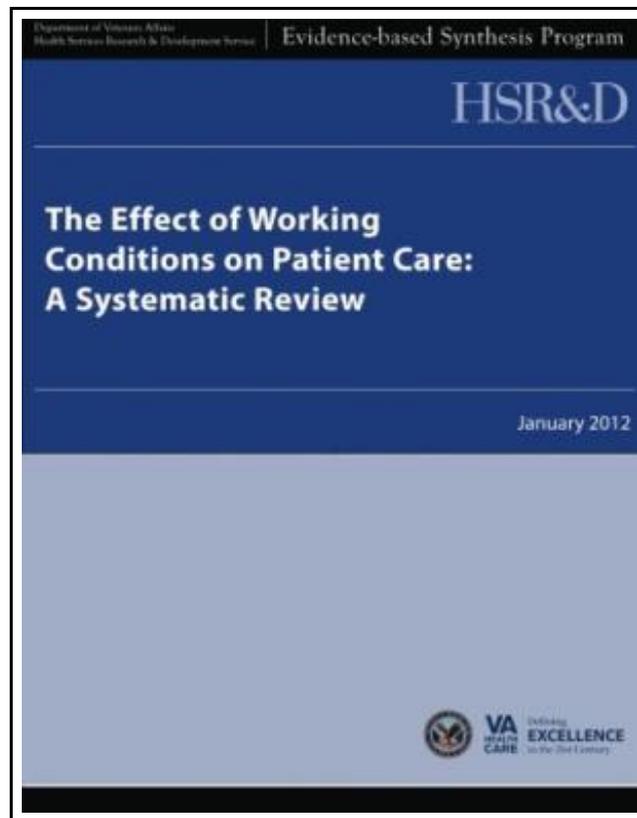


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Createspace. Paperback. Book Condition: New. This item is printed on demand. Paperback. 72 pages. Dimensions: 11.0in. x 8.5in. x 0.2in. A patient safety movement that began with a 1999 Institute of Medicine report on the prevalence of preventable medical errors has spawned both policy to change health care systems and a growing body of literature aimed at understanding the causes of such errors. A 2003 AHRQ systematic review investigated the role that workplace conditions play in explaining patient safety and found that workloads, work schedules, lengths of work shifts, and stress levels affected rates of non-fatal adverse outcomes, mortality rates, medication errors, and other patient safety measures. However, much of this evidence relies on studies based in hospitals and focuses on nurse and resident staffing or is based on studies in non-healthcare settings. A large body of evidence has shown clear linkages between workplace conditions and employee satisfaction and stress in a wide variety of organizational and industry settings. In the healthcare industry, increasing interest in understanding these linkages has stemmed from the idea that healthcare providers working environments also affect important patient outcomes, including safety, quality of care and satisfaction. Additionally, meeting objectives of the current healthcare reform to increase healthcare quality by increasing the availability of primary care providers and making care safer, more efficient, effective and patient-centered hinges on the ability to deal with the documented shortage of primary care providers in the U. S. and at the same time improve patient outcomes. The purpose of this report is to systematically review the evidence on the role of primary care providers workplace conditions in influencing patient outcomes. The focus on primary care providers work environment will provide evidence on increasing healthcare quality. While the focus of this review is on patient outcomes, we do discuss implications for providers...



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