MH940: Improving Safety & Quality in Health Care

View Online

1.

The importance of human resources management in health care: a global context. http://www.human-resources-health.com/content/4/1/20

2.

Berwick DM, Godfrey AB, Roessner J. Curing Health Care: New Strategies for Quality Improvement : A Report on the National Demonstration Project on Quality Improvement in Health Care. Jossey-Bass; 2002.

3.

Bicheno J. The Service Systems Toolbox: Integrating Lean Thinking, Systems Thinking, and Design Thinking. PICSIE Books; 2012.

4.

Bicheno J. The New Lean Toolbox: Towards Fast, Flexible Flow. 3rd ed. PICSIE Books; 2004.

5.

Bicheno J, Catherwood P, James R. Six Sigma: And the Quality Toolbox for Service and Manufacturing. Rev. ed. Picsie Books; 2005.

6.

Cusins P. Understanding Quality through Systems Thinking. TQM magazine.

1994;6(5):19-27. http://0-www.emeraldinsight.com.pugwash.lib.warwick.ac.uk/doi/pdfplus/10.1108/09544789410067853

7.

Deming WE. Out of the Crisis. 1st MIT Press ed. MIT Press; 2000.

8.

Edvardsson B, Øvretveit J, Thomasson B. Quality of Service: Making It Really Work. Vol Quality in Action. McGraw-Hill; 1994.

9.

Liker JK, Meier D. The Toyota Way Fieldbook: A Practical Guide for Implementing Toyota's 4Ps. McGraw-Hill; 2006. http://lib.myilibrary.com/browse/open.asp?id=86287&entityid=https://idp.warwick.ac.uk/idp/shibboleth

10.

Liker JK, Meier D. The Toyota Way Fieldbook: A Practical Guide for Implementing Toyota's 4Ps. McGraw-Hill; 2006.

11.

McNulty T, Ferlie E. Reengineering Health Care: The Complexities of Organizational Transformation. Oxford University Press; 2004.

12.

Schonberger R. Best Practices in Lean Six Sigma Process Improvement: A Deeper Look. John Wiley & Sons; 2008. http://lib.myilibrary.com/browse/open.asp?id=109440&entityid=https://idp.warwick.ac.uk/idp/shibboleth

13.

Schonberger R. Best Practices in Lean Six Sigma Process Improvement: A Deeper Look. John Wiley & Sons; 2008.

14.

Seddon J. Freedom from Command & Control: Rethinking Management for Lean Service. Productivity Press; 2005.

15.

Slack N, Brandon-Jones A, Johnston R. Operations Management. 7th edition. Pearson Education UK; 2013. http://lib.myilibrary.com/browse/open.asp?id=502442&entityid=https://idp.warwick.ac.uk/idp/shibboleth

16.

Slack N, Brandon-Jones A, Johnston R. Operations Management. Seventh edition. Pearson; 2013.

17.

Spear S, Kent Bowen H. Decoding the DNA of the Toyota Production System. Harvard business review. 1999;77(5):96-106. http://0-search.ebscohost.com.pugwash.lib.warwick.ac.uk/direct.asp?db=bth&jid=HBR&scope=site

18.

Womack JP, Jones DT. Lean Thinking: Banish Waste and Create Wealth in Your Corporation. Rev. and updated. Simon & Schuster; 2003.

19.

Womack JP, Jones DT, Roos D. The Machine That Changed the World. New ed. Simon & Schuster; 2007.

20.

Reason JT. Human Error. Cambridge University Press; 1990.

21.

Dekker S, Dekker S. The Field Guide to Understanding Human Error. 2nd ed. Ashgate Publishing Ltd; 2006. https://www.dawsonera.com/guard/protected/dawson.jsp?name=https://idp.warwick.ac.uk/idp/shibboleth&dest=http://www.dawsonera.com/abstract/9781472408402

22.

Dekker S, Dekker S. The Field Guide to Understanding Human Error. Ashgate; 2006.

23.

Norman DA. The Psychology of Everyday Things. Basic Books; 1988.

24.

Chassin MR. The Wrong Patient. Annals of Internal Medicine. 2002;136(11):826-833. doi:10.7326/0003-4819-136-11-200206040-00012

25.

Walshe K, Offen N. A very public failure: lessons for quality improvement in healthcare organisations from the Bristol Royal Infirmary. Quality and Safety in Health Care. 2001;10(4):250-256. doi:10.1136/qhc.0100250

26.

Walshe K, Offen N. A very public failure: lessons for quality improvement in healthcare organisations from the Bristol Royal Infirmary. Quality in Health Care. 2001;10(4):250-256. doi:10.1136/qhc.0100250

27.

Healthcare Commission. Investigation into outbreaks of Clostridium Difficile at Maidstone and Tunbridge Wells NHS Trust. Published online 2007.

http://webarchive.nationalarchives.gov.uk/20060502043818/http://healthcarecommission.org.uk/_db/_documents/Maidstone_and_Tunbridge_Wells_investigation_report_Oct_2007.pdf

28.

Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry - Executive summary. Published online 2013. http://www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf

29.

National Advisory Group on the Safety of Patients in England. Berwick Report into Improving the Safety of Patient. Published online 2013. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf

30.

McKee M. Improving the safety of patients in England. BMJ. 2013;347:5038-5038. doi:10.1136/bmj.f5038

31.

McKee M. Improving the safety of patients in England. BMJ: British medical journal. 2013;347(7921):f5038-f5038. doi:10.1136/bmj.f5038

32.

Vincent C. Patient Safety. Wiley-Blackwell; 2010.

33.

Kohn LT, Corrigan J, Donaldson MS. To Err Is Human: Building a Safer Health System. National Academy Press; 2000.

34.

Vincent C, Neale G, Woloshynowych M. Adverse events in British hospitals: preliminary retrospective record review. BMJ. 2001;322(7285):517-519. doi:10.1136/bmj.322.7285.517

35.

Vincent C, Neale G, Woloshynowych M. Adverse events in British hospitals: preliminary retrospective record review. BMJ: British medical journal. 2001;322:517-519. doi:10.1136/bmj.322.7285.517

36.

de Vries EN, Ramrattan MA, Smorenburg SM, Gouma DJ, Boermeester MA. The incidence and nature of in-hospital adverse events: a systematic review. Quality and Safety in Health Care. 2008;17(3):216-223. doi:10.1136/qshc.2007.023622

37.

de Vries EN, Ramrattan MA, Smorenburg SM, Gouma DJ, Boermeester MA. The incidence and nature of in-hospital adverse events: a systematic review. Quality & safety in health care. 2008;17:216-223. doi:10.1136/qshc.2007.023622

38.

Taxis K, Barber N. Causes of intravenous medication errors: an ethnographic study. Quality and Safety in Health Care. 2003;12(5):343-347. doi:10.1136/qhc.12.5.343

39.

Taxis K, Barber N. Causes of intravenous medication errors: an ethnographic study. Quality & safety in health care. 2003;12(5):343-347. doi:10.1136/qhc.12.5.343

40.

Burke JP. Infection Control — A Problem for Patient Safety. New England Journal of Medicine. 2003;348(7):651-656. doi:10.1056/NEJMhpr020557

41.

Burke JP. Infection control--a problem for patient safety. The New England Journal of Medicine. 2003;348(7):651-656. http://0-search.proquest.com.pugwash.lib.warwick.ac.uk/docview/223934778?accountid=14888

42.

Donaldson LJ, Great Britain. An Organisation with a Memory: Report of an Expert Group on Learning from Adverse Events in the NHS. Stationery Office; 2000.

43.

Department of Health. Safety First: a report for patients, clinicians and healthcare managers. Published online 2006. http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_064159.pdf

44.

Reason J. Human error: models and management. BMJ. 2000;320(7237):768-770. doi:10.1136/bmj.320.7237.768

45.

Reason J. Human Error: Models and Management. BMJ: British medical journal. 2000;320:768-770. doi:10.1136/bmj.320.7237.768

46.

Reason JT. Managing the Risks of Organizational Accidents. Ashgate; 1997.

47.

Dekker S. Patient Safety: A Human Factors Approach. CRC Press, Taylor & Francis Group; 2011. http://0-marc.crcnetbase.com.pugwash.lib.warwick.ac.uk/isbn/9781439852262

48.

Perrow C. Normal Accidents: Living with High Risk Technologies. Princeton University Press; 2011. http://WARW.eblib.com/patron/FullRecord.aspx?p=827819

49.

Perrow C. Normal Accidents: Living with High-Risk Technologies. Princeton University Press; 1999.

50.

Leonard MS, Frankel A, Simmonds T, Vega KB. Achieving Safe and Reliable Healthcare: Strategies and Solutions. Vol ACHE management series. Health Administration Press; 2004.

51.

Reason JT. Managing the Risks of Organizational Accidents. Ashgate; 1997.

52.

Apkon M, Leonard J, Vitale R, DeLizio L, Probst L. Design of a safer approach to intravenous drug infusions: failure mode effects analysis. Quality and Safety in Health Care. 2004;13(4):265-271. doi:10.1136/qshc.2003.007443

53.

Apkon M, Leonard J, Probst L, DeLizio L, Vitale R. Design of a safer approach to intravenous drug infusions: failure mode effects analysis. Quality & safety in health care. 2004;13(4):265-271. doi:10.1136/qshc.2003.007443

54.

Armitage G, Neary M, Hollingsworth G, Ashley L. A practical guide to Failure Mode and Effects Analysis in health care: Making the most of the team and its meetings. Joint Commission Journal on Quality and Patient Safety. 2010;36(8):358-351. doi:10.1016/S1553-7250(10)36053-3

55.

Barber N, Franklin B, Burnett S, Parand A, Shebl N. Failure mode and effects analysis: Views of hospital staff in the UK. Journal of Health Services Research and Policy. 2012;17(1):37-43. https://arlir.iii.com/nonret~S0&atitle=Failure+mode+and+effects+analysis:+Views+of+hospital+staff+in+the+UK&title=Journal+of+Health+Services+Research+and+Policy&aufirst=N.&auinit=&aulast=Barber&issn=13558196&eissn=&coden=&volume=17&issue=1&spage=37&epage=43&quarter=&ssn=&date=2012&sid=&reqtype3

56.

Barach P, Small SD. Reporting and preventing medical mishaps: lessons from non-medical near miss reporting systems. BMJ. 2000;320(7237):759-763. doi:10.1136/bmj.320.7237.759

57.

Barach P, Small SD. Reporting and preventing medical mishaps: lessons from non-medical near miss reporting systems. BMJ: British Medical Journal. 2000;320(7237):759-763. doi:10.1136/bmj.320.7237.759

58.

Benn J, Koutantji M, Wallace L, et al. Feedback from incident reporting: information and action to improve patient safety. Quality and Safety in Health Care. 2009;18(1):11-21. doi:10.1136/qshc.2007.024166

59.

Benn J, Koutantji M, Wallace L, et al. Feedback from incident reporting: information and action to improve patient safety. Quality & safety in health care. 2009;18(1):11-21. doi:10.1136/qshc.2007.024166

60.

Shojania KG. The frustrating case of incident-reporting systems. Quality and Safety in Health Care. 2008;17(6):400-402. doi:10.1136/qshc.2008.029496

61.

Shojania KG. The frustrating case of incident-reporting systems. Quality and Safety in Health Care. 2008;17(6):400-402. doi:10.1136/qshc.2008.029496

62.

Sujan MA. A novel tool for organisational learning and its impact on safety culture in a hospital dispensary. Reliability Engineering & System Safety. 2012;101:21-34. doi:10.1016/j.ress.2011.12.021

63.

Flin RH, O'Connor P, Crichton M. Safety at the Sharp End: A Guide to Non-Technical Skills. Ashgate Publishing Ltd; 2008. https://www.dawsonera.com/guard/protected/dawson.jsp?name=https://idp.warwick.ac.uk/idp/shibboleth&dest=http://www.dawsonera.com/abstract/9781472424006

64.

Flin RH, O'Connor P, Crichton M. Safety at the Sharp End: A Guide to Non-Technical Skills. Ashgate; 2008.

65.

Cohen MD, Hilligoss PB. The published literature on handoffs in hospitals: deficiencies identified in an extensive review. BMJ Quality & Safety. 2010;19(6):493-497. doi:10.1136/qshc.2009.033480

66.

Cohen MD, Hilligoss PB. The published literature on handoffs in hospitals: deficiencies identified in an extensive review. Quality & safety in health care. 2010;19(6):493-497. doi:10.1136/qshc.2009.033480

67.

Raduma-Tomas MA, Flin R, Yule S, Williams D. Doctors' handovers in hospitals: a literature review. BMJ Quality & Safety. 2011;20(2):128-133. doi:10.1136/bmjqs.2009.034389

68.

Patterson ES, Wears RL. Patient handoffs: standardized and reliable measurement tools remain elusive. Joint Commission Journal On Quality And Patient Safety. 2010;36(2):52-61. https://arlir.iii.com/nonret~S0&atitle=Patient+handoffs:+standardized+and+reliable+measurement+tools+remain+elusive.&title=Joint+Commission+Journal+On+Quality+And+Patient+Safety&aufirst=E.S.&auinit=&aulast=Patterson&issn=15537250&eissn=&coden=&volume=36&issue=2&spage=52&epage=61&quarter=&ssn=&date=2010&sid=&reqtype3

69.

Sujan M, Chessum PT, Rudd M, et al. Emergency Care Handover (ECHO study) across care boundaries – the need for joint decision making and consideration of psychosocial history. Emergency Medicine Journal. 2013;30(10):873-873. doi:10.1136/emermed-2013-203113.17

70.

Managing competing organizational priorities in clinical handover across organizational boundaries. http://hsr.sagepub.com/content/20/1_suppl/17.full

71.

Weick KE, Sutcliffe KM. Managing the Unexpected: Resilient Performance in an Age of Uncertainty. 2nd ed. Jossey-Bass; 2007. https://www.dawsonera.com/guard/protected/dawson.jsp?name=https://idp.warwick.ac.uk/idp/shibboleth&dest=http://www.dawsonera.com/abstract/9780470178591

72.

Weick KE, Sutcliffe KM. Managing the Unexpected: Resilient Performance in an Age of Uncertainty. 2nd ed. Jossey-Bass; 2007.

73.

Hollnagel E, Woods DD, Leveson N. Resilience Engineering: Concepts and Precepts. Ashgate; 2006.

74.

Hollnagel E, Braithwaite J, Wears RL. Resilient Health Care. Vol Ashgate studies in resilience engineering. Ashgate; 2013.

75.

Cook RI, Render M, Woods DD. Gaps in the continuity of care and progress on patient safety. BMJ. 2000;320(7237):791-794. doi:10.1136/bmj.320.7237.791

76.

Cook RI, Render M, Woods DD. Gaps in the Continuity of Care and Progress on Patient Safety. BMJ: British medical journal. 2000;320(7237):791-794. doi:10.1136/bmj.320.7237.791

77.

Hollnagel E. Resilient Health Care Volume 2,. The Resilience of Everyday Clinical Work. 2nd edition.