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Titolo	2: Somministrazione, comando, appalto, trasferimento d'azienda : titoli 3. e 4. : artt. 20-32 / a cura di Maria Teresa Carinci e Carlo Cester
Pubbl/distr/stampa	Milano : Ipsoa, 2004
ISBN	88-217-1866-2
Descrizione fisica	XXIV, 406 p. ; 21 cm.
Lingua di pubblicazione	Italiano
Formato	Materiale a stampa
Livello bibliografico	Monografia
2. Record Nr.	UNINA9910781795903321
Autore	Kalra Jay
Titolo	Medical errors and patient safety [[electronic resource]] : strategies to reduce and disclose medical errors and improve patient safety // Jay Kalra
Pubbl/distr/stampa	Berlin, : De Gruyter, c2011
ISBN	1-283-16629-1 9786613166296 3-11-024950-2
Descrizione fisica	1 online resource (128 p.)
Collana	Patient safety ; ; v. 1
Classificazione	XL 1503
Disciplina	610.28/9
Soggetti	Medical errors - United States Patient safety Patients - Safety measures - United States
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	An overview and introduction to concepts -- Perceptions of medical error and adverse events -- Causes of medical error and adverse events -- Medical error and strategies for working solutions in clinical

diagnostic laboratories and other health care areas -- Creating a culture for medical error reduction -- Improving quality in clinical diagnostic laboratories -- Barriers to open disclosure -- International laws and guidelines addressing error and disclosure -- The value of autopsy in detecting medical error and improving quality -- Total quality management, six-sigma, and health care.

Sommario/riassunto

Is the reporting of medical errors changing? This book shows with real cases from health care and beyond that most errors come from flaws in the system. It also shows why they don't get reported and how medical error disclosure around the world is shifting away from blaming people, to a "no-fault" model that seeks to improve the whole system of care. The book intends to provide an introduction to medical errors that result in preventable adverse events. It will examine issues that stymie efforts made to reduce preventable adverse events and medical errors, and will moreover highlight their impact on clinical laboratories and other areas, including educational, bioethical, and regulatory issues. Varying error rates of 0.1-9.3% in clinical diagnostic laboratories have been reported in the literature. While it is suggested that fewer errors occur in the laboratory than in other hospital settings, the quantum of laboratory tests used in healthcare entails that even a small error rate may reflect a large number of errors. The interdependence of surgical specialties, emergency rooms, and intensive care units - all of which are prone to higher rates of medical errors - with clinical diagnostic laboratories entails that reducing error rates in laboratories is essential to ensuring patient safety in other critical areas of healthcare. The author maintains that many such errors are preventable provided that appropriate attention is paid to systemic factors involved in laboratory errors. This book identifies possible intelligent system approaches that can be adopted to help control and eliminate these errors. It is a valuable tool for physicians, clinical biochemists, research scientists, laboratory technologists and anyone interested in reducing adverse events at all levels of healthcare processes.
