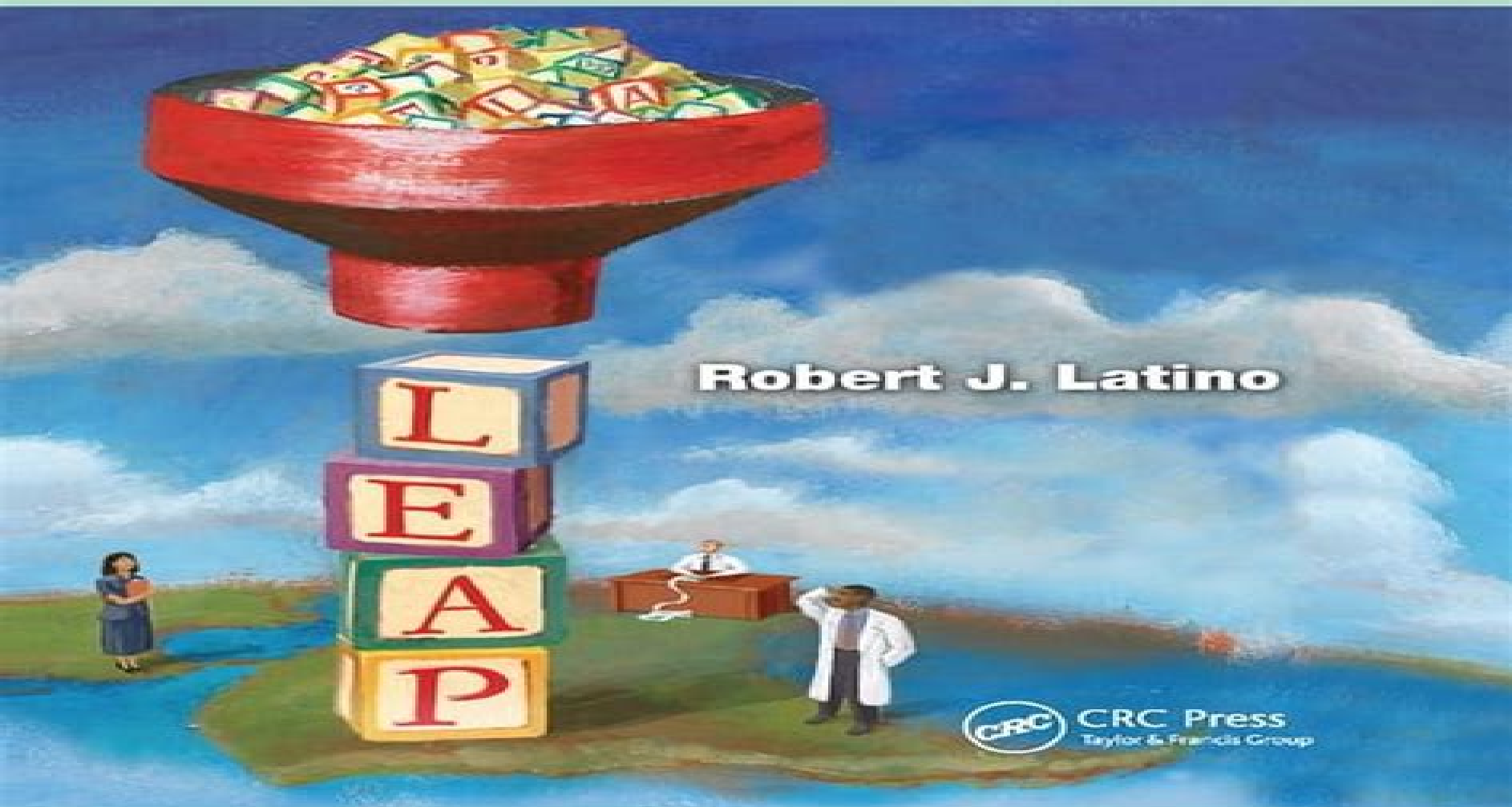


# ***PATIENT SAFETY***

## **The PROACT® Root Cause Analysis Approach**

**Robert J. Latino**



**CRC Press**  
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# Patient Safety The Proact Root Cause Analysis Approach

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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

**Root Cause Analysis (RCA) for the Improvement of Healthcare Systems and Patient Safety** David Allison, CPPS, Harold Peters, P.Eng., 2021-08-23 The book follows a proven training outline including real life examples and exercises to teach healthcare professionals and students how to lead effective and successful Root Cause Analysis RCA to eliminate patient harm This book discusses the need for RCA in the healthcare sector providing practical advice for its facilitation It addresses when to use RCA how to create effective RCA action plans and how to prevent common RCA failures An RCA training curriculum is also included This book is intended for those leading RCAs of patient harm events leaders students and patient safety advocates who are interested in gaining more knowledge about RCA in healthcare

Root Cause Analysis Mark A. Latino, Robert J. Latino, Kenneth C. Latino, 2019-07-12 This book comprehensively outlines what a holistic and effective Root Cause Analysis RCA system looks like From the designing of the support infrastructure to the measuring of effectiveness on the bottom line this book provides the blueprint for making it happen While traditionally RCA is viewed as a reactive tool the authors will show how it can be applied proactively to prevent failures from occurring in the first place RCA is a key element of any successful Reliability Engineering initiative Such initiatives are comprised of equipment process and human reliability foundations Human reliability is critical to the success of a true RCA approach This book explores the anatomy of a failure undesirable outcome as well as a potential failure high risks Virtually all failures are triggered by errors of omission or commission by human beings The methodologies described in this book are applicable to any industry because the focus is on the human being s ability to think through why things go wrong not on the industry or the nature of the failure This book correlates reliability to safety as well as human performance improvement efforts The author has provided a healthy balance between theory and practical application wrapping up with case studies demonstrating bottom line results Features Outlines in detail every aspect of an effective RCA system Displays appreciation for the role of understanding the physics of a failure 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      **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 disciplines      **The PROACT® Root Cause Analysis** Kenneth C. Latino, Mark A. Latino, Robert J. Latino, 2020-09-10 Root 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 EH S 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 PROACT On Demand SM 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

**Fehlerkulturen in der Sozialen Arbeit** Jürgen Beushausen, Kirsten Rusert, Martin Stummbaum, 2023-01-16 Nicht nur in der Medizin auch in der Sozialen Arbeit muss mit Risiken Fehlern und Nebenwirkungen gerechnet werden Viele soziale Situationen und Entscheidungen weisen Ambivalenzen auf und sind nicht plan und steuerbar Das Buch versammelt Ansätze zu einem produktiven Umgang mit Fehlern und trägt so zur Entwicklung einer reflektierten Professionalität in der Sozialen Arbeit bei

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*Patient Safety* Abha Agrawal,2013-10-04 Despite the evolution and growing awareness of patient safety many medical professionals are not a part of this important conversation Clinicians often believe they are too busy taking care of patients to adopt and implement patient safety initiatives and that acknowledging medical errors is an affront to their skills Patient Safety provides clinicians with a better understanding of the prevalence causes and solutions for medical errors bringing best practice principles to the bedside Written by experts from a variety of backgrounds each chapter features an analysis of clinical cases based on the Root Cause Analysis RCA methodology along with case based discussions on various patient safety topics The systems and processes outlined in the book are general and broadly applicable to institutions of all sizes and structures The core ethic of medical professionals is to do no harm Patient Safety is a comprehensive resource for physicians nurses and students as well as healthcare leaders and administrators for identifying solving and preventing medical error

**Maximize Patient Safety with Advanced Root Cause Analysis** Catherine Corbett (CQM.),Craig Clapper,Kerry M. Johnson,2004 Improve Patient Safety with Root Cause Analysis Ken Turnbull,Mark Paradies,2018

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