



# Patient Safety Culture

Theory,  
Methods  
and  
Application

Edited by

PATRICK WATERSON



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# Patient Safety Culture Theory Methods And Application

**Susan D. Moffatt-Bruce**



## **Patient Safety Culture Theory Methods And Application:**

*Patient Safety Culture* Patrick Waterson, 2018-10-09 How safe are hospitals Why do some hospitals have higher rates of accident and errors involving patients How can we accurately measure and assess staff attitudes towards safety How can hospitals and other healthcare environments improve their safety culture and minimize harm to patients These and other questions have been the focus of research within the area of Patient Safety Culture PSC in the last decade More and more hospitals and healthcare managers are trying to understand the nature of the culture within their organisations and implement strategies for improving patient safety The main purpose of this book is to provide researchers healthcare managers and human factors practitioners with details of the latest developments within the theory and application of PSC within healthcare It brings together contributions from the most prominent researchers and practitioners in the field of PSC and covers the background to work on safety culture e g measuring safety culture in industries such as aviation and the nuclear industry the dominant theories and concepts within PSC examples of PSC tools methods of assessment and their application and details of the most prominent challenges for the future in the area Patient Safety Culture Theory Methods and Application is essential reading for all of the professional groups involved in patient safety and healthcare quality improvement filling an important gap in the current market

*Patient Safety Culture* Patrick Waterson, 2014 **Patient Safety Culture** Patrick Waterson, 2018-10-09 How safe are hospitals Why do some hospitals have higher rates of accident and errors involving patients How can we accurately measure and assess staff attitudes towards safety How can hospitals and other healthcare environments improve their safety culture and minimize harm to patients These and other questions have been the focus of research within the area of Patient Safety Culture PSC in the last decade More and more hospitals and healthcare managers are trying to understand the nature of the culture within their organisations and implement strategies for improving patient safety The main purpose of this book is to provide researchers healthcare managers and human factors practitioners with details of the latest developments within the theory and application of PSC within healthcare It brings together contributions from the most prominent researchers and practitioners in the field of PSC and covers the background to work on safety culture e g measuring safety culture in industries such as aviation and the nuclear industry the dominant theories and concepts within PSC examples of PSC tools methods of assessment and their application and details of the most prominent challenges for the future in the area Patient Safety Culture Theory Methods and Application is essential reading for all of the professional groups involved in patient safety and healthcare quality improvement filling an important gap in the current market

Human Factors and Ergonomics in Health and Social Care Mark Sujan, Laura Pickup, Helen Vosper, Ken Catchpole, 2025-04-29 Patient safety patient and family experience and staff wellbeing are the joint responsibility of anyone working within health and social care An understanding of how Human Factors and Ergonomics can improve our interactions with systems and processes can often lead to improved patient and staff outcomes If you are responsible for

implementing Human Factors and Ergonomics programmes within a health and social care setting or if you just want to understand more about how the principles of human factors might apply to your role this practical introduction will help you navigate your way around Human Factors and Ergonomics approaches within the healthcare setting Key features include Aligned to the Chartered Institute of Ergonomics and Human Factors professional competencies this book shows how these can be framed within real life practice Packed with case studies and helpful tips you can use in your day to day practice Clear structure showing the different levels of a system with specific chapters on organisation people equipment and environment Fully illustrated to facilitate your learning

*Human Factors in Paramedic Practice* Gary Rutherford, 2020-09-22 Human factors is a scientific discipline which examines the interactions between components of a system whilst aspiring to improve system performance and human well being Paramedics are often the first on scene in emergency and urgent situations and the quality of care that patients receive is dependent on the performance of the paramedic often working alone or as part of a small team and frequently in challenging environments This book is an accessible and informative guide to the concepts of human factors and ergonomics in the field of paramedic practice It shows how an understanding and application of these principles can improve paramedic performance and well being and ultimately patient care The system components of paramedic practice consist of the patient the environment the equipment the paramedic and their team the organisation they work in and the wider culture This book brings together a range of specialist contributors to consider each of these components in detail through chapters which explore situational awareness human centred design the well being of the paramedic systems thinking and safety culture among other topics It aims to provide paramedics with practical advice and the knowledge of human factors that they need to make their first contact with a patient in need as safe and effective as possible for all involved

*Fast Facts for Patient Safety in Nursing* Deborah Dolan Hunt, 2022-08-12 This unique Fast Fact serves as a quick resource for foundational relevant data knowledge and vital information not only about the nature of medical errors but why they occur More importantly Hunt shows us how to comprehensively address problems highlighting the need for both academic and clinical professional development emphasizing approaches as theory informed practices acknowledging importance of human caring power relationship and such practices as mindful presence Jean Watson PhD RN AHN BC FAAN LL AAN Founder Watson Caring Science Institute Distinguished Professor Dean Emerita University of Colorado Denver This practical resource helps nurses develop the skills they need to avoid medical errors and promote patient safety Based on the most current research and guidance from principal scientific academic boards the text identifies the most significant errors and their causes and describes how nurses can develop and improve critical thinking logic and clinical judgement to improve patient outcomes This book presents an overview of common preventable issues and their causes including medication errors patient falls pressure ulcers infections and surgical errors It focuses on strategies for becoming a safe practitioner through education and competency development while highlighting major national safety

initiatives with improved outcomes This Fast Facts discusses several theories that promote quality of care and concrete methods for fostering critical thinking and reasoning It examines prioritization and delegation as a way to develop skills in addition to scope of practice intuition ethics leadership and emotional intelligence The final chapter addresses patient safety using a holistic approach encompassing cultural humility and artificial intelligence Each chapter includes an introduction learning objectives an illustrative case vignette discussion questions concise tips from the field special topics Fast Facts boxes suggested assignments and resources for further study Key Features Helps nurse managers to prioritize and address specific safety and medical errors immediately Delivers practical tips on improving patient care and outcomes Provides step by step guidance on preventing medication errors the leading cause of adverse events Presents multiple strategies to develop critical thinking and judgment Offers interviews with patient safety experts for context and application Includes case studies tips from the field Fast Facts boxes tables discussion questions suggested assignments and more

### **Safety in Medication**

**Use** Mary Patricia Tully, Bryony Dean Franklin, 2015-08-18 An estimated 1 in 20 patients are admitted to the hospital due to problems with their medication and 1 in 100 hospitalized patients are harmed due to medication errors during their stay The prescribing of medications is the most common health care intervention and medication safety is relevant to all health care professionals and patients in all

**Human Factors and Ergonomics: Syllabus for Indian Universities** Vivek Kant, Prathamesh Bachche, Rammohan Maikala, 2024-05-04 As India moves towards the Vision 2047 in a quest for a better future there is a growing need for the design of technology and infrastructure to enable well being safety and productivity for Indians Human Factors and Ergonomics is one discipline that supports the well being of people in terms of design maintenance management regulation and governance of technology Due to the lack of disciplinary programs that address the totality of the discipline there is a need for capacity building in the academic sector for training the next generation of practitioners This sample syllabus while covering the breadth of the discipline also provides a foundation for Indian universities to fulfil the requirements of Human Factors and Ergonomics This syllabus can be creatively adapted to suit specific master s programs in science engineering technology and design This syllabus provides a basis for a holistic academic program that supports the next generation of learners in India

**Fitting the Human: Introduction to Ergonomics/Human Factors Engineering, Eighth Edition** Katrin Kroemer Elbert, 2025-03-10 The aim of this book is to provide human engineering for workplaces tools machinery computers shift work lighting sound climate work demands offices vehicles healthcare and the home and everything else that we can produce to suit the human body and mind Now being published in its eighth edition Fitting the Human focuses on the primary ergonomic task of accommodating the human with the appropriate selection of equipment and tools work requirements and procedures physical and social conditions at work and working hours and shift arrangements This book provides the ergonomic information needed for the user friendly design of tasks equipment and workplaces It follows the successful format of previous editions with updated information and

practical guidelines that augment the previous information It offers refreshed information on ergonomic design for the home and workplace contemporary ways of working healthcare and medicine and artificial intelligence and autonomy This text also recognizes that cultural differences in living and working vary around the world so additional insights are offered into ergonomics in global cultures and regions This title will help the reader understand how to plan and design an overall system and its details to fit the human Published under the mantra of solid information easy to read easy to understand easy to apply Fitting the Human is written for students and professionals in ergonomics human factors product and work design safety architecture management and all fields of engineering Patient Safety - Cultural Perspectives Marita

Danielsson,2018-04-26 Background Shared values norms and beliefs of relevance for safety in health care can be described in terms of patient safety culture This concept overlaps with patient safety climate but culture represents the deeprooted values norms and beliefs whereas climate refers to attitudes and more superficial manifestations of culture There may be numerous subcultures within an organization including different professional cultures In recent years increased attention has been paid to patient safety culture in Sweden and the patient safety culture climate in health care is regularly measured based on the assumption that patient safety culture climate can influence various patient safety outcomes Aim The overall aim of the thesis is to contribute to an improved understanding of patient safety culture and subcultures in Swedish health care Design and methods The thesis is based on four studies applying different methods Study 1 was a survey that included 23 781 respondents Data were analysed with quantitative methods with primarily descriptive results Studies 2 and 3 were qualitative studies involving interviews with a total of 28 registered nurses 24 nurse assistants and 28 physicians Interview data were analysed using content analysis Study 4 evaluated an intervention intended to influence patient safety culture and included data from a questionnaire with both fixed and open ended questions which was answered by 200 respondents Results A key result from Study 1 was that professional groups differed in terms of their views and statements about patient safety culture climate Registered nurses and nurse assistants in Study 2 were found to have partially overlapping norms values and beliefs concerning patient safety which were identified at individual interpersonal and organizational level Study 3 found four categories of values and norms among physicians of potential relevance for patient safety Predominantly positive perceptions were found in Study 4 concerning the Walk Rounds intervention among frontline staff members local managers and top level managers who participated in the intervention However there were also reflections on disadvantages and some suggestions for improvement Conclusions According to the results of the patient safety culture climate questionnaire perceptions about safety culture climate dimensions contribute more to the rating of overall patient safety than background characteristics e g profession and years of experience There are differences in the patient safety culture between registered nurses and nurse assistants which imply that efforts for improved patient safety must be tailored to their respective values norms and beliefs Several aspects of physicians professional culture may have relevance for patient safety

Expectations of being infallible reduce their willingness to talk about errors they make thus limiting opportunities for learning from errors Walk Rounds are perceived to contribute to increased learning concerning patient safety and could potentially have a positive influence on patient safety culture

**Contemporary Ergonomics and Human Factors 2015** Sarah Sharples, 2018-06-08 Ergonomics and human factors is the discipline concerned with the application of scientific knowledge to improve people's interaction with products systems and environments This book presents the proceedings of the international conference Ergonomics and Human Factors 2015 the 29th year in which a volume in the Contemporary Ergonomics series has

**The Wiley Blackwell Handbook of the Psychology of Occupational Safety and Workplace Health** Sharon Clarke, Tahira M. Probst, Frank W. Guldenmund, Jonathan Passmore, 2015-09-23 A Wiley Blackwell Handbook of Organizational Psychology focusing on occupational safety and workplace health The editors draw on their collective experience to present thematically structured material from leading thinkers and practitioners in the USA Europe and Asia Pacific Provides comprehensive coverage of the major contributions that psychology can make toward the improvement of workplace safety and employee health Equips those who need it most with cutting edge research on key topics including wellbeing safety culture safety leadership stress bullying workplace health promotion and proactivity

**Leading Reliable Healthcare** Bandar Abdulmohsen Al Knawy, 2017-12-15 Leading Reliable Healthcare describes state of the art healthcare management systems The key focus of the publication is reliable describing how leadership can ensure never less than reliable standards of care for patients and how excellence can be achieved The focus throughout is on ensuring that patients and their families can depend on a reliable healthcare system for their needs fulfilling their expectations that hospitals are trustworthy stable and capable of dealing with their health from the simplest to the most complex illnesses Each of the chapters focuses on a different aspect of building a reliable healthcare system concentrating on the leadership necessary to deliver and manage the different component elements of the healthcare system The nominated contributors for this book are recognized leaders from various healthcare systems around the globe including the UK USA Canada and South Korea Singapore The contributors have been selected to ensure a wide perspective of healthcare management building on diverse approaches practices and experiences and are currently practicing healthcare management in their respective systems The book aims to focus on the pragmatic rather than theoretical and will provide a series of practical methodologies and case studies to help improve decision making in healthcare management With contributions by Sallie J Weaver PhD MHS Associate Professor Armstrong Institute for Patient Safety and Quality and Dept of Anesthesiology Professor of Health Policy and Management John Hopkins Bloomberg School of Public Health Frank Federico RPh Vice President Institute for Healthcare Improvement Dr Hanan Edrees Manager Quality Management KAMC Riyadh Dr Hee Hwang CIO and Associate Professor Seoul National University Bundang Hospital Department of Pediatrics Division of pediatric Neurology Center of Medical Informatics Dr M Andrew Padmos Chief Executive Officer The Royal College of Physicians and Surgeons of Canada

Professor Richard Hobbs Professor of Primary Care Health Sciences Director NIHR English School for Primary Care Research Nuffield Department of Primary Care Health Sciences University of Oxford Ms Jules Martin Managing Director Central London Clinical Commissioning Group Dr Bruno Holthof Chief Executive Officer Oxford University Hospitals Tara Donnelly Chief Executive Health Innovation Network South London G ran Henriks Chief Executive of Learning and Innovation Qulturum County Council of J nk ping Sweden

**Structural Approaches to Address Issues in Patient Safety**

Susan D. Moffatt-Bruce, 2019-10-24 This volume delves into the potential that design thinking can have when applied to organizational systems and structures in health care environments to mitigate risks reduce medical errors and ultimately improve patient safety the quality of care provider well being and the overall patient experience

**Human Factors and Ergonomics for the Gulf Cooperation Council** Shatha N. Samman, 2018-07-27 Human Factors and Ergonomics HFE is introduced to students academics researchers practitioners policy makers and others in the Gulf Cooperation Council GCC A holistic approach is taken to emphasize the breadth and depth of HFE by providing both theory and applications in the field Providing HFE perspectives from expert academics from multidisciplinary and culturally diverse backgrounds it contains case studies written by industry professionals highlighting their work from Bahrain Kuwait Oman Saudi Arabia and United Arab Emirates Features The first HFE book for the GCC region with case studies showcasing the economics of ergonomics Presents easy to read chapters covering principles methodologies applications future trends and key terms Encompasses both the theory and application of HFE fields discussing processes technologies and practices Written for readers with no prior background of HFE

**Sağlık Çalışanlarının Güvenliği** Prof. Dr. Haydar SUR, Doç. Dr. Tunçay PALTEKİ, Dr. Öğr. Üyesi Gülay YAZICI, 2022-10-27

**Handbook of Safety Principles** Niklas Möller, Sven Ove Hansson, Jan-Erik Holmberg, Carl Rollenhagen, 2018-01-04 Presents recent breakthroughs in the theory methods and applications of safety and risk analysis for safety engineers risk analysts and policy makers Safety principles are paramount to addressing structured handling of safety concerns in all technological systems This handbook captures and discusses the multitude of safety principles in a practical and applicable manner It is organized by five overarching categories of safety principles Safety Reserves Information and Control Demonstrability Optimization and Organizational Principles and Practices With a focus on the structured treatment of a large number of safety principles relevant to all related fields each chapter defines the principle in question and discusses its application as well as how it relates to other principles and terms This treatment includes the history the underlying theory and the limitations and criticism of the principle Several chapters also problematize and critically discuss the very concept of a safety principle The book treats issues such as What are safety principles and what roles do they have What kinds of safety principles are there When if ever should rules and principles be disobeyed How do safety principles relate to the law what is the status of principles in different domains The book also features Insights from leading international experts on safety and reliability Real world applications and case studies



including systems usability verification and validation human reliability and safety barriers Different taxonomies for how safety principles are categorized Breakthroughs in safety and risk science that can significantly change improve and inform important practical decisions A structured treatment of safety principles relevant to numerous disciplines and application areas in industry and other sectors of society Comprehensive and practical coverage of the multitude of safety principles including maintenance optimization substitution safety automation risk communication precautionary approaches non quantitative safety analysis safety culture and many others The Handbook of Safety Principles is an ideal reference and resource for professionals engaged in risk and safety analysis and research This book is also appropriate as a graduate and PhD level textbook for courses in risk and safety analysis reliability safety engineering and risk management offered within mathematics operations research and engineering departments NIKLAS M LLER PhD is Associate Professor at the Royal Institute of Technology in Sweden The author of approximately 20 international journal articles Dr M ller s research interests include the philosophy of risk metaethics philosophy of science and epistemology SVEN OVE HANSSON PhD is Professor of Philosophy at the Royal Institute of Technology He has authored over 300 articles in international journals and is a member of the Royal Swedish Academy of Engineering Sciences Dr Hansson is also a Topical Editor for the Wiley Encyclopedia of Operations Research and Management Science JAN ERIK HOLMBERG PhD is Senior Consultant at Risk Pilot AB and Adjunct Professor of Probabilistic Risk and Safety Analysis at the Royal Institute of Technology Dr Holmberg received his PhD in Applied Mathematics from Helsinki University of Technology in 1997 CARL ROLLENHAGEN PhD is Adjunct Professor of Risk and Safety at the Royal Institute of Technology Dr Rollenhagen has performed extensive research in the field of human factors and MTO Man Technology and Organization with a specific emphasis on safety culture and climate event investigation methods and organizational safety assessment

**Healthcare Administration: Concepts, Methodologies, Tools, and Applications** Management Association, Information Resources, 2014-08-31 As information systems become ever more pervasive in an increasing number of fields and professions workers in healthcare and medicine must take into consideration new advances in technologies and infrastructure that will better enable them to treat their patients and serve their communities Healthcare Administration Concepts Methodologies Tools and Applications brings together recent research and case studies in the medical field to explore topics such as hospital management delivery of patient care and telemedicine among others With a focus on some of the most groundbreaking new developments as well as future trends and critical concerns this three volume reference source will be a significant tool for medical practitioners hospital managers IT administrators and others actively engaged in the healthcare field Human Performance on the Flight Deck Don Harris, 2016-12-05 Taking an integrated systems approach to dealing exclusively with the human performance issues encountered on the flight deck of the modern airliner this book describes the inter relationships between the various application areas of human factors recognising that the human contribution to the operation of an airliner does not fall into

neat pigeonholes The relationship between areas such as pilot selection training flight deck design and safety management is continually emphasised within the book It also affirms the upside of human factors in aviation the positive contribution that it can make to the industry and avoids placing undue emphasis on when the human component fails The book is divided into four main parts Part one describes the underpinning science base with chapters on human information processing workload situation awareness decision making error and individual differences Part two of the book looks at the human in the system containing chapters on pilot selection simulation and training stress fatigue and alcohol and environmental stressors Part three takes a closer look at the machine the aircraft beginning with an examination of flight deck display design followed by chapters on aircraft control flight deck automation and HCI on the flight deck Part four completes the volume with a consideration of safety management issues both on the flight deck and across the airline the final chapter in this section looks at human factors for incident and accident investigation The book is written for professionals within the aviation industry both on the flight deck and elsewhere for post graduate students and for researchers working in the area

**Human Factors and Ergonomics in Practice** Steven Shorrock, Claire Williams, 2016-11-18 This edited book concerns the real practice of human factors and ergonomics HF E conveying the perspectives and experiences of practitioners and other stakeholders in a variety of industrial sectors organisational settings and working contexts The book blends literature on the nature of practice with diverse and eclectic reflections from experience in a range of contexts from healthcare to agriculture It explores what helps and what hinders the achievement of the core goals of HF E improved system performance and human wellbeing The book should be of interest to current HF E practitioners future HF E practitioners allied practitioners HF E advocates and ambassadors researchers policy makers and regulators and clients of HF E services and products

## Embracing the Track of Phrase: An Emotional Symphony within **Patient Safety Culture Theory Methods And Application**

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