

MH940: Improving Safety & Quality in Health Care

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Apkon, M., J. Leonard, L. Probst, L. DeLizio, and R. Vitale. 2004. 'Design of a Safer Approach to Intravenous Drug Infusions: Failure Mode Effects Analysis'. *Quality & Safety in Health Care* 13 (4): 265–71. <https://doi.org/10.1136/qshc.2003.007443>.

Apkon, M., J. Leonard, R. Vitale, L. DeLizio, and L. Probst. 2004. 'Design of a Safer Approach to Intravenous Drug Infusions: Failure Mode Effects Analysis'. *Quality and Safety in Health Care* 13 (4): 265–71. <https://doi.org/10.1136/qshc.2003.007443>.

Armitage, G., M. Neary, G. Hollingsworth, and L. Ashley. 2010. '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* 36 (8): 358–351. [https://doi.org/10.1016/S1553-7250\(10\)36053-3](https://doi.org/10.1016/S1553-7250(10)36053-3).

Barach, Paul, and Stephen D. Small. 2000a. 'Reporting and Preventing Medical Mishaps: Lessons from Non-Medical near Miss Reporting Systems'. *BMJ* 320 (7237): 759–63. <https://doi.org/10.1136/bmj.320.7237.759>.

———. 2000b. 'Reporting and Preventing Medical Mishaps: Lessons from Non-Medical near Miss Reporting Systems'. *BMJ: British Medical Journal* 320 (7237): 759–63. <https://doi.org/10.1136/bmj.320.7237.759>.

Barber, N., B. Franklin, S. Burnett, A. Parand, and N. Shebl. 2012. 'Failure Mode and Effects Analysis: Views of Hospital Staff in the UK'. *Journal of Health Services Research and Policy* 17 (1): 37–43. <https://arlr.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.&aunit=&aualast=Barber&issn=13558196&eissn=&coden=&volume=17&issue=1&spage=37&epage=43&quarter=&ssn=&date=2012&sid=&reqtype3>.

Benn, J., M. Koutantji, L. Wallace, P. Spurgeon, M. Rejman, A. Healey, and C. Vincent. 2009a. 'Feedback from Incident Reporting: Information and Action to Improve Patient Safety'. *Quality and Safety in Health Care* 18 (1): 11–21. <https://doi.org/10.1136/qshc.2007.024166>.

———. 2009b. 'Feedback from Incident Reporting: Information and Action to Improve Patient Safety'. *Quality & Safety in Health Care* 18 (1): 11–21. <https://doi.org/10.1136/qshc.2007.024166>.

Berwick, Donald M., A. Blanton Godfrey, and Jane Roessner. 2002. *Curing Health Care: New Strategies for Quality Improvement: A Report on the National Demonstration Project on*

Quality Improvement in Health Care. San Francisco, Calif: Jossey-Bass.

Bicheno, John. 2004. *The New Lean Toolbox: Towards Fast, Flexible Flow*. 3rd ed. Buckingham: PICSIE Books.

———. 2012. *The Service Systems Toolbox: Integrating Lean Thinking, Systems Thinking, and Design Thinking*. Buckingham: PICSIE Books.

Bicheno, John, Philip Catherwood, and Rob James. 2005. *Six Sigma: And the Quality Toolbox for Service and Manufacturing*. Rev. ed. Buckingham: PICSIE Books.

Burke, John P. 2003a. 'Infection Control — A Problem for Patient Safety'. *New England Journal of Medicine* 348 (7): 651–56. <https://doi.org/10.1056/NEJMp020557>.

Burke, John P. 2003b. 'Infection Control--a Problem for Patient Safety'. *The New England Journal of Medicine* 348 (7): 651–56.
<http://0-search.proquest.com.pugwash.lib.warwick.ac.uk/docview/223934778?accountid=14888>.

Chassin, Mark R. 2002. 'The Wrong Patient'. *Annals of Internal Medicine* 136 (11): 826–33. <https://doi.org/10.7326/0003-4819-136-11-200206040-00012>.

Cohen, M. D., and P. B. Hilligoss. 2010a. 'The Published Literature on Handoffs in Hospitals: Deficiencies Identified in an Extensive Review'. *BMJ Quality & Safety* 19 (6): 493–97. <https://doi.org/10.1136/qshc.2009.033480>.

Cohen, M.D., and P.B. Hilligoss. 2010b. 'The Published Literature on Handoffs in Hospitals: Deficiencies Identified in an Extensive Review'. *Quality & Safety in Health Care* 19 (6): 493–97. <https://doi.org/10.1136/qshc.2009.033480>.

Cook, Richard I., Marta Render, and David D. Woods. 2000a. 'Gaps in the Continuity of Care and Progress on Patient Safety'. *BMJ* 320 (7237): 791–94. <https://doi.org/10.1136/bmj.320.7237.791>.

———. 2000b. 'Gaps in the Continuity of Care and Progress on Patient Safety'. *BMJ: British Medical Journal* 320 (7237): 791–94. <https://doi.org/10.1136/bmj.320.7237.791>.

Cusins, Peter. 1994. 'Understanding Quality through Systems Thinking'. *TQM Magazine* 6 (5): 19–27.
<http://0-www.emeraldinsight.com.pugwash.lib.warwick.ac.uk/doi/pdfplus/10.1108/09544789410067853>.

Dekker, Sidney. 2011. *Patient Safety: A Human Factors Approach*. Electronic resource. Boca Raton: CRC Press, Taylor & Francis Group.
<http://0-marc.crcnetbase.com.pugwash.lib.warwick.ac.uk/isbn/9781439852262>.

Dekker, Sidney, and Sidney Dekker. 2006a. *The Field Guide to Understanding Human Error*. Electronic resource. 2nd ed. Farnham: Ashgate Publishing Ltd.
<https://www.dawsonera.com/guard/protected/dawson.jsp?name=https://idp.warwick.ac.uk/idp/shibboleth&dest=http://www.dawsonera.com/abstract/9781472408402>.

———. 2006b. *The Field Guide to Understanding Human Error*. Aldershot, England:

Ashgate.

Deming, W. Edwards. 2000. *Out of the Crisis*. 1st MIT Press ed. Cambridge, Mass: MIT Press.

Department of Health. 2006. 'Safety First: A Report for Patients, Clinicians and Healthcare Managers'.
http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_064159.pdf.

Donaldson, Liam J. and Great Britain. 2000. *An Organisation with a Memory: Report of an Expert Group on Learning from Adverse Events in the NHS*. London: Stationery Office.

Edvardsson, Bo, John Øvretveit, and Bertil Thomasson. 1994. *Quality of Service: Making It Really Work*. Vol. *Quality in Action*. Maidenhead: McGraw-Hill.

Flin, Rhona H., Paul O'Connor, and Margaret Crichton. 2008a. *Safety at the Sharp End: A Guide to Non-Technical Skills*. Farnham: Ashgate Publishing Ltd.
<https://www.dawsonera.com/guard/protected/dawson.jsp?name=https://idp.warwick.ac.uk/idp/shibboleth&dest=http://www.dawsonera.com/abstract/9781472424006>.

———. 2008b. *Safety at the Sharp End: A Guide to Non-Technical Skills*. Aldershot, England: Ashgate.

Healthcare Commission. 2007. 'Investigation into Outbreaks of Clostridium Difficile at Maidstone and Tunbridge Wells NHS Trust'.
http://webarchive.nationalarchives.gov.uk/20060502043818/http://healthcarecommission.org.uk/_db/_documents/Maidstone_and_Tunbridge_Wells_investigation_report_Oct_2007.pdf.

Hollnagel, Erik. n.d. *Resilient Health Care Volume 2, The Resilience of Everyday Clinical Work*. 2nd edition. Ashgate, 2015.

Hollnagel, Erik, Jeffrey Braithwaite, and Robert L. Wears. 2013. *Resilient Health Care*. Vol. *Ashgate studies in resilience engineering*. Farnham: Ashgate.

Hollnagel, Erik, David D. Woods, and Nancy Leveson. 2006. *Resilience Engineering: Concepts and Precepts*. Aldershot, England: Ashgate.

Kohn, Linda T., Janet Corrigan, and Molla S. Donaldson. 2000. *To Err Is Human: Building a Safer Health System*. Washington, D.C.: National Academy Press.

Leonard, Michael Steven, Allan Frankel, Terri Simmonds, and Kathleen B. Vega. 2004. *Achieving Safe and Reliable Healthcare: Strategies and Solutions*. Vol. *ACHE management series*. Chicago, IL: Health Administration Press.

Liker, Jeffrey K., and David Meier. 2006a. *The Toyota Way Fieldbook: A Practical Guide for Implementing Toyota's 4Ps*. Electronic resource. New York: McGraw-Hill.
<http://lib.myilibrary.com/browse/open.asp?id=86287&entityid=https://idp.warwick.ac.uk/idp/shibboleth>.

———. 2006b. *The Toyota Way Fieldbook: A Practical Guide for Implementing Toyota's 4Ps*.

New York: McGraw-Hill.

'Managing Competing Organizational Priorities in Clinical Handover across Organizational Boundaries'. n.d. http://hsr.sagepub.com/content/20/1_suppl/17.full.

McKee, M. 2013. 'Improving the Safety of Patients in England'. *BMJ* 347: 5038–5038. <https://doi.org/10.1136/bmj.f5038>.

McKee, Martin. 2013. 'Improving the Safety of Patients in England'. *BMJ: British Medical Journal* 347 (7921): f5038–f5038. <https://doi.org/10.1136/bmj.f5038>.

McNulty, Terry, and Ewan Ferlie. 2004. *Reengineering Health Care: The Complexities of Organizational Transformation*. Oxford: Oxford University Press.

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

Norman, Donald A. 1988. *The Psychology of Everyday Things*. New York: Basic Books.

Patterson, E.S., and R.L. Wears. 2010. 'Patient Handoffs: Standardized and Reliable Measurement Tools Remain Elusive.' *Joint Commission Journal On Quality And Patient Safety* 36 (2): 52–61. <https://arlr.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.&aunit=&aunit=Patterson&issn=15537250&eissn=&coden=&volume=36&issue=2&spage=52&epage=61&quarter=&ssn=&date=2010&sid=&reqtype3>.

Perrow, Charles. 1999. *Normal Accidents: Living with High-Risk Technologies*. Princeton, NJ: Princeton University Press.

———. 2011. *Normal Accidents: Living with High Risk Technologies*. Electronic resource. Princeton: Princeton University Press. <http://WARW.ebib.com/patron/FullRecord.aspx?p=827819>.

Raduma-Tomas, M. A., R. Flin, S. Yule, and D. Williams. 2011. 'Doctors' Handovers in Hospitals: A Literature Review'. *BMJ Quality & Safety* 20 (2): 128–33. <https://doi.org/10.1136/bmjqs.2009.034389>.

Reason, J. 2000. 'Human Error: Models and Management'. *BMJ* 320 (7237): 768–70. <https://doi.org/10.1136/bmj.320.7237.768>.

Reason, J. T. 1990. *Human Error*. Cambridge [England]: Cambridge University Press.

———. 1997a. *Managing the Risks of Organizational Accidents*. Aldershot, Hants, England: Ashgate.

———. 1997b. *Managing the Risks of Organizational Accidents*. Aldershot, Hants, England: Ashgate.

Reason, James. 2000. 'Human Error: Models and Management'. *BMJ: British Medical Journal* 320: 768–70. <https://doi.org/10.1136/bmj.320.7237.768>.

'Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry - Executive Summary'. 2013.
<http://www.midstaffpublicinquiry.com/sites/default/files/report/Executive%20summary.pdf>

Schonberger, Richard. 2008a. *Best Practices in Lean Six Sigma Process Improvement: A Deeper Look*. Electronic resource. Hoboken, N.J.: John Wiley & Sons.
<http://lib.myilibrary.com/browse/open.asp?id=109440&entityid=https://idp.warwick.ac.uk/idp/shibboleth>.

———. 2008b. *Best Practices in Lean Six Sigma Process Improvement: A Deeper Look*. Hoboken, N.J.: John Wiley & Sons.

Seddon, John. 2005. *Freedom from Command & Control: Rethinking Management for Lean Service*. New York: Productivity Press.

Shojania, K.G. 2008a. 'The Frustrating Case of Incident-Reporting Systems'. *Quality and Safety in Health Care* 17 (6): 400–402. <https://doi.org/10.1136/qshc.2008.029496>.

———. 2008b. 'The Frustrating Case of Incident-Reporting Systems'. *Quality and Safety in Health Care* 17 (6): 400–402. <https://doi.org/10.1136/qshc.2008.029496>.

Slack, Nigel, Alistair Brandon-Jones, and Robert Johnston. 2013a. *Operations Management*. 7th edition. Boston, Mass: Pearson Education UK.
<http://lib.myilibrary.com/browse/open.asp?id=502442&entityid=https://idp.warwick.ac.uk/idp/shibboleth>.

———. 2013b. *Operations Management*. Seventh edition. Harlow, England: Pearson.

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

Sujan, M., P. T. Chessum, M. Rudd, L. Fitton, M. Inada Kim, P. Spurgeon, and M. W. Cooke. 2013. 'Emergency Care Handover (ECHO Study) across Care Boundaries – the Need for Joint Decision Making and Consideration of Psychosocial History'. *Emergency Medicine Journal* 30 (10): 873–873. <https://doi.org/10.1136/emmermed-2013-203113.17>.

Sujan, Mark A. 2012. 'A Novel Tool for Organisational Learning and Its Impact on Safety Culture in a Hospital Dispensary'. *Reliability Engineering & System Safety* 101: 21–34.
<https://doi.org/10.1016/j.res.2011.12.021>.

Taxis, K, and N. Barber. 2003a. 'Causes of Intravenous Medication Errors: An Ethnographic Study'. *Quality and Safety in Health Care* 12 (5): 343–47.
<https://doi.org/10.1136/qhc.12.5.343>.

Taxis, K., and N. Barber. 2003b. 'Causes of Intravenous Medication Errors: An Ethnographic Study'. *Quality & Safety in Health Care* 12 (5): 343–47.

<https://doi.org/10.1136/qhc.12.5.343>.

'The Importance of Human Resources Management in Health Care: A Global Context'. n.d.
<http://www.human-resources-health.com/content/4/1/20>.

Vincent, Charles. 2010. Patient Safety. Chichester, West Sussex, UK: Wiley-Blackwell.

Vincent, Charles, Graham Neale, and Maria Woloshynowych. 2001a. 'Adverse Events in British Hospitals: Preliminary Retrospective Record Review'. *BMJ* 322 (7285): 517–19.
<https://doi.org/10.1136/bmj.322.7285.517>.

———. 2001b. 'Adverse Events in British Hospitals: Preliminary Retrospective Record Review'. *BMJ: British Medical Journal* 322: 517–19.
<https://doi.org/10.1136/bmj.322.7285.517>.

Vries, E N de, M A Ramrattan, S M Smorenburg, D J Gouma, and M A Boermeester. 2008a. 'The Incidence and Nature of In-Hospital Adverse Events: A Systematic Review'. *Quality and Safety in Health Care* 17 (3): 216–23. <https://doi.org/10.1136/qshc.2007.023622>.

Vries, E.N. de, M.A. Ramrattan, S.M. Smorenburg, D.J. Gouma, and M.A. Boermeester. 2008b. 'The Incidence and Nature of In-Hospital Adverse Events: A Systematic Review'. *Quality & Safety in Health Care* 17: 216–23. <https://doi.org/10.1136/qshc.2007.023622>.

Walshe, K, and N Offen. 2001a. 'A Very Public Failure: Lessons for Quality Improvement in Healthcare Organisations from the Bristol Royal Infirmary'. *Quality and Safety in Health Care* 10 (4): 250–56. <https://doi.org/10.1136/qhc.0100250>.

Walshe, K., and N. Offen. 2001b. 'A Very Public Failure: Lessons for Quality Improvement in Healthcare Organisations from the Bristol Royal Infirmary'. *Quality in Health Care* 10 (4): 250–56. <https://doi.org/10.1136/qhc.0100250>.

Weick, Karl E., and Kathleen M. Sutcliffe. 2007a. *Managing the Unexpected: Resilient Performance in an Age of Uncertainty*. Electronic resource. 2nd ed. San Francisco: Jossey-Bass.
<https://www.dawsonera.com/guard/protected/dawson.jsp?name=https://idp.warwick.ac.uk/idp/shibboleth&dest=http://www.dawsonera.com/abstract/9780470178591>.

———. 2007b. *Managing the Unexpected: Resilient Performance in an Age of Uncertainty*. 2nd ed. San Francisco: Jossey-Bass.

Womack, James P., and Daniel T. Jones. 2003. *Lean Thinking: Banish Waste and Create Wealth in Your Corporation*. Rev. and Updated. London: Simon & Schuster.

Womack, James P., Daniel T. Jones, and Daniel Roos. 2007. *The Machine That Changed the World*. New ed. London: Simon & Schuster.