PDF SAFETY AND QUALITY IN MEDICAL TRANSPORT SYSTEMS CREATING AN EFFECTIVE CULTURE

Safety and Quality in Medical Transport Systems

The Commission on Accreditation of Medical Transport Systems (CAMTS) has been accrediting air and ground transport services since 1991. One of the most significant needs the Commission has recognized is to assist transport services in creating a culture that supports safety and quality for both crews and patients. Most of the helicopter EMS (emergency medical service) accidents and many ground ambulance accidents can be attributed to human factors and systems designs that lead to poor decision-making. Management commitment is vital to create and maintain a culture that supports risk assessment, accountability, professionalism and organizational dynamics. This reference book has been created by CAMTS to address this need directly and comprehensively. It offers a groundbreaking collection of expert insights and practical solutions that can be used by EMS, Fire and Rescue, public and private services, and professional emergency and transport professionals worldwide. Quoting from the foreword written by the late Robert L. Helmreich, Professor Emeritus of Psychology at The University of Texas Human Factors Research Project, 'This is an important book which should be required reading for everyone involved in patient transport, from managers and dispatchers to those at the sharp end... The experienced and able authors and editors of this work use culture as the overarching concept needed to maximize safety while delivering patients expeditiously.'

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Gerontechnology

Two mega-trends of modern culture, the rapid aging of the population and the inexorable advances in technology, have fueled the development of gerontechnology--the use oftechnology to sustain individual autonomy to an advanced age. This expansive bookencompasses state-of-the-art research in gerontechnology and promising new technologies,products, and services that can improve activities of daily living, general health, and wellbeingof older individuals. It addresses current and future applications in such crucial areasas mobility and transportation, assistive devices, smart homes for senior citizens, in-hometechnologies, safety

and privacy, and research and development highlighting--amongothers--design. Topics include, but are not limited to, virtual environments as a research tool, sensation, perception, and cognition research advancements, novel accessibility challenges to information and communication technology, as well as the evolving characteristics of the elderly. These are among the welcome developments addressed in the book. Contributors from around the globe, including the UK, Germany, Japan, Canada, The Netherlands, Korea, the United States, and more, bring unprecedented cross-cultural insight to the intersections of aging phenomena and technology. Key Features: Disseminates empirically proven findings and evidence-based theories, models, and concepts Written by world-recognized leaders in the field of technology and aging Reflects the global usage of gerontechnological applications Includes new technologies, research, and applications for virtual environments, smart homes, assistive technology care, and robotics Discusses computer-assisted social engagement, technology-facilitated caregiving, business case examples, and more

Establishing a Culture of Patient Safety

The purpose of this book is to provide a road map to help healthcare professionals establish a \"culture of patient safety\" in their facilities and practices, provide high quality healthcare, and increase patient and staff satisfaction by improving communication among staff members and between medical staff and patients. It achieves this by describing what each of six types of people will do in distress, by providing strategies that will allow healthcare professionals to deal more effectively with staff members and patients in distress, and by showing healthcare professionals how to keep themselves out of distress by getting their motivational needs met positively every day. The concepts described in this book are scientifically based and have withstood more than 40 years of scrutiny and scientific inquiry. They were first used as a clinical model to help patients help themselves, and indeed are still used clinically. The originator of the concepts, Dr. Taibi Kahler, is an internationally recognized clinical psychologist who was awarded the 1977 Eric Berne Memorial Scientific Award for the clinical application of a discovery he made in 1971. That discovery enabled clinicians to shorten significantly the treatment time of patients by reducing their resistance as a result of miscommunication between their doctors and themselves.

Safety Culture

In Safety Culture: Building and Sustaining a Cultural Change in Aviation and Healthcare, the four authors draw upon their extensive teaching, research and field experience from multiple industries to describe the dynamic nature of a culture-change process, particularly in safety-critical domains. They use a \"stories to numbers\" approach that starts with felt experiences and stories of certain change programs that they have documented, then proceed to describe the use of key measurement tools that can be used to analyze the state of a change program. The book concludes with a description of empirical models that illustrate the dynamic nature of change programs.

Human Factors in Paramedic Practice

\"This book is too good for one profession. It needs to be read by those in all safety-critical industries.\" Martin Bromiley OBE FRCSEd (ad hom), Founder, Clinical Human Factors Group \"I would highly recommend this book, not only to paramedics but also to their colleagues in healthcare. It has been written by a premier league team of human factors specialists and frontline experts who share their knowledge and experience of applying human factors science to paramedic practice.\" Rhona Flin, Professor of Industrial Psychology, Robert Gordon University, UK \"This book will be essential reading for paramedics in all practice settings as it covers the key elements which will allow paramedics to better understand the complex sociotechnical realities of the care they provide to patients.\" Andy Collen, author of Decision Making in Paramedic Practice The system elements of paramedic practice are interconnected and complex. These elements can include the patient, the paramedic and their colleagues, the environment, the equipment, the tasks, and the processes and procedures of the organisation. Considering the socio-technical realities of care that paramedics provide are so complex, how can you best meet these challenges to support safe and effective

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practice as a clinician? Written as an introduction to the discipline of human factors, the authors highlight key principles and theories and relate these to aspects of paramedic practice. Containing practical prehospital examples, this resource provides a firm understanding of systems thinking and design, enabling you to look for instances where the principles of human factors might be applied in your own practice. Accompanied by 40 full-colour images, chapters cover key topics including: ‘Human error’ Systems thinking Human-centred design Interaction with the patient Well-being of the paramedic Safety culture Non-technical skills of individuals and teams. Whether you are a pre-hospital care professional who is involved in education, learning from events, procurement, or influencing safety culture, you will benefit from the tools and techniques provided throughout.

Essentials for Quality and Safety Improvement in Health Care

Patient safety and quality improvement in health care remain a global priority. Subpar performance in health care, however, is still common more than a decade after the christening of patient safety in Africa. The core principle of safety and quality improvement systems is to identify and assess the root cause of failures in order to learn from them and devise a means to improve and to avoid recurrence. This book is designed to encourage, facilitate and empower healthcare workers in the development and implementation of strategically driven patient safety and quality improvement initiatives for safer healthcare systems and healthcare facilities in low- and middle-income countries (LMICs) of Africa. It also highlights some of the profound challenges and barriers to designing and implementing patient safety and quality improvement interventions or programmes in the region and reiterates the need to remain focused and determined to work out solutions with confidence and overcome these barriers. In the book, chapters highlight six essential components crucial for achieving evolutionary progress in safety and quality improvement in a healthcare system: Standard operating procedure Audit Research Safety management Quality management Evaluation Practical steps in planning and conducting these six essential components are outlined with some specific features to aid learning and facilitate their implementation. The authors have experience and expertise in the medical practice gained in Africa and a decade of knowledge and experience from consultancy work in safety and quality improvement in health care within and outside the region. Essentials for Quality and Safety Improvement in Health Care: A Resource for Developing Countries is authored for both medical professionals and those from other professions who are interested in and enthusiastic about patient safety and healthcare quality and therefore willing to build a career in this field. It is relevant to all health institutions, health and non-health workers, and can be used as a checklist while rendering quality and safe health care.

Building Safer Healthcare Systems

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.

Keeping Patients Safe

Building on the revolutionary Institute of Medicine reports To Err is Human and Crossing the Quality Chasm, Keeping Patients Safe lays out guidelines for improving patient safety by changing nurses' working conditions and demands. Licensed nurses and unlicensed nursing assistants are critical participants in our

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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.

Patient Safety Culture

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.

Textbook of Patient Safety and Clinical Risk Management

Implementing safety practices in healthcare saves lives and improves the quality of care: it is therefore vital to apply good clinical practices, such as the WHO surgical checklist, to adopt the most appropriate measures for the prevention of assistance-related risks, and to identify the potential ones using tools such as reporting & learning systems. The culture of safety in the care environment and of human factors influencing it should be developed from the beginning of medical studies and in the first years of professional practice, in order to have the maximum impact on clinicians' and nurses' behavior. Medical errors tend to vary with the level of proficiency and experience, and this must be taken into account in adverse events prevention. Human factors assume a decisive importance in resilient organizations, and an understanding of risk control and containment is fundamental for all medical and surgical specialties. This open access book offers recommendations and examples of how to improve patient safety by changing practices, introducing organizational and technological innovations, and creating effective, patient-centered, timely, efficient, and equitable care systems, in order to spread the quality and patient safety culture among the new generation of healthcare professionals, and is intended for residents and young professionals in different clinical specialties.

Zero Harm: How to Achieve Patient and Workforce Safety in Healthcare

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.

Taking the Lead in Patient Safety

Written by industry professionals: a workplace safety specialist in conjunction with a practicing physician and medical manager. Provides recommendations for assessing hospital safety practices as well as specific suggestions for behavioural interventions. Brings a systematic approach to healthcare safety, identifying common problems through illustrative case studies and offering solutions. Offers several different perspectives including patient safety, doctor safety, and administrator safety.

A Socio-cultural Perspective on Patient Safety

This edited volume of original chapters brings together researchers from around the world who are exploring the facets of health care organization and delivery that are sometimes marginal to mainstream patient safety theories and methodologies but offer important insights into the socio-cultural and organizational context of patient safety. By examining these critical insights or perspectives and drawing upon theories and methodologies often neglected by mainstream safety researchers, this collection shows we can learn more about not only the barriers and drivers to implementing patient safety programmes, but also about the more fundamental issues that shape notions of safety, alternate strategies for enhancing safety, and the wider implications of the safety agenda on the future of health care delivery. In so doing, A Socio-cultural Perspective on Patient Safety challenges the taken-for-granted assumptions around fundamental philosophical and political issues upon which mainstream orthodoxy relies. The book draws upon a range of theoretical and empirical approaches from across the social sciences to investigate and question the patient safety movement. Each chapter takes as its focus and question a particular aspect of the patient safety reforms, from its policy context and theoretical foundations to its practical application and manifestation in clinical practice, whilst also considering the wider implications for the organization and delivery of health care services. Accordingly, the chapters each draw upon a distinct theoretical or methodological approach to critically explore specific dimensions of the patient safety agenda. Taken as a whole, the collection advances a strong, coherent argument that is much needed to counter some of the uncritical assumptions that need to be described and analyzed if patient safety is indeed to be achieved.

Washington Manual of Patient Safety and Quality Improvement

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

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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.

The role of healthcare work environments in shaping a

The Role of Healthcare Work Environments in Shaping a Safety Culture Patient safety is a basic goal of all Canadian healthcare tions on patient safety (AHRQ 2003). [...] HSAA represents dozens of health professional, para-profes- The purpose of this article is to clarify the role of healthcare sional, technical and support occupations throughout the work environment factors in creating a culture of safety, using Alberta health system. [...] The Role of Healthcare Work Environments in Shaping a Safety Culture services and the rest in community health, Figure 1. Safety culture indicators emergency medical services and long-term care. [...] This Overall, the importance of work comprehensive perspective on safety culture is captured in the environment factors, especially teamwork and logic model presented in Figure 8. fair processes, overshadowed that of any other As documented, safety and service quality go hand in hand. [...] The Role of Healthcare Work Environments in Shaping a Safety Culture Table 3. Relationship between safety culture and strategically examined in this study, it appears that teamwork, fair important employee outcomes* workplace processes, supportive and people-centred supervision and leadership and a learning environment Safety Culture Scale Score (%) contribute to a culture that values safety.

Hospital Survey on Patient Safety Culture

The Agency for Healthcare Research & Quality (AHRQ) is the lead Fed. agency charged with conducting & supporting research to improve patient safety & health care quality for all Americans. AHRQ's goal is to support a culture of safety & quality improvement in the Nation's healthcare system that will help speed the adoption of research findings into practice & policy. To that end, AHRQ has sponsored the development of this survey on patient safety culture. This tool is useful for assessing the safety culture of a hospital as a whole, or for specific units within hospitals. Moreover, the survey can be used to track changes in patient safety over time & to evaluate the impact of patient safety interventions. Illustrations.

Human Factors in Paramedic Practice

The system elements of paramedic practice are interconnected and complex. These elements can include the patient, the paramedic and their colleagues, the environment, the equipment, the tasks, and the processes and procedures of the organisation. Considering the socio-technical realities of care that paramedics provide are so complex, how can you best meet these challenges to support safe and effective practice as a clinician? Written as an introduction to the discipline of human factors, the authors highlight key principles and theories and relate these to aspects of paramedic practice. Containing practical prehospital examples, this resource provides a firm understanding of systems thinking and design, enabling you to look for instances where the principles of human factors might be applied in your own practice. Accompanied by 40 full-colour images, chapters cover key topics including: 'Human error' Systems thinking Human-centred design Interaction with the patient Well-being of the paramedic Safety culture Non-technical skills of individuals and teams. Whether you are a pre-hospital care professional who is involved in education, learning from events, procurement, or influencing safety culture, you will benefit from the tools and techniques provided throughout.

Patient Safety and Quality

\"Nurses play a vital role in improving the safety and quality of patient car -- not only in the hospital or ambulatory treatment facility, but also of community-based care and the care performed by family members. Nurses need know what proven techniques and interventions they can use to enhance patient outcomes. To address this need, the Agency for Healthcare Research and Quality (AHRQ), with additional funding from the Robert Wood Johnson Foundation, has prepared this comprehensive, 1,400-page, handbook for nurses on

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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/

The Measurement and Monitoring of Safety

Recent serious and sometimes fatal accidents in chemical research laboratories at United States universities have driven government agencies, professional societies, industries, and universities themselves to examine the culture of safety in research laboratories. These incidents have triggered a broader discussion of how serious incidents can be prevented in the future and how best to train researchers and emergency personnel to respond appropriately when incidents do occur. As the priority placed on safety increases, many institutions have expressed a desire to go beyond simple compliance with regulations to work toward fostering a strong, positive safety culture: affirming a constant commitment to safety throughout their institutions, while integrating safety as an essential element in the daily work of laboratory researchers. Safe Science takes on this challenge. This report examines the culture of safety in research institutions and makes recommendations for university leadership, laboratory researchers, and environmental health and safety professionals to support safety as a core value of their institutions. The report discusses ways to fulfill that commitment through prioritizing funding for safety equipment and training, as well as making safety an ongoing operational priority. A strong, positive safety culture arises not because of a set of rules but because of a constant commitment to safety throughout an organization. Such a culture supports the free exchange of safety information, emphasizes learning and improvement, and assigns greater importance to solving problems than to placing blame. High importance is assigned to safety at all times, not just when it is convenient or does not threaten personal or institutional productivity goals. Safe Science will be a guide to make the changes needed at all levels to protect students, researchers, and staff.

Culture Change in the NHS

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

Safe Science

Regarded as one of the most influential management books of all time, this fourth edition of Leadership and Organizational Culture transforms the abstract concept of culture into a tool that can be used to better shape the dynamics of organization and change. This updated edition focuses on today's business realities. Edgar Schein draws on a wide range of contemporary research to redefine culture and demonstrate the crucial role

leaders play in successfully applying the principles of culture to achieve their organizational goals.

Joint Commission Journal on Quality and Patient Safety

This review incorporates the views and visions of 2,000 clinicians and other health and social care professionals from every NHS region in England, and has been developed in discussion with patients, carers and the general public. The changes proposed are locally-led, patient-centred and clinically driven. Chapter 2 identifies the challenges facing the NHS in the 21st century: ever higher expectations; demand driven by demographics as people live longer; health in an age of information and connectivity; the changing nature of disease; advances in treatment; a changing health workplace. Chapter 3 outlines the proposals to deliver high quality care for patients and the public, with an emphasis on helping people to stay healthy, empowering patients, providing the most effective treatments, and keeping patients as safe as possible in healthcare environments. The importance of quality in all aspects of the NHS is reinforced in chapter 4, and must be understood from the perspective of the patient's safety, experience in care received and the effectiveness of that care. Best practice will be widely promoted, with a central role for the National Institute for Health and Clinical Excellence (NICE) in expanding national standards. This will bring clarity to the high standards expected and quality performance will be measured and published. The review outlines the need to put frontline staff in control of this drive for quality (chapter 5), with greater freedom to use their expertise and skill and decision-making to find innovative ways to improve care for patients. Clinical and managerial leadership skills at the local level need further development, and all levels of staff will receive support through education and training (chapter 6). The review recommends the introduction of an NHS Constitution (chapter 7). The final chapter sets out the means of implementation.

Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry

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 indicatorsâ€\"measures of utilization and outcomeâ€\"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.

Organizational Culture and Leadership

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

Modern Healthcare

The costs of failure to manage health and safety successfully are high. This manual was prepared by HSE's Accident Prevention Advisory Unit as a practical guide for directors, managers and health and safety professionals intent on improving health and safety performance. The advice given here will be increasingly used by HSE inspectors as a basis for testing the performance of organizations against the general duties of the Health and Safety at Work etc Act 1974.

High Quality Care for All

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

Access to Health Care in America

Safety has traditionally been defined as a condition where the number of adverse outcomes was as low as possible (Safety-I). From a Safety-I perspective, the purpose of safety management is to make sure that the number of accidents and incidents is kept as low as possible, or as low as is reasonably practicable. This means that safety management must start from the manifestations of the absence of safety and that - paradoxically - safety is measured by counting the number of cases where it fails rather than by the number of cases where it succeeds. This unavoidably leads to a reactive approach based on responding to what goes wrong or what is identified as a risk - as something that could go wrong. Focusing on what goes right, rather than on what goes wrong, changes the definition of safety from ’avoiding that something goes wrong’ to ’ensuring that everything goes right’. More precisely, Safety-II is the ability to succeed under varying conditions, so that the number of intended and acceptable outcomes is as high as possible. From a Safety-II perspective, the purpose of safety management is to ensure that as much as possible goes right, in the sense that everyday work achieves its objectives. This means that safety is managed by what it achieves (successes, things that go right), and that likewise it is measured by counting the number of cases where things go right. In order to do this, safety management cannot only be reactive, it must also be proactive. But it must be proactive with regard to how actions succeed, to everyday acceptable performance, rather than with regard to how they can fail, as traditional risk analysis does. This book analyses and explains the principles behind both approaches and uses this to consider the past and future of safety management practices. The analysis makes use of common examples and cases from domains such as aviation, nuclear power production, process management and health care. The final chapters explain the theoret

Equity and excellence:

This open access book provides a concise yet comprehensive overview on how to build a quality management program for hematopoietic stem cell transplantation (HSCT) and cellular therapy. The text reviews all the essential steps and elements necessary for establishing a quality management program and achieving accreditation in HSCT and cellular therapy. Specific areas of focus include document development and implementation, audits and validation, performance measurement, writing a quality management plan, the accreditation process, data management, and maintaining a quality management program. Written by experts in the field, Quality Management and Accreditation in Hematopoietic Stem Cell Transplantation and Cellular Therapy: A Practical Guide is a valuable resource for physicians, healthcare professionals, and

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laboratory staff involved in the creation and maintenance of a state-of-the-art HSCT and cellular therapy program.

Successful Health & Safety Management

Now in its Fifth Edition, this respected reference helps readers tackle the common and often challenging ethical issues that affect patient care. The book begins with a concise discussion of clinical ethics that provides the background information essential to understanding key ethical issues. Readers then explore a wide range of real-world ethical dilemmas, each accompanied by expert guidance on salient issues and how to approach them. The book's two-color design improves retention of material for visual learners. An accompanying website lets readers access the full text, along with features designed to reinforce understanding and test knowledge. New to the Fifth Edition: This edition includes new discussions of ethical issues as they relate to clinical practice guidelines and evidence-based medicine, electronic medical records, genetic testing, and opioid prescription. The book also includes an increased focus on ethical issues in ambulatory care. Readers will also find more detailed analysis of cases, more examples of ethical reasoning, more highlight pages relating clinical ethics to emergency medicine, oncology, palliative care, and family medicine. Also new are discussions of quality improvement and use of advance care planning rather than advance directives.

BMJ

The results of this study presents, analyses and benchmarks the public transport networks and mobility services of thirty six UNECE Capitals.

Quality Assurance of Aseptic Preparation Services

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.

Safety-I and Safety-II

This edited textbook is a fully updated and expanded version of the highly successful first edition of Human Factors in Aviation. Written for the widespread aviation community - students, engineers, scientists, pilots, managers, government personnel, etc., HFA offers a comprehensive overview of the topic, taking readers from the general to the specific, first covering broad issues, then the more specific topics of pilot performance, human factors in aircraft design, and vehicles and systems. The new editors offer essential breath of experience on aviation human factors from multiple perspectives (i.e. scientific research, regulation, funding agencies, technology, and implementation) as well as knowledge about the science. The contributors are experts in their fields. Topics carried over from the first edition are fully updated, several by new authors who are now at the fore of the field. New material - which represents 50% of the volume - focuses on the challenges facing aviation specialists today. One of the most significant developments in this decade has

been NextGen, the Federal Aviation Administration's plan to modernize national airspace and to address the impact of air traffic growth by increasing airspace capacity and efficiency while simultaneously improving safety, environmental impacts and user access. NextGen issues are covered in full. Other new topics include: High Reliability Organizational Perspective, Situation Awareness & Workload in Aviation, Human Error Analysis, Human-System Risk Management, LOSA, NOSS and Unmanned Aircraft System. Comprehensive text with up-to-date synthesis of primary source material that does not need to be supplemented New edition thoroughly updated with 50% new material and full coverage of NexGen and other modern issues Instructor website with test bank and image collection makes this the only text offering ancillary support Liberal use of case examples exposes readers to real-world examples of dangers and solutions

Quality Management and Accreditation in Hematopoietic Stem Cell Transplantation and Cellular Therapy

This volume updates and combines two National Academy Press bestsellers--Prudent Practices for Handling Hazardous Chemicals in Laboratories and Prudent Practices for Disposal of Chemicals from Laboratories--which have served for more than a decade as leading sources of chemical safety guidelines for the laboratory. Developed by experts from academia and industry, with specialties in such areas as chemical sciences, pollution prevention, and laboratory safety, Prudent Practices for Safety in Laboratories provides step-by-step planning procedures for handling, storage, and disposal of chemicals. The volume explores the current culture of laboratory safety and provides an updated guide to federal regulations. Organized around a recommended workflow protocol for experiments, the book offers prudent practices designed to promote safety and it includes practical information on assessing hazards, managing chemicals, disposing of wastes, and more. Prudent Practices for Safety in Laboratories is essential reading for people working with laboratory chemicals: research chemists, technicians, safety officers, chemistry educators, and students.

Resolving Ethical Dilemmas

Sustainable Urban Mobility and Public Transport in UNECE Capitals

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