

Safety and risk management interventions in hospitals: a systematic review of the literature.

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Improving patient safety requires development of a [culture of safety](#) and transformation into a [learning organization](#)—one that has the capacity to rapidly address problems through information sharing and learning from past experience. In this systematic review, the authors characterize the published literature on organizational safety programs, and summarize published data on error detection methods (such as [incident reporting](#) systems), error analysis, and systems to [mitigate](#) and reduce specific errors (such as [diagnostic errors](#) and medication errors). The review is limited by publication bias (the preferential publication of studies with positive results) and the descriptive nature of most studies, reducing the generalizability of these studies for other organizations. An AHRQ WebM&M [perspective](#) discusses organizational approaches to safety improvement in academic and community settings.