Improving The Safety And Quality Of Eggs And Egg Products Egg Safety And Nutritional Quality Woodhead Publishing Series In Food Science Technology And Nutrition

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Patient Safety and Quality of Care in Intensive Care Medicine
Quality and Safety Education for Nurses, Third Edition
Optimal Resources for Surgical Quality and Safety
Building Safer Healthcare Systems
Patient Safety and Quality
To Err Is Human
Still Not Safe

SHELDON CONRAD

Improving Healthcare Quality in Europe Characteristics, Effectiveness and Implementation of Different Strategies
Springer Nature
Organizations around the world are using Lean to redesign care and improve processes in a way that achieves and sustains meaningful results for patients, staff, physicians, and health systems. Lean Hospitals, Third Edition explains how to use the Lean methodology and mindsets to improve safety, quality, access, and morale while reducing costs, increasing capacity, and strengthening the long-term bottom line. This updated edition of a Shingo Research Award recipient begins with an overview of Lean methods. It explains how Lean practices can help reduce various frustrations for caregivers, prevent delays and harm for patients, and improve the long-term health of your organization. The second edition of this book presented new material on identifying waste, A3 problem solving, engaging employees in continuous improvement, and strategy deployment. This third edition adds new sections on structured Lean problem solving methods (including Toyota Kata), Lean Design, and other topics. Additional examples, case studies, and explanations are also included throughout the book. Mark Graban is also the co-author, with Joe Swartz, of the book Healthcare Kaizen: Engaging Frontline Staff in Sustainable Continuous Improvements, which is also a Shingo Research Award recipient. Mark and Joe also wrote The Executive's Guide to Healthcare Kaizen.
Patient Safety and Hospital Accreditation Elsevier
Second in a series of publications from the Institute of Medicine's Quality of Health Care in America project Today's health care providers have more research findings and more technology available to them than ever before. Yet recent reports have raised serious doubts about the quality of health care in America. Crossing the Quality Chasm makes an urgent call for fundamental change to close the quality gap. This book recommends a sweeping redesign of the American health care system and provides overarching principles for specific direction for policymakers, health care leaders, clinicians, regulators, purchasers, and others. In this comprehensive volume the committee offers: A set of performance expectations for the 21st century health care system. A set of 10 new rules to guide patient-clinician relationships. A suggested organizing framework to better align the incentives inherent in payment and accountability with improvements in quality. Key steps to promote evidence-based practice and strengthen clinical information systems. Analyzing health care organizations as complex systems, Crossing the Quality Chasm also documents the causes of the quality gap, identifies current practices that impede quality care, and explores how systems approaches can be used to implement change.
Safety-I and Safety-II Department of Health and Human Services
As tree nuts and peanuts become increasingly recognised for their health-promoting properties, the provision of safe, high quality nuts is a growing concern. Improving the safety and quality of nuts reviews key aspects of nut safety and quality management.Part one explores production and processing practices and their influence on nut contaminants. Chapters discuss agricultural practices to reduce microbial contamination of nuts, pest control in postharvest nuts, and the impact of nut postharvest handling, de-shelling, drying and storage on quality. Further chapters review the validation of processes for reducing the microbial load on nuts and integrating Hazard Analysis Critical Control Point (HACCP) and Statistical Process Control (SPC) for safer nut processing. Chapters in part two focus on improving nut quality and safety and highlight oxidative rancidity in nuts, the impact of roasting on nut quality, and advances in automated nut sorting. Final chapters explore the safety and quality of a variety of nuts including almonds, macadamia nuts, pecans, peanuts, pistachios and walnuts.Improving the safety and quality of nuts is a comprehensive resource for food safety, product development and QA professionals using nuts in foods, those involved in nut growing, nut handling and nut processing, and researchers in food science and horticulture departments interested in the area. - Reviews key aspects of nut safety and quality management and addresses the influences of production and processing practices on nut safety - Analyses particular nut contaminants, safety management in nut processing and significant nut quality issues, such as oxidative rancidity - Places focus on quality and safety in the production and processing of selected types of nuts
Improving Patient Safety National Academies Press
Drawing on the universal values in health care, the second edition of Quality and Safety in Nursing continues to devote itself to the nursing community and explores their role in improving quality of care and patient safety. Edited by key members of the Quality and Safety Education for Nursing (QSEN) steering team, Quality and Safety in Nursing is divided into three sections. Itfirst looks at the national initiative for quality and safety and links it to its origins in the IOM report. The second section defines each of the six QSEN competencies as well as providing teaching and clinical application strategies, resources and current references. The final section now features redesigned chapters on implementing quality and safety across settings. New to this edition includes: Instructional and practice approaches including narrative pedagogy and integrating the competencies in simulation A new chapter exploring the application of clinical learning and the

critical nature of inter-professional teamwork A revised chapter on the mirror of education and practice to better understand teaching approaches This ground-breaking unique text addresses the challenges of preparing future nurses with the knowledge, skills, and attitudes (KSAs) necessary to continuously improve the health care system in which they practice.

Improving the Safety and Quality of Eggs and Egg Products Academic Press

This book offers a global perspective on healthcare reform and its relationship with efforts to improve quality and safety. It looks at the ways reforms have developed in 30 countries, and specifically the impact national reform initiatives have had on the quality and safety of care. It explores how reforms drive quality and safety improvement, and equally how they act to negate such goals. Every country included in this book is involved in a reform and improvement process, but each takes place in a particular social, cultural, economic and developmental context, leading to differing emphases and varied progress. Methods for tackling common problems - financing, efficiencies, effectiveness, evidence-based practice, institutional reforms, quality improvement, and patient safety initiatives - also differ. Representatives from each nation provide a chapter to convey their own situation. The editors draw a conclusion from these numerous contributions and synthesize the themes emerging into a coherent ‘lessons learned’ summary that delivers value to the numerous stakeholders. Healthcare Reform, Quality and Safety forms a compendium of the current ‘state of the art’ in global healthcare reform. This is the first book of its type, and offers a unique opportunity for cross-fertilization of ideas to the mutual benefit of countries involved in the project. The content will be of interest to governments, policymakers, managers and leaders, clinicians, teaching academics, researchers and students.

Crossing the Quality Chasm McGraw Hill Professional

NAMED A DOODY’S CORE TITLE! Designed as both a text for the DNP curriculum and a practical resource for seasoned health professionals, this acclaimed book demonstrates the importance of using an interprofessional approach to translating evidence into nursing and healthcare practice in both clinical and nonclinical environments. This third edition reflects the continuing evolution of translation frameworks by expanding the Methods and Process for Translation section and providing updated exemplars illustrating actual translation work in population health, specialty practice, and the healthcare delivery system. It incorporates important new information about legal and ethical issues, the institutional review process for quality improvement and research, and teamwork and building teams for translation. In addition, an unfolding case study on translation is threaded throughout the text. Reorganized for greater ease of use, the third edition continues to deliver applicable theory and practical strategies to lead translation efforts and meet DNP core competency requirements. It features a variety of relevant change-management theories and presents strategies for improving healthcare outcomes and quality and safety. It also addresses the use of evidence to improve nursing education, discusses how to reduce the divide between researchers and policy makers, and describes the interprofessional collaboration imperative for our complex healthcare environment. Consistently woven throughout are themes of integration and application of knowledge into practice. NEW TO THE THIRD EDITION: Expands the Methods and Process for Translation section Provides updated exemplars illustrating translation work in population health, specialty practice, and the healthcare delivery system Offers a new, more user-friendly format Includes an entire new section, Enablers of Translation Delivers expanded information on legal and ethical issues Presents new chapter, Ethical Responsibilities of Translation of Evidence and Evaluation of Outcomes Weaves an unfolding case study on translation throughout the text KEY FEATURES: Delivers applicable theories and strategies that meet DNP core requirements Presents a variety of relevant change-management theories Offers strategies for improving outcomes and quality and safety Addresses the use of evidence to improve nursing education Discusses how to reduce the divide between researchers and policy makers Supplies extensive lists of references, web links, and other resources to enhance learning Purchase includes digital access for use on most mobile devices or computers

Translation of Evidence Into Nursing and Healthcare Springer Publishing Company

When you are ready to implement measures to improve patient safety, this is the book to consult. Charles Vincent, one of the world's pioneers in patient safety, discusses each and every aspect clearly and compellingly. He reviews the evidence of risks and harms to patients, and he provides practical guidance on implementing safer practices in health care. The second edition puts greater emphasis on this practical side. Examples of team based initiatives show how patient safety can be improved by changing practices, both cultural and technological, throughout whole organisations. Not only does this benefit patients; it also impacts positively on health care delivery, with consequent savings in the economy. Patient Safety has been praised as a gateway to understanding the subject. This second edition is more than that – it is a revelation of the pervading influence of health care errors, and a guide to how these can be overcome. "... The beauty of this book is that it describes the complexity of patient safety in a simple coherent way and captures the breadth of issues that encompass this fascinating field. The author provides numerous ways in which the reader can take this subject further with links to the international world of patient safety and evidence based research... One of the most difficult aspects of patient safety is that of implementation of safer practices and sustained change. Charles Vincent, through this book, provides all who read it clear examples to help with these challenges" From a review in Hospital Medicine by Dr Suzette Woodward, Director of Patient Safety. Access 'Essentials of Patient Safety – Free Online Introduction': www.wiley.com/go/vincent/patientsafety/essentials

Lean Hospitals Ashgate Publishing, Ltd.

v. 1. Research findings -- v. 2. Concepts and methodology -- v. 3. Implementation issues -- v. 4. Programs, tools and products.

Pediatric Patient Safety and Quality Improvement John Wiley & Sons

"Perfecting Patient Journeys is a guide for leaders of healthcare organizations who want to implement lean thinking. Readers will learn how to identify and select a problem, define a project scope, and create a shared understanding of what's occurring in the value stream. Readers will also learn to develop a shared vision of an improved future, and how to work together to make that vision a reality"--Provided by publisher.

Pediatric Board Study Guide BoD – Books on Demand

Global aquaculture production has grown rapidly over the last 50 years. It is generally accepted that there is limited potential to increase traditional fisheries since most fish stocks are well or fully exploited. Consequently increased aquaculture production is required in order to maintain global per capita fish consumption

at the present level. Fish farming enables greater control of product quality and safety, and presents the possibility of tailoring products according to consumer demands. This important collection reviews safety and quality issues in farmed fish and presents methods to improve product characteristics.The first part of the book focuses on chemical contaminants, chemical use in aquaculture and farmed fish safety. After an opening chapter discussing the risks and benefits of consumption of farmed fish, subsequent contributions consider environmental contaminants, pesticides, drug use and antibiotic resistance in aquaculture. Part two addresses important quality issues, such as selective breeding to improve flesh quality, the effects of dietary factors including alternative lipids and proteins sources on eating quality, microbial safety of farmed products, parasites, flesh colouration and off-flavours. Welfare issues and the ethical quality of farmed products are also covered. The final part discusses ways of managing of product quality, with chapters on HACCP, monitoring and surveillance, authenticity and product labelling.With its distinguished editor and international team of contributors, Improving farmed fish quality and safety is a standard reference for aquaculture industry professionals and academics in the field. - Reviews safety and quality issues in farmed fish and presents methods to improve product characteristics - Discusses contaminants, persistent organic pollutants and veterinary drug residues and methods for their reduction and control - Addresses important quality issues, genetic control of flesh characteristics and the effects of feed on product nutritional and sensory quality

Patient Safety Lippincott Williams & Wilkins

Americans should be able to count on receiving health care that is safe. To achieve this, a new health care delivery system is needed â€" a system that both prevents errors from occurring, and learns from them when they do occur. The development of such a system requires a commitment by all stakeholders to a culture of safety and to the development of improved information systems for the delivery of health care. This national health information infrastructure is needed to provide immediate access to complete patient information and decision-support tools for clinicians and their patients. In addition, this infrastructure must capture patient safety information as a by-product of care and use this information to design even safer delivery systems. Health data standards are both a critical and time-sensitive building block of the national health information infrastructure. Building on the Institute of Medicine reports To Err Is Human and Crossing the Quality Chasm, Patient Safety puts forward a road map for the development and adoption of key health care data standards to support both information exchange and the reporting and analysis of patient safety data.

Quality and Safety in Nursing Springer Publishing Company

Patient Safety and Healthcare Improvement at a Glance isa timely and thorough overview of healthcare quality writtenspecifically for students and junior doctors and healthcareprofessionals. It bridges the gap between the practical and thetheoretical to ensure the safety and wellbeing of patients.Featuring essential step-by-step guides to interpreting andmanaging risk, quality improvement within clinical specialties, andpractice development, this highly visual textbook offers the bestpreparation for the increased emphasis on patient safety andquality-driven focus in today’s healthcare environment. Healthcare Improvement and Safety at a Glance: • Maps out and follows the World Health OrganizationPatient Safety curriculum • Draws upon the quality improvement work of theInstitute for Healthcare Improvement This practical guide, covering a vital topic of increasingimportance in healthcare, provides the first genuine introductionto patient safety and quality improvement grounded in clinicalpractice.

Advances in Patient Safety National Academies Press

"I congratulate the editors of [this book] on their commitment to continuously updating the resources needed by nursing leaders, faculty, and students who seek to develop or enhance their quality and safety competencies. The chapters and the contents of this edition align magnificently with new domains of the AACN accreditation standards (2021). Whatever your level of education or role in nursing, this textbook is rich in resources to support your growth." -Linda Cronenwett, PhD, RN (ret.), FAAN Professor & Dean Emeritus University of North Carolina at Chapel Hill School of Nursing Former Principal Investigator, QSEN: Quality and Safety Education for Nurses (From the Foreword) This Third Edition of Quality and Safety Education for Nurses has been thoroughly updated for students in undergraduate Associate, Baccalaureate, Accelerated and BSN completion Nursing programs. There is a chapter focusing on each of the six Quality and Safety Education for Nurses (QSEN) Competency areas, with content on Nursing Leadership and Patient Care Management infused throughout the chapters. The Third Edition also includes new chapters on Systems Thinking, Implementation Science, and Population Health. It includes an Instructor’s manual and Powerpoints. New to the Third Edition: New Chapters: Chapter 3: Systems Thinking Chapter 13: Implementation Science Chapter 15: Population Health and the Role of Quality and Safety Incorporates new content based on The Future of 2020-2030 Report and the 2021 AACN Essentials Contains a "Competency Crosswalk" connecting each chapter's content to QSEN/AACN Competencies Key Features: Supports nursing schools to fulfill accreditation standards for Quality and Safety curricula Includes Clinical Judgment Activities, Case Studies, Interviews, NCLEX-Style Questions, Figures, Tables, Bibliography, Suggested Readings, and more to clarify content Designed to be used in a stand-alone Quality and Safety course, Leadership and Management Nursing course, or as a support for Nursing courses Provides instructor package with an unfolding case study with suggestions for assignments, questions and answers for case study and critical thinking exercises, PowerPoint slides, and more

Keeping Patients Safe Springer

This book focuses exclusively on the surgical patient and on the perioperative environment with its unique socio-technical and cultural issues. It covers preoperative, intraoperative, and postoperative processes and decision making and explores both sharp-end and latent factors contributing to harm and poor quality outcomes. It is intended to be a resource for all healthcare practitioners that interact with the surgical patient. This book provides a framework for understanding and addressing many of the organizational, technical, and cultural aspects of care to one of the most vulnerable patients in the system, the surgical patient. The first section presents foundational principles of safety science and related social science. The second exposes barriers to achieving optimal surgical outcomes and details the various errors and events that occur in the perioperative environment. The third section contains prescriptive and proactive tools and ways to eliminate errors and harm. The final section focuses on developing continuous quality improvement programs with an emphasis on safety and reliability. Surgical Patient Care: Improving Safety, Quality and Value targets an international audience which includes all hospital, ambulatory and clinic-based

operating room personnel as well as healthcare administrators and managers, directors of risk management and patient safety, health services researchers, and individuals in higher education in the health professions. It is intended to provide both fundamental knowledge and practical information for those at the front line of patient care. The increasing interest in patient safety worldwide makes this a timely global topic. As such, the content is written for an international audience and contains materials from leading international authors who have implemented many successful programs.

Textbook of Patient Safety and Clinical Risk Management Elsevier

Implementing safety practices in healthcare saves lives and improves the quality of care: it is therefore vital to apply good clinical practices, such as the WHO surgical checklist, to adopt the most appropriate measures for the prevention of assistance-related risks, and to identify the potential ones using tools such as reporting & learning systems. The culture of safety in the care environment and of human factors influencing it should be developed from the beginning of medical studies and in the first years of professional practice, in order to have the maximum impact on clinicians' and nurses' behavior. Medical errors tend to vary with the level of proficiency and experience, and this must be taken into account in adverse events prevention. Human factors assume a decisive importance in resilient organizations, and an understanding of risk control and containment is fundamental for all medical and surgical specialties. This open access book offers recommendations and examples of how to improve patient safety by changing practices, introducing organizational and technological innovations, and creating effective, patient-centered, timely, efficient, and equitable care systems, in order to spread the quality and patient safety culture among the new generation of healthcare professionals, and is intended for residents and young professionals in different clinical specialties.

Perfecting Patient Journeys National Academies Press

Experts estimate that as many as 98,000 people die in any given year from medical errors that occur in hospitals. That's more than die from motor vehicle accidents, breast cancer, or AIDSâ€"three causes that receive far more public attention. Indeed, more people die annually from medication errors than from workplace injuries. Add the financial cost to the human tragedy, and medical error easily rises to the top ranks of urgent, widespread public problems. To Err Is Human breaks the silence that has surrounded medical errors and their consequenceâ€"but not by pointing fingers at caring health care professionals who make honest mistakes. After all, to err is human. Instead, this book sets forth a national agendaâ€"with state and local implicationsâ€"for reducing medical errors and improving patient safety through the design of a safer health system. This volume reveals the often startling statistics of medical error and the disparity between the incidence of error and public perception of it, given many patients' expectations that the medical profession always performs perfectly. A careful examination is made of how the surrounding forces of legislation, regulation, and market activity influence the quality of care provided by health care organizations and then looks at their handling of medical mistakes. Using a detailed case study, the book reviews the current understanding of why these mistakes happen. A key theme is that legitimate liability concerns discourage reporting of errorsâ€"which begs the question, "How can we learn from our mistakes?" Balancing regulatory versus market-based initiatives and public versus private efforts, the Institute of Medicine presents wide-ranging recommendations for improving patient safety, in the areas of leadership, improved data collection and analysis, and development of effective systems at the level of direct patient care. To Err Is Human asserts that the problem is not bad people in health careâ€"it is that good people are working in bad systems that need to be made safer. Comprehensive and straightforward, this book offers a clear prescription for raising the level of patient safety in American health care. It also explains how patients themselves can influence the quality of care that they receive once they check into the hospital. This book will be vitally important to federal, state, and local health policy makers and regulators, health professional licensing officials, hospital administrators, medical educators and students, health caregivers, health journalists, patient advocatesâ€"as well as patients themselves. First in a series of publications from the Quality of Health Care in America, a project initiated by the Institute of Medicine

Lean Six Sigma for Hospitals: Improving Patient Safety, Patient Flow and the Bottom Line, Second Edition CRC Press

The purpose of this book is to provide a road map to help healthcare professionals establish a "culture of patient safety" in their facilities and practices, provide high quality healthcare, and increase patient and staff satisfaction by improving communication among staff members and between medical staff and patients. It achieves this by describing what each of six types of people will do in distress, by providing strategies that will allow healthcare professionals to deal more effectively with staff members and patients in distress, and by showing healthcare professionals how to keep themselves out of distress by getting their motivational needs met positively every day. The concepts described in this book are scientifically based and have withstood more than 40 years of scrutiny and scientific inquiry. They were first used as a clinical model to help patients help themselves, and indeed are still used clinically. The originator of the concepts, Dr. Taibi Kahler, is an internationally recognized clinical psychologist who was awarded the 1977 Eric Berne Memorial Scientific Award for the clinical application of a discovery he made in 1971. That discovery enabled clinicians to shorten significantly the treatment time of patients by reducing their resistance as a result of miscommunication between their doctors and themselves.

Establishing a Culture of Patient Safety Elsevier

This unique and engaging open access title provides a compelling and ground-breaking account of the patient safety movement in the United States, told from the perspective of one of its most prominent leaders, and arguably the movement’s founder, Lucian L. Leape, MD. Covering the growth of the field from the late 1980s to 2015, Dr. Leape details the developments, actors, organizations, research, and policy-making activities that marked the evolution and major advances of patient safety in this time span. In addition, and perhaps most importantly, this book not only comprehensively details how and why human and systems errors too often occur in the process of providing health care, it also promotes an in-depth understanding of the principles and practices of patient safety, including how they were influenced by today’s modern safety sciences and systems theory and design. Indeed, the book emphasizes how the growing awareness of systems-design thinking and the self-education and commitment to improving patient safety, by not only Dr. Leape but a wide range of other clinicians and health executives from both the

private and public sectors, all converged to drive forward the patient safety movement in the US. Making Healthcare Safe is divided into four parts: I. In the Beginning describes the research and theory that defined patient safety and the early initiatives to enhance it. II. Institutional Responses tells the stories of the efforts of the major organizations that began to apply the new concepts and make patient safety a reality. Most of these stories have not been previously told, so this account becomes their histories as well. III. Getting to Work provides in-depth analyses of four key issues that cut across disciplinary lines impacting patient safety which required special attention. IV. Creating a Culture of Safety looks to the future, marshalling the best thinking about what it will take to achieve the safe care we all deserve. Captivatingly written with an “insider’s” tone and a major contribution to the clinical literature, this title will be of immense value to health care professionals, to students in a range of academic disciplines, to medical trainees, to health administrators, to policymakers and even to lay readers with an interest in patient safety and in the critical quest to create safe care.

Patient Safety and Quality Improvement in Healthcare Quality Press

Print+CourseSmart

Handbook of Research on Patient Safety and Quality Care through Health Informatics National Academies Press

Building on the revolutionary Institute of Medicine reports To Err is Human and Crossing the Quality Chasm, Keeping Patients Safe lays out guidelines for improving patient safety by changing nurses' working conditions and demands. Licensed nurses and unlicensed nursing assistants are critical participants in our national effort to protect patients from health care errors. The nature of the activities nurses typically perform â€" monitoring patients, educating home caretakers, performing treatments, and rescuing patients who are in crisis â€" provides an indispensable resource in detecting and remedying error-producing defects in the U.S. health care system. During the past two decades, substantial changes have been made in the organization and delivery of health care â€" and consequently in the job description and work environment of nurses. As patients are increasingly cared for as outpatients, nurses in hospitals and nursing homes deal with greater severity of illness. Problems in management practices, employee deployment, work and workspace design, and the basic safety culture of health care organizations place patients at further risk. This newest edition in the groundbreaking Institute of Medicine Quality Chasm series discusses the key aspects of the work environment for nurses and reviews the potential improvements in working conditions that are likely to have an impact on patient safety.

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