Bibliography

Journal Articles:

Andel, C. et al. The Economics of Health Care Quality and Medical Errors. J Health Care Finance. 2012; 39(1): 39-50.

Bishop, T. et al. Paid Malpractice Claims for Adverse Events in Inpatient and Outpatient Settings. JAMA.2011; 305(23): 2427-2431.

Camargo, C. et al. Safety Climate and Medical Errors in 62 U.S. Emergency Departments. Annals of Emergency Medicine. 2012; 60(5):555-563e20.

Chamberlain, C. et al. Disclosure of "Nonharmful" Medical Errors and Other Events. Arch Surg.2012; 147(3)282-286.

Classen, D. et al. "Global Trigger Tool" shows that adverse events in hospitals may be 10x greater than previously measured. Health Aff. 2011; 30(4):581-589.

Davis, R.E. et al. Hospital patient's reports of medical errors and undesirable events in their health care. J of Eval in Clinical Practice. 2012; 1-7.

Gallagher, T. et al. Patients' and Physicians' Attitudes Regarding the Disclosure of Medical Errors. JAMA.2003; 289(8):1001-1007.

Gandi, T. et al. Missed and Delayed Diagnoses in the Ambulatory Setting: A Study of Closed Malpractice Claims. Annals of Int Med.2006; 145:488-496.

Kooienga, S. and Stewart, V. "Putting a Face on Medical Errors: A Patient Perspective. Journal for Healthcare Quality. 2011; 35(4):37-41.

Landrigan, C. et al. Temporal Trends in Rates of Patient Harm Resulting from Medical Care. N Engl J Med. 2010; 363:2124-2134.

Loren, D. et al. Risk Managers, Physicians and Disclosure of Harmful Medical Errors. Joint Commission Journal on Quality and Patient Safety. 2010; 36(3): 101-108.

Mello, M. et al. Who Pays for Medical Errors? An Analysis of Adverse Event Costs and the Medical Liability System and Incentives for Patient Safety Improvement. J of Empirical Legal Studies. 2007; 4(4): 835-860.

Moore, C. et al. Medical Errors Related to Discontinuity of Care from an Inpatient to an Outpatient Setting. J Gen Intern Med. 2003; 18:646-651.

Shanafelt, T. et al. Burnout and Medical Errors among American Surgeons. Annals of Surgery. 2009 published online at www.annalsofsurgery.com.

Singer, S. and Vogus T. Reducing Hospital Errors: Interventions that Build Safety Culture. Annu. Rev. Public Health. 2013; 34:373-396.

Stelfox, H.T. et al. The "To Err is Human" report and patient safety literature. Qual Saf Health Care. 2006; 15:174-178.

Tamang, S. et al. "Improving End of Life Care: an Information Systems Approach to Reducing Medical Errors. Medical and Care Compunetics 2. 2005; 93-104.

Van Den Bos, J. et al. The $17.1 Billion Problem: The Annual Cost of Measurable Medical Errors. Health Affairs. 2011. 30(4); 596-603.

Wasserman, M. et al. Identifying and Preventing Medical Errors in Patients with Limited English Proficiency: Key Findings and Tools for the Field. J for Healthcare Quality. 2014; 36(3): 5-16.

Woods, D. et al. Ambulatory care adverse events and preventable adverse events leading to a hospital admission. Qual Saf Health Care. 2007; 16: 127-131.

Additional Resources

Harden, S. Creating and Sustaining a Culture of Safety. Patient Safety and Quality Healthcare: psqh.com. September/October 2008.

"The Institute of Medicine Report on Medical Errors: Misunderstanding Can Do Harm". Quality of Healthcare in America Committee. Medscape General Medicine. 2000; 2(3). Accessed at http://www.medscape.com/viewarticle/418841

Nicholson, S. A Hands -On Approach to" Hand Off" Communication: Who is the" Physical Therapist of Record"? PT in Motion magazine. April 2010.

Sentinel Event Data Event Type By Year 1995-2013. The Joint Commission, Office of Quality Monitoring. Available at http://www.jointcommission.org/se_data_event_type_by_year_/

Sentinel Event Data Root Causes by Event Type 2004-2013. The Joint Commission. Office of Quality Monitoring. Available at http://www.jointcommission.org/Sentinel_Event_Statistics/

Sherwin, J. Contemporary Topics in Healthcare: Root Cause Analysis. PT in Motion magazine. May 2011.

"To Err is Human: Building a Safer Health System" IOM Report. November 1999. Accessed at http://www.iom.edu/~/media/Files/Report%20Files/1999/To-Err-is-Human/To%20Err%20is%20Human%201999%20%20report%20brief.pdf

"To Err is Human- To Delay is Deadly: Ten Years Later, a million lives lost, billions of dollars wasted. Consumers Union (nonprofit publisher of Consumer Reports).   2009. Published at SafePatientProject.org.