1. Record Nr. UNINA9910452574803321

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Titolo	Practical patient safety [[electronic resource] /] / by John Reynard, John Reynolds, Peter Stevenson
Pubbl/distr/stampa	Oxford ; ; New York, : Oxford University Press, 2009
ISBN	0-19-176856-1 1-283-58109-4 9786613893543 0-19-157540-2
Descrizione fisica	1 online resource (319 p.)
Altri autori (Persone)	ReynoldsJohn, Dr. StevensonPeter
Disciplina	610.289
Soggetti	Medical errors - Prevention Patients - Safety measures Electronic books.
Lingua di pubblicazione	Inglese
Formato	Materiale a stampa
Livello bibliografico	Monografia
Note generali	Description based upon print version of record.
Nota di bibliografia	Includes bibliographical references and index.
Nota di contenuto	Preface; Acknowledgements; Contents; 1 Clinical error: the scale of the problem; The Harvard Medical Practice Study 1984; The Quality in Australian Healthcare Study 1992; The University College London Study 2001; Danish, New Zealand, Canadian, and French studies; The frequency and costs of adverse drug events; Accuracy of retrospective studies; Error rates revealed in retrospective studies are of the same order of magnitude as those found in observational studies; Error rates according to type of clinical activity; Deaths from adverse events; Extra bed days as a consequence of error Criminal prosecutions for medical errorsReliability: other industries; Reliability: healthcare; References; 2 Clinical errors:What are they?; Sources of error in primary care and office practice; Sources of error along the patient pathway in hospital care and potential methods of error prevention; Errors in dealing with referral letters; Errors of identification; Errors in note keeping; Errors with medical records in general; Other slips in letters that you have dictated; Errors as a consequence of patients failing to attend appointments for

investigations or for outpatient consultations

Washing your hands between patients and attention to infection controlAdmission to hospital; Diagnostic errors in general; Errors in drug prescribing and administration; Reducing errors in blood transfusion; Intravenous drug administration; Errors in the operating theatre; The use of diathermy; Harm related to patient positioning; Leg supports that give way; Generic safety checks prior to any surgical procedure; Failure to give DVT prophylaxis; Failure to give antibiotic prophylaxis; Errors in the postoperative period; Shared care; Medical devices; References

3 Safety culture in high reliability organizationsHigh reliability organizations: background; High reliability organizations: common features; The consequences of failure; 'Convergent evolution' and its implication for healthcare; Learning from accidents: overview of basic high reliability organizational culture; Elements of the safety culture; Counter-intuitive aspects of high reliability organization safety culture; References; 4 Case studies; Case study 1: wrong patient; Case study 2: wrong blood; Case study 3: wrong side nephrectomy; Case study 4: another wrong side nephrectomy

Case study 5: yet another wrong side nephrectomy caseCase study 6: medication error-wrong route (intrathecal vincristine); Case study 7: another medication error-wrong route (intrathecal vincristine); Case study 8: medication error-wrong route (intrathecal vincristine); Case study 9: medication error-miscalculation of dose; Case study 10: medication error-frequency of administration mis-prescribed as 'daily' instead of 'weekly'; Case study 11: medication error-wrong drug; Case study 12: miscommunication of path lab result; Case study 13: biopsy results for two patients mixed up

Case study 14: penicillin allergy death

Sommario/riassunto

Following recent high profile cases of surgical error in the UK and USA, patient safety has become a key issue in healthcare, now placed at heart of junior doctor's training. Errors made by doctors are very similar to those made in other high risk organisations, such as aviation, nuclear and petrochemical industries. Practical Patient Safety aims to demonstrate how core principles of safety from these industries can be applied in surgical and medical practice, in particular through training for health care professionals and healthcare managers.Whilst theoretical aspects of risk management form

2. Record Nr. UNINA9910709898703321

Titolo	Applications of research from the U.S. Geological Survey program, assessment of regional earthquake hazards and risk along the Wasatch Front, Utah / / edited by Paula L. Gori
Pubbl/distr/stampa	Washington : , : U.S. Department of the Interior, U.S. Geological Survey, , 1993
Descrizione fisica	1 online resource (viii, 167 pages) : illustrations, maps
Collana	U.S. Geological Survey professional paper ; ; 1519
Soggetti	Earthquake hazard analysis - Wasatch Range (Utah and Idaho) Seismology - Wasatch Range (Utah and Idaho) Natural disasters - Utah Faults (Geology) - Wasatch Range (Utah and Idaho) Geology, Stratigraphic Geology - Wasatch Range (Utah and Idaho) Earthquake hazard analysis Faults (Geology) Geology Natural disasters Seismology United States Wasatch Range Utah
Lingua di pubblicazione	Inglese
Formato	Materiale a stampa
Livello bibliografico	Monografia
Note generali	"Contributions from Utah Geological Survey, Utah Division of Comprehensive Emergency Management, University of Utah, and Utah State University." "This report documents how pertinent information about earthquake hazards along the Wasatch Front, Utah, was transferred to researchers, public officials, design professionals, land-use planners, and emergency managers as part of the U.S. Geological Survey's effort to mitigate the effects of earthquake hazards."
Nota di bibliografia	Includes bibliographical references.