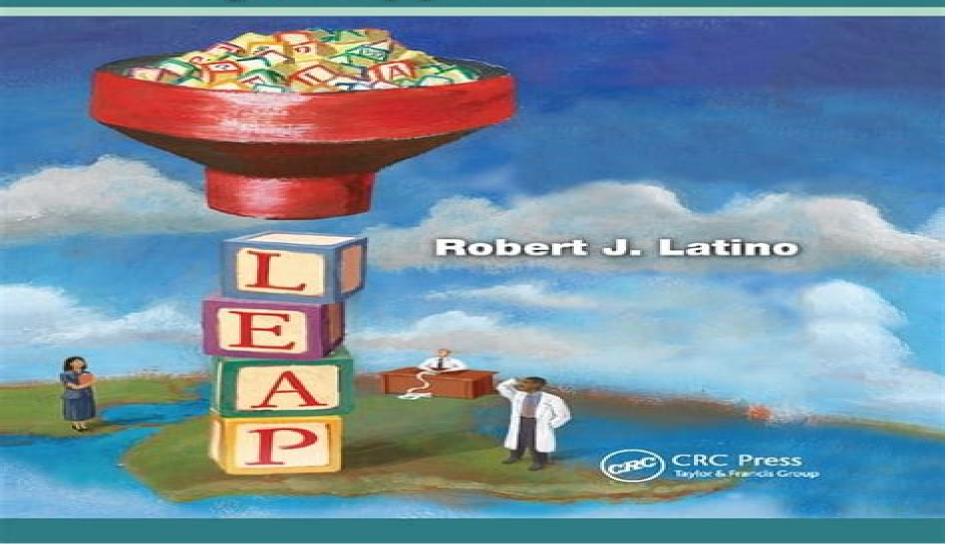
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as well as the human and system's contribution Demonstrates the role of RCA in a comprehensive Asset Performance Management APM system Explores the correlation between Reliability Engineering and safety Integrates the concepts of Human Performance Improvement Learning Teams and Human Error Reduction approaches into RCA Robert J. Latino, 2008-10-14 Are you ready and willing to get to the root causes of problems As Medicare Medicaid and major insurance companies increasingly deny payment for never events it has become imperative that hospitals and doctors develop new ways to prevent these avoidable catastrophes from recurring Proactive tools such as root cause analysis RCA Root Cause Analysis, Second Edition Duke Okes, 2019-02-06 This best seller can help anyone whose role is to basic failur try to find specific causes for failures It provides detailed steps for solving problems focusing more heavily on the analytical process involved in finding the actual causes of problems It does this using figures diagrams and tools useful for helping to make our thinking visible This increases our ability to see what is truly significant and to better identify errors in our thinking In the sections on finding root causes this second edition now includes more examples on the use of multi vari charts how thought experiments can help guide data interpretation how to enhance the value of the data collection process cautions for analyzing data and what to do if one can t find the causes In its guidance on solution identification biomimicry and TRIZ have been added as potential solution identification techniques In addition the appendices have been revised to include an expanded breakdown of the 7 M s which includes more than 50 specific possible causes forms for tracking causes and solutions which can help maintain alignment of actions techniques for how to enhance the interview process and example responses to problem situations that the reader can analyze for appropriateness Patient Safety B.S. Dhillon, 2011-11-08 With unintended harm during hospital care costing billions of dollars to the world economy not to mention millions of deaths each year it s no wonder the issue is equally front and center in the minds of healthcare providers and the public Although the issue has been tackled in journal articles and conference proceedings there are very few books on the topic And none consider how methods and techniques developed in the area of engineering can handle safety and human error related problems Until now Written by an expert with vast know how in engineering management design reliability safety and quality Patient Safety An Engineering Approach brings together the pertinent information scattered throughout books and journals eliminating the need to consult many different and diverse sources to find what you need B S Dhillon draws on his real world experience to demonstrate how to handle patient safety related problems using engineering techniques and backs this up with references for further reading at the end of each chapter He sets the stage with introductory chapters on mathematical patient safety and human factors concepts essential to understanding materials presented in subsequent chapters Dhillon's clear concise discussion of the topics presents the information in such a way that no previous knowledge is required to understand the contents yet he does not present it at a merely rudimentary level He brings a fresh approach and engineering perspective to the issues giving you a new tool kit for performing patient safety related analysis designing better medical

systems devices and handling patient safety related problems from an engineering perspective Error Reduction in Health Care Patrice L. Spath, 2011-02-25 Error Reduction in Health Care A Systems Approach to Improving Patient Safety 2nd Edition Completely revised and updated this book offers a step by step guide for implementing the Institute of Medicine guidelines to reduce the frequency of errors in health care services and mitigate the impact of those errors that do occur It explores the fundamental concepts and tools of error reduction and shows how to design an effective error reduction initiative The book pinpoints how to reduce and eliminate medical mistakes that threaten the health and safety of patients and teaches how to identify the root cause of medical errors implement strategies for improvement and monitor the effectiveness of these new approaches Emergency Management for Healthcare Norman Ferrier, 2022-07-13 This series of books focuses on highly specialized Emergency Management arrangements for healthcare facilities and organizations It is designed to assist any healthcare executive with a body of knowledge which permits a transition into the application of emergency management planning and procedures for healthcare facilities and organizations. This series is intended for both experienced practitioners of both healthcare management and emergency management and also for students of these two The PROACT® Root Cause Analysis Kenneth C. Latino, Mark A. Latino, Robert J. Latino, 2020-09-10 Root disciplines Cause Analysis or RCA What is it Everyone uses the term but everyone does it differently How can we have any uniformity in our approach much less accurately compare our results if we re applying different definitions At a high level we will explain the difference between RCA and Shallow Cause Analysis because that is the difference between allowing a failure to recur or dramatically reducing the risk of recurrence In this book we will get down to basics about RCA the fundamentals of blocking and tackling and explain the common steps of any investigative occupation Common investigation steps include Preserving evidence data not allowing hearsay to fly as fact Organizing an appropriate team minimizing potential bias Analyzing the events reconstructing the incident based on actual evidence Communicating findings and recommendations ensuring effective recommendations are actually developed and implemented Tracking bottom line results ensuring that identified meaningful metrics were attained We explore Why don t things always go as planned When our actual plans deviate from our intended plans we usually experience some type of undesirable or unintended outcome We analyze the anatomy of a failure undesirable outcome and provide a step by step guide to conducting a comprehensive RCA based on our 3 decades of applying RCA as we have successfully practiced it in the field This book is written as a how to guide to effectively apply the PROACT RCA methodology to any undesirable outcome is directed at practitioners who have to do the real work focuses on the core elements of any investigation and provides a field proven case as a model for effective application This book is for anyone charged with having a thorough understanding of why something went wrong such as those in EHS maintenance reliability quality engineering and operations to name just a few **The Handbook of Patient Safety Compliance** Fay A. Rozovsky, James R. Woods, Jr., 2016-12-05 Written for virtually every professional and leader in the health care field as well as

students who are preparing for careers in health services delivery this book presents a framework for developing a patient safety program shows how best to examine events that do occur and reveals how to ensure that appropriate corrective and preventative actions are reviewed for effectiveness. The book covers a comprehensive selection of topics including The link between patient safety and legal and regulatory compliance. The role of accreditation and standard setting organizations in patient safety Failure modes and effect analysis Voluntary and regulatory oversight of medical error Evidence based outcomes and standards of care Creation and preservation of reports data and device evidence in medical error situations Claims management when dealing with patient safety events Full disclosure Patient safety in human research Managing confidentiality in the face of litigation Managing patient safety compliance through accountability based credentialing for health care professionals Planning for the future Root Cause Analysis Robert J. Latino, Kenneth C. Latino, Mark A. Latino, 2011-06-17 What is RCA It seems like such an easy question to answer yet from novices to veterans and practitioners to providers no one seems to have come to agreement or consensus on an acceptable definition for the industry Now in its fourth edition Root Cause Analysis Improving Performance for Bottom Line Results discusses why it is so hard to get such consensus and why various providers are reluctant for that to happen See what s new in the Fourth Edition Human Error Reduction Techniques HERT new chapter Failure Scene Investigation FSI Disciplined Evidence Gathering Categorical versus Cause and Effect RCA Tools Analysis Tools Review The Germination of a Failure Constructing a Logic Tree Introduction of PROACTOnDemandSM The Advantages of Software as a Service SaaS The Pros and Cons of RCA Templates Three New Client Case Histories The authors discuss evidence collection and strategy failure scene investigation techniques the human element and the contribution of human performance and human factors to poor decision making They clarify definitions that can be considered ambiguous and underscore the distinctions between applying PROACT manually using a paper based system versus using an automated software tool Written by practitioners for practitioners the book outlines an entire RCA system which involves a cultural paradigm change about how failure is perceived and acted upon in an organization The authors trademark down to earth style provides a step by step action plan for how to construct and implement a root cause analysis system that can be applied to any industry Read MRI Safety 10 Years Later co authored by Robert Latino

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