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Nota di contenuto	Intro -- Preface -- Acknowledgments -- Abbreviations -- Contents -- About the Author -- Chapter 1: What Is PI? (and What It Is Not) -- Why PI? -- Definitions of Process Improvement and Patient Safety -- What Is "Ego-Based" Medicine? -- Science of Safety -- Differentiating PI from the Discussion and Peer Review -- References -- Chapter 2: Philosophy of PI -- Avoiding Bias and Ageism -- Triage of Issues -- Frequent Versus Rare, Significant Harm Versus Trivial Harm -- Chapter 3: PI Techniques and Tools -- PDSA -- Brent James and Intermountain Health [2] -- Six Sigma [3] -- Lean [4] -- TOPIC [5] -- References -- Chapter 4: Program Personnel and Regulatory Requirements -- Leadership -- Data Collection -- Meetings -- Chapter 5: Program Setup -- What Is Reviewed? -- Deaths -- Audit Filters -- Performance Measures and Benchmarking Tools -- Reference -- Chapter 6: Trauma Registries and Other Data Sources -- Purpose of the Registry -- Registry Leadership -- Routine Activities -- Special Activities -- Research Versus PI -- Chapter 7: Event Identification -- Safety Reporting (Hospital and Trauma Program) -- Sentinel Events --

Collection of Events -- Initial Discussion -- Chapter 8: Levels of Review -- Examples -- Deaths -- Adverse Events -- System Issues -- Personal Issues -- Chapter 9: Documentation of PI Process and Meeting Minutes -- What Is the Minimum Documentation? -- Templates -- Coordination Systems -- Situational Awareness of Open Issues -- Review of Opportunities for Improvement -- Chapter 10: Loop Closure -- What Does Loop Closure Mean? -- Can You Close All Loops? -- Loop Closure Methods -- Discussion -- Education -- Personal Intervention -- Equipment Alterations -- Guidelines -- Hardwiring Change -- Use of EMR -- Gatekeepers and Safety Officers -- Chapter 11: Types of Issues -- Clinician Performance and Decision-Making -- Vignette 1. Performance Improvement Investigation -- Discussion -- Corrective Action Plan -- Blood Transfusion Error -- Vignette #2 -- Performance Improvement Investigation -- Discussion -- Corrective Actions -- Staffing and Education Problems -- Vignette #3 -- Performance Improvement -- Analysis and Opportunities for Improvement -- External Issues (EMS, Transfer Hospitals) -- Vignette #4 -- Transfer Hospitals -- Vignette #5 -- Chapter 12: Complex Opportunities for Improvement and Difficult Loop Closure -- Physician Practice and Disagreement Among Specialists -- Nursing and Hospital Practice -- Conflict with Hospital Quality Programs -- Financial Limitations -- FTEs -- Equipment -- The Interdepartmental Conflict -- Lack of Hospital or Clinician Commitment -- Chapter 13: Inspection of PI Process by Reviewers -- Chart and Document Setup -- Content of Documents -- Supplemental Material -- Open Loops -- Reference -- Chapter 14: Performance Improvement Case Studies -- Documents and Slides -- Cases -- Missed Injuries -- Failure to Rescue and Escalation -- The Impact of Learners on Outcomes, Airway Management -- Unstable Patients at Referring Hospitals -- New Technologies -- Airway Management -- Patients with Life-Threatening Injuries Who Die in the Operating Room -- Life-Threatening Thoracic Trauma -- Adverse Events -- Dislodged Gastrostomy Tubes -- Optimal Case -- Pediatric -- Geriatric Death with Low Injury Severity and Multiple Comorbidities -- A Patient with Multiple Life-Threatening Conditions -- Index.
