Patient Safety:
Selected Landmark Publications

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1. Institute of Medicine. Committee on the Health Professions Education Summit. Greiner, A. C., Knebel, E., (Eds.). (2003).*Health professions education. A bridge to quality.* Washington, D.C.: National Academies Press.
2. Institute of Medicine. Committee on Identifying and Preventing Medication Errors. Aspden, P., Wolcott, J., Bootman, J.L. & Cronenwett, L.R. (Eds.) (2007). *Preventing medication errors*. Washington, D.C.: National Academies Press.
3. Institute of Medicine. Committee on Quality of Health Care. (2001). *Crossing the quality chasm*. Washington, DC: National Academy Press.
4. Institute of Medicine. Committee on Quality of Health Care. Kohn, L. T., Corrigan, J.M., & Donaldson, M.S. (Eds.) (2000). *To err is human*. Washington, D.C.: National Academy Press.
5. Institute of Medicine. Committee on the Work Environment for Nurses and Patient Safety. Page, A. (Ed.) (2004). *Keeping patients safe. Transforming the work environment of nurses.* Washington, DC.: National Academies Press.
6. Leape, L. L. & Berwick, D.M. Five years after *To err is human*. What have we learned? (2005). *Journal of the American Medical Association 293*: 384-2390.
7. Reason, J. T. (1990). *Human error*. New York, NY: Cambridge University Press.
8. Weick, K.E., & Sutcliffe, K.M. (2001). *Managing the unexpected.* San Francisco: Jossey-Bass.

AHRQ Criteria for Designating Classics and Landmark Publications.

- The selection should be drawn from the peer-reviewed literature or from other reputable sources.
- The selection should be regularly cited as a reference in other literature.
- Theoretical pieces should articulate foundational concepts that help readers understand the methods and philosophies of patient safety.
- Empirical studies should report results that materially advance the field of patient safety by creating new knowledge that influences the fundamental understanding of the field and/or results in significant changes in practice.
- Review articles or books should present particularly eloquent or unique discussions of an issue (or issues) pertaining to patient safety.
- Contributions by key figures in the patient safety field, if well executed, may be of particular impact, and thus are more likely to be included.
- Selections may be designated as an "Instant Classic" in those (very unusual) circumstances in which a relatively new article, book, or report has a profound impact on understanding and practice, and which the editors believe will "stand the test of time."

References (in addition to landmark publications listed above):

Agency for Healthcare Research and Quality [AHRQ]. (n.d.) *AHRQ PSNET Classics Selection.* Retrieved 7/24/07 from http://www.psnet.ahrq.gov/about.aspx#selection

Agency for Healthcare Research and Quality [AHRQ]. (n.d). AHRQ PSNET. *Human Error.* Retrieved 8/1/07 from http://www.psnet.ahrq.gov/resource.aspx?resourceID=1592

Agency for Healthcare Research and Quality [AHRQ]. (n.d.) *Classics*. Retrieved 7/24/07 from http://www.psnet.ahrq.gov/classics.aspx

Colorado Patient Safety Coalition. *Patient Safety Reading*. (2007). Retrieved 7/24/07 from http://www.coloradopatientsafety.org/reading.html

Joint Commission International Center for Patient Safety. (n.d.) *Bibliography: Patient Safety Books.* Retrieved 8/10/06 from http:www.jcipatientsafety.org/show.asp?durki=9996&site+149&return+9334

Joint Commission International Center for Patient Safety. (n.d.) *Resources: Patient Safety Link.* Retrieved 7/24/07 form http://www.jcipatientsafety.org/14630/

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