Artikel Ilmiah
The Role for Leaders of Health Care Organizations in Patient Safety

Penelitian Ilmiah
Pembangunan Metode MPS Bar-for Size EQQ Disertai Hasil Forecasting Terpilih dengan Maximum-Minimum Block Level (Simulasi) Perencanaan dan Pengendalian Persediaan di RS Siti Khodijah
Hubungan Sumber Tarbiongnya Budaya Organisasi dengan Budaya Organisasi Puskesmas (Sebuah Analisis di Kabupaten dan Kota Kendari)
Analisis Efektivitas Upaya Penenun Pendarita Kusta Baru Secara Akif dan Pasif Menggunakan Metode Cost Effectiveness Analysis (Studi Kasus di Puskesmas Dangke Kabupaten Sumenep)
Strategi dan Pencanaan Bauran Pemasaran Berdasarkan Kebutuhan dan Harapan Masyarakat terhadap Pelayanan Pelayan di Kabupaten Sumenep
Upaya Pemasaran untuk Meningkatkan Pemanfaatan Rawat Inap di Bagian Kebidanan dan Kandungan RSD Dr. H. Moh. Anwar Sumenep Berdasarkan Analisis Perilaku Konsumen
Upaya Pencairan Target BTA Positif pada Suspek TBC di Kabupaten Timur Tengah Belu, Provinsi NTT (Analisis Determina Kinerja Pelugas Laboratorium Puskesmas)

Critical Appraisal
Upaya Pencairan Target BTA Positif pada Suspek TBC di Kabupaten Timur Tengah Belu, Provinsi NTT Sebuah Tinjauan Kritis

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

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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:


