

PATIENT SAFETY

A Human Factors Approach

Patient Safety A Human Factors Approach

Annelise Matthews



Patient Safety A Human Factors Approach:

Patient Safety Sidney Dekker, 2016-04-19 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 Handbook of Human Factors and Ergonomics in Health Care and Patient Safety, Second Edition Pascale Carayon, 2011-11-09 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 Patient Safety Culture Patrick Waterson, 2018-10-09 How safe are hospitals Why do some hospitals have higher rates of accident and errors involving patients How can we accurately measure and assess staff attitudes towards safety How can hospitals and other healthcare environments improve their safety culture and minimize harm to patients These and other questions have been the focus of research within the area of Patient Safety Culture PSC in the last decade More and more hospitals and healthcare managers are trying to understand the nature of the culture within their organisations and implement strategies for improving patient safety The main purpose of this book is to provide researchers healthcare managers and human factors practitioners with details of the latest developments within the theory and application of PSC within healthcare It brings together contributions from the most prominent researchers and practitioners in the field of PSC and covers the background to work on safety culture e g measuring safety culture in industries such as aviation and the nuclear industry the dominant theories and concepts within PSC examples of PSC tools methods of assessment and their application and details of the most prominent challenges for the future in the area Patient Safety Culture Theory Methods and Application is essential reading for all of the professional groups involved in patient safety and healthcare quality improvement filling an important gap in the current market **Around the Patient Bed** Yoel

Donchin, Daniel Gopher, 2013-10-16 The occurrence of failures and mistakes in health care from primary care procedures to the complexities of the operating room has become a hot button issue with the general public and within the medical community Around the Patient Bed Human Factors and Safety in Health Care examines the problem and investigates the tools to improve health care quality and safety from a human factors engineering viewpoint the applied scientific field engaged in the interaction between the human operator functionary worker task requirements the governing technical systems and the characteristics of the work environment The book presents a systematic human factors based proactive approach to the improvement of health care work and patient safety The proposed approach delineates a more direct and powerful alternative to the contemporary dominant focus on error investigation and care providers accountability It demonstrates how significant improvements in the quality of care and enhancement of patient safety are contingent on a major shift from efforts and investments driven by a retroactive study of errors incidents and adverse events to an emphasis on proactive human factors driven intervention and the development of corresponding conceptual approaches and methods for its systematic implementation Edited by Yoel Donchin representing the medical profession and Daniel Gopher from the human factors engineering field the book brings together experts who have collaborated to present studies that reveal a wide range of problems and weaknesses of the contemporary health care system which impair safety and quality and increase workload The book presents practical solutions based on human factors engineering components and cognitive psychology and explains their driving principles and methodologies This approach provides tools to significantly reduce the number of errors creates a safe environment and improves the quality of health care

Handbook of Human Factors and Ergonomics in Health Care and Patient Safety Pascale Carayon, 2016-04-19 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

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Safety Claire Cox, Jordan Nicholls, Helen Hughes, 2024-08-13 OVERVIEW There are few resources and books for professionals within the patient safety sector that use case studies to model the practical application of theories of patient safety incident investigation Exploring these theories this text brings together contributors from a variety of academic and healthcare professions alongside those with lived experience to help you understand some of the emerging theories of safety science and their practical application The NHS's approach to incident reporting in investigations the Patient Safety Incident Response Framework PSIRF has given rise to new found opportunities and freedom of investigation and incident management This book aims to explore emerging safety sciences by leading experts and the practical application of them in differing clinical and organisational contexts Written by people who work in patient safety and with chapters on subjects such as System Engineering Initiative for Patient Safety SEIPS AcciMaps and Human Factors this book is for everyone with an interest in how the landscape of patient safety is changing and how to apply good practice for the reduction of avoidable harm TABLE OF CONTENTS Foreword by Ted Baker Chapter 1 Introduction Chapter 2 The theory of change management and its application in quality and safety Chapter 3 The Systems Engineering Initiative for Patient Safety SEIPS A Human Factors approach to work system analysis Chapter 4 Patient and family engagement following patient safety incidents Chapter 5 Safety II Chapter 6 After Action Review Chapter 7 Walk Through Talk Through analysis to support safety and improvement activity A Human Factors approach to observations Chapter 8 Accimaps Chapter 9 Transformative simulation To patient safety and beyond Chapter 10 Thematic reviews in patient safety Chapter 11 Conclusion

Human Factors in Healthcare: Level Two Debbie Rosenorn-Lanng, 2015-09-24 Building on Level One this volume of Human Factors in Healthcare continues to enhance and develop the SHEEP model delving deeper into the challenges of leadership conflict resolution and decision making that healthcare professionals currently face Presenting the five components of the SHEEP framework Systems Human Interaction Environment Equipment and Personal this book allows readers to develop their own human factors based approach within their workplace Through a wealth of real life examples of errors and patient safety issues drawn from the author's experience from over twenty years in healthcare it enables the identification of potential patient safety pitfalls and offers solutions on how to avoid them Written in a clear and engaging style this is a valuable resource for guiding healthcare professionals including doctors and nurses through the requirements of the human factors based approach to leadership conflict resolution and decision making See also Human Factors in Healthcare Level One 978 0 19 967060 4

Global patient safety action plan 2021-2030 World Health Organization, 2021-08-03 Patient safety is fundamental to the provision of health care in all settings However avoidable adverse events errors and risks associated with health care remain major challenges for patient safety globally The Seventy second World Health Assembly in 2019 adopted resolution WHA72.6 on global action on patient safety and mandated for development of a global patient safety action plan This global action plan was adopted by Seventy Fourth World Health Assembly in 2021 with a vision of a world in which no one is harmed in health

care and every patient receives safe and respectful care every time everywhere The purpose of the action plan is to provide strategic direction for all stakeholders for eliminating avoidable harm in health care and improving patient safety in different practice domains through policy actions on safety and quality of health services as well as for implementation of recommendations at the point of care The action plan provides a framework for countries to develop their respective national action plans on patient safety as well to align existing strategic instruments for improving patient safety in all clinical and health related programmes

Building Safer Healthcare Systems Peter Spurgeon, Mark-Alexander Sujan, Stephen Cross, Hugh Flanagan, 2019-08-21 This book offers a new practical approach to healthcare reform Departing from the priorities applied in traditional approaches it instead assesses both theoretically and practically the successful lessons learned in other safety critical industries and applies them to healthcare settings The authors focus on the importance of human factors and performance measures to establish proactive systematic methods for healthcare system design This approach helps to identify potential hazards before accidents occur enhancing patient safety In addition the book details the new approach on the basis of real world applications in the NHS and insights from NHS staff Case studies and results are presented demonstrating the significant improvements that can be achieved in risk reduction and safety culture Lastly the book outlines what steps healthcare organisations need to take in order to successfully adopt this new approach The approach and experiential learning is brought together through the development of a new holistic patient safety education syllabus

Patient Safety Claire Cox, Helen Hughes, Jordan Nicholls, 2024-08-14 There are few resources and books for professionals within the patient safety sector that use case studies to model the practical application of theories of patient safety incident investigation Exploring these theories this text brings together contributors from a variety of academic and healthcare professions alongside those with lived experience to help you understand some of the emerging theories of safety science and their practical application The NHS's approach to incident reporting in investigations the Patient Safety Incident Response Framework PSIRF has given rise to new found opportunities and freedom of investigation and incident management This book aims to explore emerging safety sciences by leading experts and the practical application of them in differing clinical and organisational contexts Written by people who work in patient safety and with chapters on subjects such as System Engineering Initiative for Patient Safety SEIPS AcciMaps and Human Factors this book is for everyone with an interest in how the landscape of patient safety is changing and how to apply good practice for the reduction of avoidable harm

Patient Safety Now Suzette Woodward, 2022-10-04 Over the past decade or so we have seen a multitude of improvement programmes and projects to improve the safety of patient care in healthcare However the full potential of these efforts and especially those that seek to address an entire system has not yet been reached The current pandemic has made this more evident than ever We have tended to focus on problems in isolation one harm at a time and our efforts have been simplistic and myopic If we are to save more lives and significantly reduce patient harm we need to adopt a holistic

systematic approach that extends across cultural technological and procedural boundaries Patient Safety Now is about the fact that it is time to care for everyone impacted by patient safety how we need to take the time to care for everyone in a meaningful way and how hospitals need to enable staff time to care safely This book builds on the author s two previous books on patient safety Rethinking Patient Safety talked about ways in which we need to rethink patient safety in healthcare and describes what we ve learned over the last two decades Implementing Patient Safety talked about what we can do differently and how we can use those lessons learned to improve the way we implement patient safety initiatives and encourage a culture of safety across a healthcare system Patient Safety Now unites the concepts theories and ideas of the previous two books with updated material and examples including what has been learned by patient safety specialists during a pandemic Patient Safety Now provides the reader with a unique view of patient safety that looks beyond the traditional negative and retrospective approach to one that is proactive and recognizes the impact of conditions behaviours and cultures that exist in healthcare on everyone It is written not only for healthcare professionals and patient safety personnel but for patients and their families who all want the same thing Too often when things go wrong relationships quickly become adversarial when in fact this can be avoided by recognizing that rather than being in separate camps there are shared needs and goals in relations to patient safety

Human Factors for Healthcare E-Book Ally Ackbarally,Catie Paton,2024-04-04

Human factors such as fatigue and poor communication can increase the risk of safety incidents This new book is the first to address the specific needs in this area of nurses and allied health professionals who make up the majority of the workforce The aim of the book is to support understanding of human factors and the role they play in quality and safety It will help the reader identify risks understand human error and develop non technical skills social cognitive and personal that will support them in their practice across a range of clinical environments With contributions by leading experts in this emerging area many of whom remain in practice Human Factors for Healthcare A Guide for Nurses and Allied Health Professionals is an ideal textbook for teaching and learning in both academic and clinical settings Covers the basic concepts right through to the most up to date research on human factors including Patient safety Human error Human factors for non medical practitioners Human Factors in urgent unscheduled and emergency care Non technical skills The role of communication Teamwork Leadership Situation Awareness and Decision Making Workplace culture Stress and fatigue Resilience Reflects the requirements of the 2018 NMC Standards of Proficiency for RNs and HCPC 2023 Standards of Proficiency for AHPs Features experts in the field from a variety of settings Embraces a broad range of speciality areas ranging from wards to A E and ITU Contains clinical scenarios case studies tips and questions to help the reader reflect and engage

Patient Safety Jonathan Davis,2016-01-22 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 Patient Safety in Emergency Medicine Pat Croskerry, Karen S. Cosby, 2009 With the increased emphasis on reducing medical errors in an emergency setting this book will focus on patient safety within the emergency department where preventable medical errors often occur The book will provide both an overview of patient safety within health care the culture of safety importance of teamwork organizational change and specific guidelines on issues such as medication safety procedural complications and clinician fatigue to ensure quality care in the ED Special sections discuss ED design medication safety and awareness of the culture of safety *Patient Safety* Heather Gluyas, Paul Morrison, 2013-12-04 How can we make health care processes safer and more consistent How do we improve care outcomes for patients With a range of coaching tips activities scenarios and reflective exercises this book enables you to translate current research on patient safety in to everyday good practice by increasing understanding of the key concepts and helping you to develop strategies to minimise the risk of patient harm It focusses on Human Factors to support understanding of the relationship between human behaviour and fallibility and the design of systems and processes environments tools tasks and technology to improve patient safety It also reflects the WHO Patient Safety Curriculum Patient Safety is an essential text for all healthcare professionals *Patient Safety* B.S. Dhillon, 2011-11-08 With unintended harm during hospital care costing billions of dollars to the world economy not to mention millions of deaths each year it s no wonder the issue is equally front and center in the minds of healthcare providers and the public Although the issue has been tackled in journal articles and conference proceedings there are very few book **Human Factors in Healthcare** Debbie Rosenorn-Lanng, 2014-02-06 The majority of errors litigation and complaints in the health service are due to human factors yet the term is still not widely understood and is sometimes used interchangeably to refer to team training or communication skills Although including these the subject of human factors goes far beyond this to look at systems environmental influences and interactions with equipment in addition to self awareness and human interaction All of these aspects are captured in Human Factors in Healthcare and are built into a new framework the SHEEP model which breaks down into five key areas Systems Human Interaction Environment Equipment and Personal providing a structured way to focus on adopting safety positive behaviours Written in a clear and engaging way the book is ideal for clinicians and non clinicians alike Through the use of relevant real world healthcare examples and exercises the book encourages interaction and thinking as well as illustrating how mistakes can be avoided The book also sets out ways on how to improve the experience of patients and staff across healthcare in particular focusing on how to improve patient safety In light of regular news reports about patient care Human Factors in Healthcare presents a timely and proactive approach to these issues and is essential reading for doctors

nurses managers and everyone working in the healthcare profession *World Congress on Medical Physics and Biomedical Engineering September 7 - 12, 2009 Munich, Germany* Olaf Dössel, Wolfgang C. Schlegel, 2010-01-04 Present Your Research to the World The World Congress 2009 on Medical Physics and Biomedical Engineering the triennial scientific meeting of the IUPESM is the world's leading forum for presenting the results of current scientific work in health related physics and technologies to an international audience With more than 2 800 presentations it will be the biggest conference in the fields of Medical Physics and Biomedical Engineering in 2009 Medical physics biomedical engineering and bioengineering have been driving forces of innovation and progress in medicine and healthcare over the past two decades As new key technologies arise with significant potential to open new options in diagnostics and therapeutics it is a multidisciplinary task to evaluate their benefit for medicine and healthcare with respect to the quality of performance and therapeutic output Covering key aspects such as information and communication technologies micro and nanosystems optics and biotechnology the congress will serve as an inter and multidisciplinary platform that brings together people from basic research R D industry and medical application to discuss these issues As a major event for science medicine and technology the congress provides a comprehensive overview and in depth first hand information on new developments advanced technologies and current and future applications With this Final Program we would like to give you an overview of the dimension of the congress and invite you to join us in Munich Olaf Dössel Congress President Wolfgang C. Schlegel

Improving Handover in an In-patient Hospice Using a Human Factors Approach to Patient Safety Annelise Matthews, 2017 Sue Ryder St John's Hospice is a 15 bed in patient hospice A multi disciplinary handover of all patients is held at 9am attended by nursing medical family support and allied health professionals Staff became concerned that handover was both too long and failing to allocate responsibility for tasks Staff recognised this as a patient safety issue and decided to use a Human Factors approach We identified the Paediatrics Situational Awareness For Everyone SAFE project as potentially having significant crossover to a palliative care environment being based around large multi disciplinary teams complex interventions unwell patients who may lack capacity and families in crisis Aims To use a Human Factors approach to improve patient handover Methods A Plan Do Study Act cycle was undertaken Using the SAFE Toolkit in the Plan phase the SAFE Huddle Observation Tool was adapted to Palliative Care and an audit of our handover was undertaken for 9 days In the Do phase a new Script and Rules were created for handover inspired by the SAFE Huddle This was re audited for 9 days In the Study phase the results were analysed and in Act final changes were made to our script Results The average length of handover reduced from 1 hour to 30 minutes Critical information discussed improved for diagnosis 49% to 100% whether patients were having observations 45% to 100% and daily OACC scores 55% to 100% Patients were identified as u00b4watchersu00b4 if they were having complex interventions or needed early medical review Each patient task was allocated to an individual staff member Conclusion Using a script made a time saving in handover while improving the quality of information discussed Patient safety was improved by the creation

of a formal process for identification of complex patients This is a novel adaptation of paediatric format Other tools in the SAFE project and in Human Factors are likely to have significant benefits to patient safety in palliative care *Human Factors and Ergonomics in Health and Social Care* Mark Sujan, Laura Pickup, Helen Vosper, Ken Catchpole, 2025-04-29 Patient safety patient and family experience and staff wellbeing are the joint responsibility of anyone working within health and social care An understanding of how Human Factors and Ergonomics can improve our interactions with systems and processes can often lead to improved patient and staff outcomes If you are responsible for implementing Human Factors and Ergonomics programmes within a health and social care setting or if you just want to understand more about how the principles of human factors might apply to your role this practical introduction will help you navigate your way around Human Factors and Ergonomics approaches within the healthcare setting Key features include Aligned to the Chartered Institute of Ergonomics and Human Factors professional competencies this book shows how these can be framed within real life practice Packed with case studies and helpful tips you can use in your day to day practice Clear structure showing the different levels of a system with specific chapters on organisation people equipment and environment Fully illustrated to facilitate your learning

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