



Patient Safety and Hospital Accreditation: A Model for Ensuring Success

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Improving the culture of safety in our health care institutions is an essential component of preventing or reducing errors as well as improving overall health care quality. This book presents the clinically tested Myer's Patient Safety Model for health care system leaders, middle managers, and administrators to build their patient safety program and to help sustain, renew, or obtain accreditation.

The author provides detailed explanations of why medical errors still occur in accredited hospitals, and provides the much needed organization-wide steps to prevent these errors and enhance patient safety for improved outcomes. Current patient safety challenges are discussed with an emphasis on the concept of reliability. The Myers Model is examined in detail, along with current evidence for its three interrelated levels of organizational structure—the leadership (system) level, the unit (microsystem) level, and the individual level. The text includes interviews about key aspects of patient safety with three leaders of major health care accreditation programs in the U.S., Canada, and Australia. Additionally, it provides an overview of reporting systems within the U.S. and covers two essential tools for patient safety—root cause analysis and failure mode and effect analysis. The book links all aspects of patient safety with accreditation standards at the national level, and also discusses efforts to globalize accreditation criteria and procedures.

Key Features:

- Presents a clinically tested model for building a patient safety program and helping to sustain, renew, or obtain accreditation
- Provides tools for use in ensuring patient safety and accreditation, including root cause analysis and failure mode and effect analysis
- Discusses how aggregate data inform patient safety documentation and accreditation through integrated perspectives
- Offers a global view of accreditation and patient safety
- Includes techniques to improve communication among members of health care teams

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Barbara Goodman:

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