem. It demonstrates what the approach does do, that is offer the substance and guidance to consider the issues in all their nuance and complexity.

Principles of Risk Management and Patient Safety identifies changes in the industry and describes how these changes have influenced the functions of risk management in all aspects of healthcare. The book is divided into four sections. The first section describes the current state of the healthcare industry and looks at the importance of risk management and the emergence of patient safety. It also explores the importance of working with other sectors of the health care industry such as the pharmaceutical and device manufacturers. Important Notice: The digital edition of this book is missing some of the images or content found in the physical edition.

Whether you're new to medication safety or an experienced Medication Safety Officer, this guide will be an invaluable resource. TheMedication Safety Officer's Handbook offers expert guidance in every area of your work, from setting up safety systems to dealing with personnel problems, along with sample forms, checklists and other job tools.

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.

The book follows a proven training outline, including real-life examples and exercises, to teach healthcare professionals and students how to lead effective and successful Root Cause Analysis (RCA) to eliminate patient harm. This book discusses the need for RCA in the healthcare sector, providing practical advice for its facilitation. It addresses when to use RCA, how to create effective RCA action plans, and how to prevent common RCA failures. An RCA training curriculum is also included. This book is intended for those leading RCAs of patient harm events, leaders, students, and patient safety advocates who are interested in gaining more knowledge about RCA in healthcare.

Provides step-by-step instructions on how to establish a patient safety plan for a variety of healthcare settings, summarizing each of the key patient safety requirements implemented by federal, state, and accreditation agencies, including the federal Patient Safety and Quality Improvement Act of 2005.

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
Drive to provide high value healthcare has created a field of medical quality improvement and safety. A Quality Improvement (QI) project would often aim in translate medical evidence (e.g. hand hygiene saves lives) into clinical practice (e.g. actually washing your hands before you see the patient, suffice it to say that not all hospitals are able to report 100% compliance with hand-hygiene). All doctoral residents in the United States must now satisfy a new requirement from the American College of Graduate Medical Education that they participate in a QI initiative. However, few departments are equipped to help their residents develop and implement a QI initiative. Resident's Handbook is a short, not fussy, and practical introduction to developing a QI initiative. Meant not only for residents seeking to jump-start a QI initiative but also for attending physicians looking to improve their clinical practice, residency program directors and even medical students already eyeing what residency training holds for them; the book introduces and explains the basic tools needed to conduct a QI project. It provides numerous real-life examples of QI projects by the residents, fellows and attendings who designed them, who discuss their successes and failures as well as the specific tools they used. Several chapters provide a more senior perspective on resident involvement in QI projects and feature contributions from several QI leaders, a hospital administration VP and a residency program director. Though originally designed with physicians in mind, the book will also be helpful for physician assistants, nurses, physical, occupational and speech language pathology therapists, as well as students in these disciplines. Since no QI intervention is likely to be successful if attempted in isolation more non-physician clinicians are joining the ranks of quality and safety leadership. Therefore several non-physician clinician led initiatives included in the manuscript constitute an integral part of this book.The book serves as a short introduction to the field of medical quality improvement and safety emphasizing the practical pointers of how to actually implement a project from its inception to publication. To our knowledge this is the first concise do-it-yourself publication of its kind. Some of the topics covered include: how to perform an efficient literature search, how to get published, how to scope a project, how to generate improvement ideas, effective communication, team, project management and basic quality improvement tools like PDCA, DMAIC, Lean, Six Sigma, human factors, medical informatics etc.. Although no substitute for the services of a trained clinical statistician, chapters on statistics and critical assessment of the medical literature familiarizes residents with basic statistical methodologies, clinical trials and evidence based medicine (EBM). Since no QI project is complete without providing evidence for post-intervention improvement we provide a short introduction to the free statistical language R, which helps residents independently run basic statistical calculations. Because much of QI involves assessment of subjective human experiences, there is also a chapter on how to write surveys. Resident's Handbook of Medical Quality and Safety is not an exhaustive QI textbook but rather a hands-on pocket guide to supplement formal training by other means.div
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.
Advancements in technology regularly influence the healthcare field and developing aspects on medical patient safety. Implementing electronic health records, decision support systems, and computerized physician order entry systems reduces risk in the potential for e-health to make errors leading to adverse events. E-Health Technologies and Improving Patient Safety: Exploring Organizational Factors presents an overview on information and communication technologies and addresses the impacts on the field of both patient safety and e-health. This book offers insightful perspectives and concentrated research on concepts related to these areas, as well as issues and current trends in patient safety in e-health.
"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.
Complete coverage of the core principles of patient safety Understanding Patient Safety, 2e is the essential text for anyone wishing to learn the key clinical, organizational, and systems issues in patient safety. The book is filled with valuable cases and analyses, as well as up-to-date tables, graphics, references, and tools -- all designed to introduce the patient safety field to medical trainees, and be the go-to book for experienced clinicians and non-clinicians alike. Features NEW chapter on the critically important role of checklists in medical practice NEW case examples throughout Expanded coverage of the role of computers in patient safety and outcomes Expanded coverage of new patient initiatives from the Joint Commission
The Correctional Health Care Patient Safety Handbook provides practical evidence-based help to improve your clinical

program and, thereby, reduce clinical error, managing risk and improving clinical quality. By reading this book, you will discover: How a patient safety framework can reduce legal liability while enhancing continuous quality improvement efforts The best methods to assess and improve an organizational culture to support patient safety The key ways therapeutic systems support patient safety Why communication and teamwork are so important for reducing clinical error How to involve your patients to reduce errors and liability The practitioner issues that can sink your clinical program and what to do about them This book is a must-read for anyone working in the correctional health care setting, but especially for those who have opportunity to create and improve systems of care such as: Health Service Administrators Medical Directors Directors of Nursing Risk Management Professionals Operational Leaders Lorry Schoenly is a nurse author and educator specializing in correctional health care. She provides consulting services to jails and prisons across the country on projects to improve professional nursing practice and patient safety. Dr. Schoenly actively promotes correctional health care through social media outlets and increases the visibility of the specialty through her popular blog - CorrectionalNurse.Net. Her podcast, Correctional Nursing Today, reviews correctional healthcare news and interviews correctional health care leaders. She is recipient of the National Commission on Correctional Health Care 2013 B. Jaye Anno Award of Excellence in Communication. Lorry is co-editor and chapter author of Essentials of Correctional Nursing, the first primary practice text for the correctional nursing specialty. She resides in the mountains of north central Pennsylvania.

Patients are increasingly encouraged to take an active role in managing their health and health care. New technologies, cultural shifts, trends in healthcare delivery, and policies have brought to the forefront the "work" patients, families, and other non-professionals perform in the pursuit of health. This volume closely examines notable application areas for the emerging discipline of Patient Ergonomics – the science of patient work. The Patient Factor: Applications of Patient Ergonomics, Volume II reviews the definition of Patient Ergonomics and discusses the application of Patient Ergonomics across contexts. It analyzes patient work performed in emergency departments, transitions of care, home and community settings, retail pharmacies, and online communities. It also examines applications to groups including veterans, pediatric patients, older adults, the underserved, and people engaged in health promotion. The Patient Factor is ideal for academics working in health care and patient-centered research, their students, human factors practitioners working in healthcare organizations or at technology companies, frontline healthcare professionals, and leaders of healthcare delivery organizations.

Ethical medical treatment is an important aspect of healthcare that is affected by multiple influencing factors in, both private and public, medical organizations. By understanding and adapting the components of the health system to these influencing factors, healthcare can have better outcomes for patients and practitioners. Healthcare Administration for Patient Safety and Engagement provides emerging research on the theoretical and practical aspects of healthcare management for optimal patient care and communication. While highlighting topics, such as clinical communication, ethical dilemmas, and preventive medicine, this book will teach readers about the tools and applications of ethical treatment and hospital behavior in both private and public medical organizations. This book is an important resource for managers and employees of health units, physicians, medical students, psychology and sociology professionals, and researchers seeking current research on healthcare organization and patient satisfaction.

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.

The Hospital Safety Professional's Handbook, Fifth Edition Cindy Taylor, ARM, CSPHP This trusted resource is your guide through the complex and changing world of healthcare safety and regulatory compliance. Completely updated, this book removes the stress from the role of healthcare safety professional by providing straightforward coverage of all the most important topics, including life safety and emergency management scenarios, keeping up with The Joint Commission, and the increased presence of CMS in the safety space. The Hospital Safety Professional's Handbook, Fifth Edition, gives you the necessary resources to handle evolving safety requirements. With a new emphasis on risk assessment, emergency planning, and complex issues such as hazardous waste disposal, this is the one handbook you need to handle all of your safety duties! This book will help you: Emphasize risk assessment as a core measure of planning, growth, and continuity of operations Meet the regulatory requirements related to life safety and emergency management Train hospital staff on communication and safety topics, including safety-related staff competency requirements based on revised Joint Commission standards Clarify key issues such as the 96-hour rule, corridor clutter, Sentinel Event Alerts, and more Strategically integrate building safety and patient safety, infection control, and relevant National Patient Safety Goals Navigate the safety director's role during construction and renovation projects Table of Contents: Chapter 1: An Overview: The Hospital Safety Professional Chapter 2: Managing Risks in Healthcare Chapter 3: Setting Up and Organizing Your Program Chapter 4: Budgeting for Safety Chapter 5: Creating a Safety Manual

Chapter 6: Safety & Security Management Chapter 7: Hazardous Materials and Wastes Chapter 8: Preparing for and Responding to Emergencies (Including Utility Systems Capabilities) Chapter 9: Life and Fire Safety Management (Including ILSMs) Chapter 10: Medical Equipment and Utilities Chapter 11: Performance Improvement/Effective Organization/Management of Your EOC Committee Chapter 12: Education and Training Chapter 13: Final Recommendations

Health Sciences & Professions

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.

Learn how financial management fits into the healthcare organization. Financial Management for Nurse Managers and Executives, 5th Edition covers the latest accounting and financial management practices distinctly from the nurse manager’s point of view. Topics include how financial management fits into the health care organization, financial accounting, cost analysis, planning and control management of the organization’s financial resources, various management tools, and the future of financial management with respect to healthcare reform and international accounting standards. This new edition includes updated information on the Affordable Care Act, Accountable Care Organizations, Value Based Payment, and Team and Population Based Care. Nursing-focused content thoroughly describes healthcare finance and accounting from the nurse manager’s point of view. Numerous worksheets and tables including healthcare spreadsheets, budgets, and calculations provide you with specific examples of how to apply financial management principles to nursing practice. NEW! Information about the Affordable Care Act details how changes and developments affects coverage for millions of Americans. NEW! Value-Based Payment reimbursement information details what nurse executives need to know in order to use this new system NEW! Coverage of Accountable Care Organizations provides current information on one of the emerging forms of managed care and how it works within the financial system of healthcare. NEW! Team-and Population-Based care information covers how to work with healthcare professionals outside of nursing.

Ambulatory care organizations are challenged by medication safety, infection prevention and control, environment of care, communication, and other patient safety issues; however, most available benchmarks and initiatives concerning patient safety were developed specifically for hospitals and do not translate easily to ambulatory care settings. Ambulatory surgical centers, office-based surgery practices, community health centers, diagnostic imaging centers, urgent care centers, medical and dental centers, and other ambulatory care facilities face critical and unique patient safety issues on a daily basis. A Patient Safety Handbook for Ambulatory Health Care provides proven solutions for keeping patients safe in an ambulatory setting and addresses challenging patient safety concerns. The book explores seven system-level issues: patient-centered care, communication, medication use, surgical safety, infection prevention and control, environment and equipment, and staff education and training. It contains useful tools that educate staff and physicians about patient safety in ambulatory care: Easy-to-adapt forms, checklists, and solutions Critical lessons learned about which approaches work, which don't, and why Real-life case studies on improving patient safety in ambulatory settings Discussions on growing concerns in ambulatory health care, such as the following: Safe medication use, such as chemotherapy drugs and multi-use medication vials Anesthesia issues, such as undiagnosed sleep apnea, patient falls, and malignant hyperthermia Effective infection control, such as hand hygiene and flash sterilization

Patient Safety: Perspectives on Evidence, Information and Knowledge Transfer provides background on the patient safety movement, systems safety, human error and other key philosophies that support change and innovation in the reduction of medical error. The book draws from multidisciplinary areas within the acute care environment to share models that support the proactive changes necessary to provide safe care delivery. The publication discusses how the tenets of safety (described in the beginning of the book) can be actively applied in the field to make evidence, information and knowledge (EIK) sharing processes reliable, effective and safe. This is a wide-ranging and important book that is designed to raise awareness of the latent risks for patient safety that are present in the EIK identification, acquisition and distribution processes, structures, and systems of many healthcare institutions across the world. The expert contributors offer systemic, evidence-based improvement processes, assessment concepts and innovative activities to identify these risks to minimize their potential to adversely impact care. These ideas are presented to create opportunities for the field to design and use strategies that enable meaningful implementation and management of EIK. Their thoughts will enable healthcare staff to see EIK as a tangible element contributing toward sustainable patient safety improvements.

Patient safety is an issue which in recent years has grown to prominence in a number of countries’ political and health service agendas. The World Health Organisation has launched the World Alliance for Patient Safety. Millions of patients, according to the Alliance, endure prolonged ill-health, disability and death caused by unreliable practices, services, and poor health care environments. At any given time 1.4 million people worldwide are suffering from an infection acquired in a health facility. Patient Safety, Law Policy and Practice explores the impact of legal systems on patient safety initiatives. It asks whether legal systems are being used in appropriate ways to support state and local managerial systems in developing patient safety procedures, and what

alternative approaches can and should be utilized. The chapters in this collection explore the patient safety managerial structures that exist in countries where there is a developed patient safety infrastructure and culture. The legal structures of these countries are explored and related to major in-country patient safety issues such as consent to treatment protocols and guidelines, complaint handling, adverse incident reporting systems, and civil litigation systems, in order to draw comparisons and conclusions on patient safety.

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.

Risk Management Handbook for Health Care Organizations, Student Edition This comprehensive textbook provides a complete introduction to risk management in health care. Risk Management Handbook, Student Edition, covers general risk management techniques; standards of health care risk management administration; federal, state and local laws; and methods for integrating patient safety and enterprise risk management into a comprehensive risk management program. The Student Edition is applicable to all health care settings including acute care hospital to hospice, and long term care. Written for students and those new to the topic, each chapter highlights key points and learning objectives, lists key terms, and offers questions for discussion. An instructor's supplement with cases and other material is also available. American Society for Healthcare Risk Management (ASHRM) is a personal membership group of the American Hospital Association with more than 5,000 members representing health care, insurance, law, and other related professions. ASHRM promotes effective and innovative risk management strategies and professional leadership through education, recognition, advocacy, publications, networking, and interactions with leading health care organizations and government agencies. ASHRM initiatives focus on developing and implementing safe and effective patient care practices, preserving financial resources, and maintaining safe working environments.

The first comprehensive, authoritative review of one of the most fundamental and important issues in infection control and patient safety, hand hygiene. Developed and presented by the world's leading scholar-clinicians, Hand Hygiene is an essential resource for all medical professionals. Developed and presented by the world leaders in this fundamental topic Fully integrates World Health Organization (WHO) guidelines and policies Offers a global perspective in tackling hand hygiene issues in developed and developing countries Coverage of basic and highly complex clinical applications of hand hygiene practices Includes novel and unusual aspects and issues in hand hygiene such as religious and cultural aspects and patient participation Offers guidance at the individual, institutional, and organizational levels for national and worldwide hygiene promotion campaigns

In the current climate of managed care, tight cost controls, limited resources, and the growing demand for health care services, conditions of errors are ripe. This book offer practical guidance on implementing systems and processes to improve outcomes and advance patient safety.

Patient Safety HandbookJones & Bartlett Publishers

Patients have always been encouraged to be active participants in managing their health. New technologies, cultural shifts, trends in healthcare delivery, and policies have brought the patients' role in healthcare to the forefront. This 2-volume set reviews and advances the emerging discipline of Patient Ergonomics. The set focuses on patients and their performance. It presents practical recommendations and case studies useful for researchers and practitioners. It covers diverse healthcare settings outside of hospitals and clinics, and provides a combination of foundational content and specific applications in detail. The 2-volume set will be ideal for academics working in healthcare and patient-centered research, their students, human factors practitioners (consultants, employees of health systems and technology/medical device compaines), healthcare professionals (physicians, nurses, pharmacists), and organizational leaders (healthcare administrators and executives).

Offering a concise yet comprehensive review of current practices in surgery and patient safety, Handbook of Perioperative and Procedural Patient Safety is an up-to date, practical resource for practicing surgeons, anesthesiologists, surgical nurses, hospital administrators, and surgical office staff. Edited by Drs. Juan A. Sanchez and Robert S. D. Higgins and authored by expert contributors from Johns Hopkins, it provides an expansive look at the scope of the problem, causes of error, minimizing errors, surgical suite and surgical team design, patient experience, and other related topics. Presents the knowledge and experience of a multidisciplinary team from Johns Hopkins University, which created the Comprehensive Unit-based Safety Program (CUSP), an approach for improving safety culture and engaging frontline clinicians to identify and mitigate defects in care delivery. Discusses the scope and prevalence of perioperative harm, causes of error in healthcare, and perioperative never events. Covers safe practices, cognitive workload and fatigue, and the effects of noise in the OR. Includes several team-based chapters such as the dynamics of surgical teams, safer perioperative team communication, and the culture of safety. Consolidates today's available information and guidance into a single, convenient resource.

Written for virtually every professional and leader in the health care field, as well as students who are preparing for careers in health services delivery, this book presents a framework for developing a patient safety program, shows how best to examine events that do occur, and reveals how to ensure that appropriate corrective and preventative actions are reviewed for effectiveness. The book covers a comprehensive selection of topics including The link between patient safety and legal and regulatory compliance The role of accreditation and standard-setting organizations in patient safety Failure modes and effect analysis Voluntary and regulatory oversight of medical error Evidence-based outcomes and standards of care Creation and preservation of reports, data, and device evidence in medical error situations Claims management when dealing with patient safety events Full disclosure Patient safety in human research Managing confidentiality in the face of litigation Managing patient safety compliance through accountability-based credentialing for health care professionals Planning for the future

The Vaccine Handbook has a simple purpose- to draw together authoritative information about vaccines into a simple and concise resource that can be used in the office, clinic, and hospital. Not an encyclopedia or scientific textbook, The Vaccine Handbook gives practical advice and provides enough background for the practitioner to understand the recommendations and explain them to his or her patients. For each vaccine, the authors discuss the disease and its epidemiology, the vaccine’s efficacy and safety, and the practical questions most frequently asked about the vaccine’s use. The authors also discuss problems such as allergies, breastfeeding, dosing intervals and missed vaccines, and immunocompromised individuals. This handbook is also available electronically for handheld computers. See Media listing for details.