Artikel Ilmiah

The Role for Leaders of Health Care Organizations in Patient Safety

Penelitian Ilmiah

Pembangunan Metode MPS Bar-for Size EOQ
Disertai Hasil Forecasting Terpilih dengan
Maximum-Minimum Stock Level (Simulasi)
Pencapaian dan Pengendalian Perseaan di RG
Siti Khodiah

Hubungan Sumber Tarbunfuknya Budaya Organisasi
dengan Budaya Organisasi Puakesmas (Sebuah
Analisis di Kabupaten dan Kota Kendari)

Analisis Efektivitas Upaya Penemuan Pendarita
Kusta Baru Secara Aktilis dan Pasif Menggunakan
Metode Cost Effectiveness Analysis (Studi Kasus di
Puakesmas Dangkei Kabupaten Sumenep)

Strategi dan Rencana Bauran Pemasaran
Berdasarkan Kebutuhan dan Harapan Masyarakat
Terhadap Pelayanan Pelayan di Kabupaten
Sumenep

Diterbitkan Oleh:
YAYASAN SUMBER DAYA MANUSIA BIDANG KESEHATAN
(SUADA SEHAT)

PROGRAM STANDARISASI DAN KEBIJAKAN KESEHATAN

PROGRAM PASCASARJANA UNIVERSITAS Airlangga

Critical Appraisal

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TB di Kabupaten Timur Tengah Boluakan, Provinsi
NTT (Analisis Determinan Kinerja Pelugas
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New Release

Increase Patient Safety by Creating a Quieter
Hospital Environment
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The Role for Leaders of Health Care Organizations in Patient Safety

Peran Pemimpin Organisasi Kesehatan untuk Keselamatan Pasien

1. John R. Clarke --> University of Philadelphia
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Abstract

We review what leaders of health care systems, including chief executive officers and board members, need to know to have patient safety literacy and do to make their systems safe. High reliability organizations produce reliable results that are not dependent on providers being perfect. Their characteristics include the commitment of leadership to safety as a system responsibility, with a culture of safety that decreases variability with standardized care and does not condone at-risk behavior. A business case can be made for investing resources into systems that produce good outcomes reliably. Leaders must see patient safety problems as problems with their system, not with their employees. Leaders need to give providers information to make and monitor system progress. All medical errors, including near misses, and processes associated with all adverse events may provide information for system improvement. Improving systems should produce better long-term results than educating workers to be more careful. (Am J Med Qual 2007;22:311-318).

Keyword: adverse, event;, at-risk, behavior;, benchmark;, clinical, pathway;, culture, of, safety;, disclosure, of, medical, error;, error, reporting;, failure, mode, and, effect, analysis;, health, care, leadership;, high, reliability, organization;, medical, error;, near, miss;, patient, safety;, proactive, hazard,

Daftar Pustaka:


