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Altri autori (Persone)	HurwitzBrian SheikhAziz
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Nota di contenuto	Cover; Contents; List of contributors; Foreword; 1 Health care mistakes, violations and patient safety; Part 1: Understanding patient safety; 2 When is an 'error' not an error?; 3 Intentionally harmful violations and patient safety: the example of Harold Shipman; 4 Patient safety and patient error; 5 Health care safety and organisational change; 6 How does the law recognise and deal with medical errors?; 7 The many advantages and some disadvantages of a no-blame culture regarding medical errors; Part 2: Threats to patient safety 8 Diagnostic errors: psychological theories and research implications9 'Mince' or 'mice'? Clinical miscommunications and patient safety in a linguistically diverse society; 10 Clinical transitions: implications for patient safety; 11 Medicines management; 12 The patient's role in preventing errors and promoting safety; Part 3: Responses to health care errors and violations; 13 Aftermath of error for patients and health care staff; 14 Significant event auditing and root cause analysis; 15 Patient safety-epidemiological considerations; 16 Analysis of health

	care error reports 17 Patient safety education and curriculum design18 Teaching and learning about patient safety; 19 Health care errors, patient safety and the media; Index; A; B; C; D; E; F; G; H; I; J; K; L; M; N; O; P; Q; R; S; T; U; V; W
Sommario/riassunto	The detection, reporting, measurement, and minimization of medical errors and harms is now a core requirement in clinical organizations throughout developed societies. This book focuses on this major new area in health care. It explores the nature of medical error, its incidence in different health care settings, and strategies for minimizing errors and their harmful consequences to patients. Written by leading authorities, it discusses the practical issues involved in reducing errors in health care - for the clinician, the health policy adviser, and ethical and legal health professionals.