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The Patient Safety Handbook

Edited by Barbara J. Youngberg, BSN, MSW, JD University HealthSystem Consortium, Oak Brook, IL

> Martin J. Hatlie, JD Partnership for Patient Safety, Chicago, IL

With over **98,000 accidental deaths** from medical errors in American hospitals reported each year, the focus on patient safety is increasingly a challenge to all health care leaders. Creating a consistently safe, high-quality, culturally-sensitive environment for your patients is vital to protecting your institution's reputation and its financial viability. The **first investment** you need to make towards ensuring this care is the *The Patient Safety Handbook*!

784 Pages; September 2003 *The Patient Safety Handbook* is the master reference to the art and science of implementing systems and processes that will help you transform your organization into a safe and accountable health care environment for both and crippling monetary penalties stemming from medical error and negligent care.

This unprecedented, comprehensive resource from the nation's leading health care professionals covers the full spectrum of patient safety and risk reduction, building from the fundamentals of the science of safety, to a thorough discussion of operational issues and the actual application of the principles of research. Real-life case studies from prominent health care organizations and their leadership help you apply proven strategies to your patient safety program.

Experts put you on the leading edge with specific examples, problems, strategies, limitations, and success stories!

- Learn from other high-reliability industries—See how building a safe environment required leaders in the commercial airline, nuclear power, and automobile industries to challenge assumptions about their mission, core competencies, market, technology, and structures of their organizations' operations.
- Create a healing organizational culture—Strategies are presented for refocusing your organization's environment from a culture of blame to a culture of sustainable change and trust that welcomes error detection and reporting as opportunities to improve patient care and patient safety.
- Understand why things go wrong-Learn what is gained through the investigation and analysis of clinical incidents, and benefit from the advice of noted experts as they present strategies for moving forward.
- Joint Commission Standards defined—An overview of the JCAHO standards for patient safety and medical/health care error reduction helps you to interpret what the standards mean for your organization and how to ensure that you are compliant.
- Utilize the concepts of epidemiology–Apply epidemiologic tools to augment your understanding of medical errors, and complement traditional case examination approaches.
- Lead your organization through teamwork—Nowhere will you find a more in-depth discussion of teams, teamwork, collaboration, and communication—essential skills necessary to coordinate and implement a highly-integrated, organization-wide safety program.
- Benefit from authoritative, hands-on guidance–Fulfill your commitment to improved patient safety, risk reduction, and renewed health care consumer confidence using the practical strategies outlined in this comprehensive reference.

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Martin Hatlie, **JD**, is founding president of Partnership for Patient Safety (P4PS), a collaborative network of health care leaders dedicated to reducing the harm caused by health care errors. Mr. Hatlie coordinated the establishment of the National Patient Safety Foundation (NPSF) and served as its first executive director. He is a nationally recognized expert on patient safety, loss prevention, and professional liability issues, including coalition-building and patient safety product development.

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Barbara J. Youngberg, RN, MSW, JD

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Edited by Florence Kavaler, MD, MPH and Allen D. Spiegel, PhD, MPH

ISBN: 0-7637-2314-2, 476 Pages, Paperback, Copyright 2003, \$59.95 (U.S. List)

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