



# Patient Safety Incident Report

## I. Incident Details

- **Date of Incident:** May 15, 2050
- **Time of Incident:** 2:30 PM
- **Location:** Ward 3B, [YOUR COMPANY NAME]
- **Patient Name:** [PATIENT'S NAME]
- **Patient ID:** JD-816419

### Description of Incident:

While transferring the patient from the bed to a wheelchair for transport to the radiology department, the patient slipped and fell due to a wet spot on the floor near the nurse's station. The nursing staff attempted to catch the patient but were unable to prevent the fall. The patient landed on their right side and complained of immediate pain in the right hip area.

## II. Clinical Assessment

**Injuries:** The patient sustained a bruise on the right hip and complained of tenderness in the area.

### Vital Signs at the Time of Incident:

Parameter	Reading
Blood Pressure	120/80 mmHg
Pulse Rate	82 bpm
Respiratory Rate	16 bpm

# Lehrer Report Patient Safety

**LM Reder**



## **Lehrer Report Patient Safety:**

The MacNeil/Lehrer Report ,1982      **Better By Mistake** Alina Tugend,2011-03-17 New York Times columnist Alina Tugend delivers an eye opening big idea Embracing mistakes can make us smarter healthier and happier in every facet of our lives In this persuasive book journalist Alina Tugend examines the delicate tension between what we re told we must make mistakes in order to learn and the reality we often get punished for them She shows us that mistakes are everywhere and when we acknowledge and identify them correctly we can improve not only ourselves but our families our work and the world around us as well Bold and dynamic insightful and provocative Better by Mistake turns our cultural wisdom on its head to illustrate the downside of striving for perfection and the rewards of acknowledging and accepting mistakes and embracing the imperfection in all of us      Valuing Life Steven E. Rhoads,1980      **The Trust Crisis in Healthcare** David A. Shore,2007 This is a comprehensive survey of the causes and consequences of declining trust in healthcare and provides suggestions for its restoration The authors identify the elements of trust in the environment of modern healthcare and analyse the sources of mistrust in key areas of medicine      **Core Curriculum for Forensic Nursing** Bonnie Price,Kathleen Maguire,2015-10-06 The International Association of Forensic Nurses has developed The Core Curriculum for Forensic Nursing First Edition for nurses who aim to work in and gain certification in the field The book is well illustrated with full cover photographs and images vital to a solid understanding of forensic nursing Written by the world s experts in forensic nursing the Core Curriculum for Forensic Nursing offers a practical organization and writing style to help with subject mastery and retention      *Emerging Values in Health Care* Stephen Pattison,Roisin Pill,Huw Thomas,Ben Hannigan,2010-02-15 This volume explains how health care professions and their values have changed over the last forty years charting where they have come from where they are now and how they might develop in the future There is coverage of a wide range of professions within healthcare Chapters are followed by critical responses from senior practitioners

**Technology and the Aging** United States. Congress. House. Select Committee on Aging. Subcommittee on Health and Long-Term Care,1984      Congressional Record United States. Congress,1981 The Congressional Record is the official record of the proceedings and debates of the United States Congress It is published daily when Congress is in session The Congressional Record began publication in 1873 Debates for sessions prior to 1873 are recorded in The Debates and Proceedings in the Congress of the United States 1789 1824 the Register of Debates in Congress 1824 1837 and the Congressional Globe 1833 1873      **Biennial Report - Wisconsin Educational Communications Board** Wisconsin. Educational Communications Board,1971      Bioethics Megan-Jane Johnstone,2022-11-15 Now in its eighth edition Bioethics A Nursing Perspective provides practical guidance on the ethical issues you might come across in nursing practice with real world examples that help to bring this important subject to life Author Dr Megan Jane Johnstone AO Australia s foremost nursing ethics scholar provides a comprehensive framework for negotiating the ethical challenges obligations and

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Patterns ,1993 **Medical Errors and Patient Safety** Jay Kalra,2011 Patient Safety emphasizes the reporting analysis and prevention of medical errors that very often leads to adverse healthcare situations 1 in 10 patients are impacted by medical errors The WHO calls the patient safety issue an endemic concern A number of well known experts of all areas in the medical field have collected very valuable information for a better patient treatment and higher safety culture in all medical disciplines *Motor Field* ,1911 *Scene, Channel 2 and 17* ,1983 **The Health Sciences Audiovisual Resource List** University of Connecticut. Health Center,1978 *Lawyers' Medical Cyclopedia of Personal Injuries and Allied Specialties* ,2002 **Broadcasting** ,1981 **To Err Is Human** Institute of Medicine,Committee on Quality of Health Care in America,2000-03-01 Experts estimate that as many as 98 000 people die in any given year from medical errors that occur in hospitals That s more than die from motor vehicle accidents breast cancer or AIDS three causes that receive far more public attention Indeed more people die annually from medication errors than from workplace injuries Add the financial cost to the human tragedy and medical error easily rises to the top ranks of urgent widespread public problems To Err Is Human breaks the silence that has surrounded medical errors and their consequence but not by pointing fingers at caring health care professionals who make honest mistakes After all to err is human Instead this book sets forth a national agenda with state and local implications for reducing medical errors and improving patient safety through the design of a safer health system This volume reveals the often startling statistics of medical error and the disparity between the incidence of error and public perception of it given many patients expectations that the medical profession always performs perfectly A careful examination is made of how the surrounding forces of legislation regulation and market activity influence the quality of care provided by health care organizations and then looks at their handling of medical mistakes Using a detailed case study the

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