# Safe Patients Smart Hospitals How One Doctor S Che

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## NICHOLSON MELENDEZ

**First, Do Less Harm** CRC Press
Health is regarded as one of the global challenges for mankind. Healthcare is a complex system that covers processes of diagnosis, treatment, and prevention of diseases. It constitutes a fundamental pillar of the modern society. Modern healthcare is technological healthcare. Technology is everywhere. This book focuses on twenty-one emerging technologies in the healthcare industry. An emerging technology is one that holds the promise of creating a new economic engine and is trans-industrial. Emerging technological trends are rapidly transforming businesses in general and healthcare in particular in ways that we find hard to imagine. Artificial intelligence (AI), machine learning, robots, blockchain, cloud computing, Internet of things (IoT), and augmented & virtual reality are some of the technologies at the heart of this revolution and are covered in this book. The convergence of these technologies is upon us and will have a huge impact on the patient experience

Patient Safety National Academies Press
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.

*Case Studies in Patient Safety* Springer

From newborns switched in the nursery to medication mix-ups and hospital-acquired infections, we are all familiar with the horror stories about hospital safety, and unfortunately, the statistics say we aren‘t exaggerating. The safety issue in U.S. hospitals has become so profound and embedded, that we cannot hope to fix it without a paradigm shift

**Connected Health in Smart Cities** Health Administration Press

Improving the culture of safety in our health care institutions is an essential component of preventing or reducing errors as well as improving overall health care quality. This book presents the clinically tested Myer's Patient Safety Model for health care system leaders, middle managers, and administrators to build their patient safety program and to help sustain, renew, or obtain accreditation. The author provides detailed explanations of why medical errors still occur in accredited hospitals, and provides the much needed organization-wide steps to prevent these errors and enhance patient safety for improved outcomes. Current patient safety challenges are discussed with an emphasis on the concept of reliability. The Myers Model is examined in detail, along with current evidence for its three interrelated levels of organizational structure-the leadership (system) level, the unit (microsystem) level, and the individual level. The text includes interviews about key aspects of patient safety with three leaders of major health care accreditation programs in the U.S., Canada, and Australia. Additionally, it provides an overview of reporting systems within the U.S. and covers two essential tools for patient safety-root cause analysis and failure mode and effect analysis. The book links all aspects of patient safety with accreditation standards at the national level, and also discusses efforts to globalize accreditation criteria and procedures. Key Features: Presents a clinically tested model for building a patient safety program and helping to sustain, renew, or obtain accreditation Provides tools for use in ensuring patient safety and accreditation, including root cause analysis and failure mode and effect analysis Discusses how aggregate data inform patient safety documentation and accreditation through integrated perspectives Offers a global view of accreditation and patient safety Includes techniques to improve communication among members of health care teams

**Smart Health** McGraw-Hill Education

v. 1. Research findings -- v. 2. Concepts and methodology -- v. 3. Implementation issues -- v. 4. Programs, tools and products.

*YOU: The Smart Patient* McGraw Hill Professional

This book reports on the theoretical foundations, fundamental applications and latest advances in various aspects of connected services for health information systems. The twelve chapters highlight state-of-the-art approaches, methodologies and systems for the design, development, deployment and innovative use of multisensory systems and tools for health management in smart city ecosystems. They exploit technologies like deep learning, artificial intelligence, augmented and virtual reality, cyber physical systems and sensor networks. Presenting the latest developments, identifying remaining challenges, and outlining future research directions for sensing, computing, communications and security aspects of connected health systems, the book will mainly appeal to academic and industrial researchers in the areas of health information systems, smart cities, and augmented reality.

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

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

*Health IT and Patient Safety* Springer Publishing Company

This book is based on stunning true stories about people of all ages in a wide variety of situations. The stories illustrate how unrecognized, incorrect assumptions can cause mistakes, misunderstandings, and tragic outcomes. Assumptions are interwoven into the very fabric of our lives. When we make an assumption we take something for granted. We accept it as fact. The stories also show our need to be respected and understood, the types of assumptions we make, and how we can recognize assumptions before we make them. This is a book about us and how our assumptions affect us. The stories led to the book's title and chapter titles. Most chapters begin with stories. Some of the twenty-one chapter titles are: Urgent!; Tenacious Assumptions, Dogged Beliefs; Automatic Assumptions Can Mislead; Betrayed; Now Will You Listen; Our Doctors Need Our Stories; When We Are Patients; Hospitals; Recognizing Assumptions. Because medical errors are a serious problem, we, as patients, and our medical professionals need to be aware of incorrect assumptions that can compromise our care. Orlando has shown us how we can recognize assumptions and get the story right. Whether in health care or elsewhere, getting the story right can sometimes be crucial.

**Patient Safety** Rowman & Littlefield

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.

Patient Safety and Hospital Accreditation Rand Corporation
Argues for more transparent, democratic and safer healthcare practices to keep patients better informed and hold poor-performing doctors and flawed systems accountable.

Achieving Safe Health Care Penguin
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.

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

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

**Healthcare Choices** Hachette Go
Making healthcare decisions is hard, but making the right choices has never mattered more. Healthcare Choices: 5 Steps to Getting the Care You Want and Needgives you the tools you need to choose the best medical care—for you. Archelle Georgiou, MD, explainsher CARES model, the formula she developed to help family, friends, and thousands of television viewers make smart healthcare decisions that balance the best medical options with individual preferences. Using more than 30 real-life stories and insider tips, she demonstrates how to use this step-by-step guide to access the medical information you need to evaluate your options and make well-informed choices. Whether you are addressing a life-threatening illness, self-managing a minor ailment, selecting a doctor, or buying insurance, Georgiou's roadmap shows you how to be an active participant in your care. Her "go to" approach describes how to: Identify all treatment options for an illness, including those not mentioned by your doctor. Make treatment decisions that reflect your priorities and preferences. Find the best doctor to treat your condition. Communicate with your doctor and make shared treatment decisions. Choose the health insurance plan that's right for you. Maintain a voice in your lifestyle as you age. Healthcare Choiceswill give you the confidence to advocate for the healthcare you want, need, and deserve.

**The Patient's Checklist** Springer Nature
Each year, hospital-acquired infections, prescribing and treatment errors, lost documents and test reports, communication failures, and other problems have caused thousands of deaths in the United States, added millions of days to patients' hospital stays, and cost Americans tens of billions of dollars. Despite (and sometimes because of) new medical information technology and numerous well-intentioned initiatives to address these problems, threats to patient safety remain, and in some areas are on the rise. In First, Do Less Harm, twelve health care professionals and researchers plus two former patients look at patient safety from a variety of perspectives, finding many of the proposed solutions to be inadequate or impractical. Several contributors to this book attribute the failure to confront patient safety concerns to the influence of the "market model" on medicine and emphasize the need for hospital-wide teamwork and greater involvement from frontline

workers (from janitors and aides to nurses and physicians) in planning, implementing, and evaluating effective safety initiatives. Several chapters in First, Do Less Harm focus on the critical role of interprofessional and occupational practice in patient safety. Rather than focusing on the usual suspects-physicians, safety champions, or high level management-these chapters expand the list of "stakeholders" and patient safety advocates to include nurses, patient care assistants, and other staff, as well as the health care unions that may represent them. First, Do Less Harm also highlights workplace issues that negatively affect safety: including sleeplessness, excessive workloads, outsourcing of hospital cleaning, and lack of teamwork between physicians and other health care staff. In two chapters, experts explain why the promise of health care information technology to fix safety problems remains unrealized, with examples that are at once humorous and frightening. A book that will be required reading for physicians, nurses, hospital administrators, public health officers, quality and risk managers, healthcare educators, economists, and policymakers, First, Do Less Harm concludes with a list of twenty-seven paradoxes and challenges facing everyone interested in making care safe for both patients and those who care for them.
Communication for Nurses F.A. Davis
"The tough-minded and revealing story of a leading doctor's crusade against medical harm...Fascinating reading." -Atul Gawande, author of The Checklist Manifesto. First, do no harm. Doctors, nurses, and clinicians swear by this code of conduct. Yet, medical errors are made every single day-avoidable mistakes that often cost lives. Inspired by two such mistakes, Dr. Peter Pronovost made it his personal mission to improve patient safety and make preventable deaths a thing of the past, one hospital at a time. Safe Patients, Smart Hospitals shows how Dr. Pronovost started a revolution by creating a simple checklist that standardized a common ICU procedure. His reforms are being implemented in all fifty states and have saved hundreds of lives by cutting hospital-acquired infection rates by 70%. Atul Gawande profiled Dr. Pronovost's reforms in a New Yorker article and his bestselling book The Checklist Manifesto is based upon Dr. Pronovost's success in patient safety. But Safe Patients, Smart Hospitals is the real story: an inspiring, thought-provoking, accessible insider's narrative about how doctors and nurses are improving patient care for all Americans, today.
*Zero Harm: How to Achieve Patient and Workforce Safety in Healthcare* Department of Health and Human Services
This text uses a case-based approach to share knowledge and techniques on how to operationalize much of the theoretical underpinnings of hospital quality and safety. Written and edited by leaders in healthcare, education, and engineering, these 22 chapters provide insights as to where the field of improvement and safety science is with regards to the views and aspirations of healthcare advocates and patients. Each chapter also includes vignettes to further solidify the theoretical underpinnings and drive home learning. End of chapter commentary by the editors highlight important concepts and connections between various chapters in the text. Patient Safety and Quality Improvement in Healthcare: A Case-Based Approach presents a novel approach towards hospital safety and quality with the goal to help healthcare providers reach zero harm within their organizations.
*Cancer with Hope* AuthorHouse
Winner of a 2016 Shingo Research and Professional Publication Award! A recent article published in the Journal of Patient Safety estimated that more than 400,000 lives are lost each year due to preventable patient events in American hospitals. Preventable patient safety events are the third leading cause of death in the United States. While most health care organizations know they need to improve patient safety, most lack an understanding of the steps required to develop and implement an effective patient safety program. Baylor Scott & White Health has successfully created a strong culture of patient safety. In 2013, Baylor Health Care System published the book Achieving STEEEP Health Care, which describes its quality improvement journey via the STEEEP framework of delivering care that is Safe, Timely, Effective, Efficient, Equitable, and Patient-centered. This book provides a detailed overview of the Baylor Scott & White Health approach to the delivery of safe care, the leading aim of the STEEEP quality and patient safety framework. It presents real-life examples, practical approaches, and tools for improving patient safety. The book is structured around some of the key components of patient safety such as the importance of strategic efforts in categories of culture, processes, and technology. Maintaining a focus on human factors in patient safety and health care, the book explains the need for advanced analytics along with long-term learning and corporate resources. This book describes how to develop appropriate goals, formulate strategies to meet those goals, and implement techniques to improve patient safety based on the experience of Baylor Scott & White Health.
*Safer Healthcare* John Wiley & Sons
Prolonged life expectancy along with the increasing complexity of medicine and health services raises health costs worldwide dramatically. Whilst the smart health concept has much potential to support the concept of the emerging P4-medicine (preventive, participatory, predictive, and personalized), such high-tech medicine produces large amounts of high-dimensional, weakly-structured data sets and massive amounts of unstructured information. All these technological approaches along with “big data” are turning the medical sciences into a data-intensive science. To keep pace with the growing amounts of complex data, smart hospital approaches are a commandment of the future, necessitating context aware computing along with advanced interaction paradigms in new physical-digital ecosystems. The very successful synergistic combination of methodologies and approaches from Human-Computer Interaction (HCI) and Knowledge Discovery and Data Mining (KDD) offers ideal conditions for the vision to support human intelligence with machine learning. The papers selected for this volume focus on hot topics in smart health; they discuss open problems and future challenges in order to provide a research agenda to stimulate further research and progress.
**Josie's Story** McGraw Hill Professional
This unique compendium of case studies on patient safety – told from the perspective of the patient and family – illustrates 24 stories of preventable health care errors that led to irreparable patient harm. The reader is guided through a structured analysis of the events, eliciting lessons learned and strategies for preventing similar events in the future. Learning objectives for each case facilitate the reader’s development of a set of core competencies related to improving safety and quality of health care. Students of the health professions including medicine, nursing, pharmacy, health administration, public health, as well as practicing professionals such as patient safety officers, chief quality officers, risk managers, and health service researchers will gain valuable insight into the real-world of medical errors and a better understanding of how they can be prevented through practical, actionable methods.

Best Sellers - Books :
• Meditations: A New Translation By Marcus Aurelius

- The Shadow Work Journal: A Guide To Integrate And Transcend Your Shadows
- Things We Hide From The Light (knockemout Series, 2)
- Twisted Games (twisted, 2) By Ana Huang
- Icebreaker: A Novel (the Maple Hills Series)
- Twisted Love (twisted, 1) By Ana Huang
- Twisted Lies (twisted, 4) By Ana Huang
- The Ballad Of Songbirds And Snakes (a Hunger Games Novel) (the Hunger Games)
- Fahrenheit 451 By Ray Bradbury
- Goodnight Moon