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Management"; " The Team STEPPS approach"; " SBAR"; " Critical Language"; " Conclusion and Key Lessons Learned"; "References"; "Chapter 3: Handoff and Care Transitions"; "Introduction"; " Case Studies"; "Case 1: Poor Management of Postpartum Hemorrhage"; "Clinical Summary"; " Case 2: Opioid-Induced Respiratory Depression in a Head Injury Patient"; "Clinical Summary"
" Root Cause Analysis""Case 1"; "What Happened?"; " Why Did It Happen?"; "Communication Failure"; "Inadequate Training"; "Poor Staff Allocation"; " How Can It Be Prevented?"; " Case 2"; "What Happened?"; " Why Did It Happen?"; " Poor Staffing Level and Inadequate Supervision"; "Communication Failures"; "Lack of Guidelines"; "How Can It Be Prevented?"; " Discussion"; "Transition of Care: A Point of Vulnerability"; " Barriers to Effective Handoff Communication"; "The Diversity of Teams"; "Time and Resource Constraints"
" Delegating Care: The Importance of Supervision"" Improvement Strategies"; "Standardization"; "The Role of Information Technology"; "The Role of Supervision During Handoff"; " Conclusion and Key Lessons Learned"; "References"; "Chapter 4: Graduate Medical Education and Patient Safety"; "Introduction"; " Case Studies"; "Case 1: Poor Outcome Due to Suboptimal Supervision and Failure to Call for Help"; "Clinical Summary"; " Analysis and Discussion"; " Clinical Supervision"; " Measuring Clinical Supervision"; " Best Practices in Clinical Supervision"
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Sommario/riassunto

Despite the evolution and growing awareness of patient safety, many medical professionals are not a part of this important conversation. Clinicians often believe they are too busy taking care of patients to adopt and implement patient safety initiatives and that acknowledging medical errors is an affront to their skills. Patient Safety provides clinicians with a better understanding of the prevalence, causes and solutions for medical errors; bringing best practice principles to the bedside. Written by experts from a variety of backgrounds, each chapter features an analysis of clinical cases based on the Root Cause Analysis (RCA) methodology, along with case-based discussions on various patient safety topics. The systems and processes outlined in the book are general and broadly applicable to institutions of all sizes and structures. The core ethic of medical professionals is to “do no harm”. Patient Safety is a comprehensive resource for physicians, nurses and students, as well as healthcare leaders and administrators for identifying, solving and preventing medical error.
