



NORTH AMERICAN SPINE SOCIETY



## Patient Safety 101 Presentation: Reference Material

### Slide 4

Centers for Disease Control and Prevention (National Center for Health Statistics).  
*Deaths: Final Data For 1997*. National Vital Statistics Reports. 1999;47:27.

Centers for Disease Control and Prevention (National Center for Health Statistics). *Births  
And Deaths: Preliminary Data For 1998*. National Vital Statistics Reports.  
1999;47:6.

Kohn LT, Corrigan JM, Donalson MS, eds. *To Err Is Human*. Institute of Medicine,  
Washington, DC: National Academy Press; 1999.

### Slide 5

Brennan TA, Leape LL, Laird NM, et al. Incidence of adverse events and negligence in  
hospitalized patients: results of the Harvard Medical Practice Study I. *N Engl J  
Med*. 1991;324:370-376.

Leape LL, Brennan TA, Laird NM, et al. The nature of adverse events in hospitalized  
patients: results of the Harvard Medical Practice Study II. *N Engl J Med*.  
1991;324:377-384.

Thomas EJ, Studdert DM, Burstin HR, et al. Incidence and types of adverse events and  
negligent care in Utah and Colorado. *Med Care*. 2000;38:261-271.

McDonald CJ, Weiner M, Hui SL. Deaths due to medical errors are exaggerated in  
Institute of Medicine report. *JAMA*. 2000;284:93-95.

### Slide 8

Joint Commission on Accreditation of Healthcare Organizations. *Sentinel Event  
Statistics-March 19, 2003*. Available at: <http://www.jcaho.org>. Accessed: March  
24, 2003.

### Slide 9

Kohn LT, Corrigan JM, Donalson MS, eds. *To Err Is Human*. Institute of Medicine,  
Washington, DC: National Academy Press; 1999.

### Slide 10

Kohn LT, Corrigan JM, Donalson MS, eds. *To Err Is Human*. Institute of Medicine,  
Washington, DC: National Academy Press; 1999.



## NORTH AMERICAN SPINE SOCIETY

Brennan TA. The Institute of Medicine report on medical errors-could it do harm. *N Engl J Med.* 2000;342:1123-1125.

### Slide 13

Chassin M. Is health care ready for six sigma quality? *Millbank.* 1998;76:565-591.

### Slide 14

Chassin M. Is health care ready for six sigma quality? *Millbank.* 1998;76:565-591.

Eichhorn JH. Prevention of intraoperative anesthesia accidents and related severe injury through safety monitoring. *Anesthesiology.* 1989;70:572-577.

Ross AF, Tinerk JH. Anesthesia risk. In: Miller RD, ed. *Anesthesia.* 4th ed. New York: Churchill-Livingston;1994.

Orking FW. Patient monitoring during anesthesia as an exercise in technology assessment. In: Saidman LJ, Smith NT, eds. *Monitoring in Anesthesia,* 3rd ed. London, UK: Butterworth-Heinemann; 1993.

### Slide 16

Reason James. *Human Error.* Cambridge University Press. 1990.

### Slide 17

Eisenberg JM. Continuing education meets the learning organization: the challenge of systems approach to patient safety. *Journal of Continuing Education in Health Professions.* 2000;20;197-207.

### Slide 18

Eisenberg JM. Continuing education meets the learning organization: the challenge of systems approach to patient safety. *Journal of Continuing Education in Health Professions.* 2000;20;197-207.

### Slide 19

Kohn LT, Corrigan JM, Donalson MS, eds. *To Err Is Human.* Institute of Medicine, Washington, DC: National Academy Press; 1999.