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Investigating Errors And  
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*This unique and engaging open access title provides a compelling and*

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*ground-breaking account of the  
patient safety movement in the United  
States, told from the perspective of  
one of its most prominent leaders,  
and arguably the movement's  
founder, Lucian L. Leape, MD.*

*Covering the growth of the field from*

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*the late 1980s to 2015, Dr. Leape details the developments, actors, organizations, research, and policy-making activities that marked the evolution and major advances of patient safety in this time span. In addition, and perhaps most*

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*importantly, this book not only  
comprehensively details how and why  
human and systems errors too often  
occur in the process of providing  
health care, it also promotes an in-  
depth understanding of the principles  
and practices of patient safety,*

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*including how they were influenced  
by today's modern safety sciences and  
systems theory and design. Indeed, the  
book emphasizes how the growing  
awareness of systems-design thinking  
and the self-education and  
commitment to improving patient*

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*safety, by not only Dr. Leape but a wide range of other clinicians and health executives from both the private and public sectors, all converged to drive forward the patient safety movement in the US. Making Healthcare Safe is divided*

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*into four parts: I. In the Beginning describes the research and theory that defined patient safety and the early initiatives to enhance it. II.*

*Institutional Responses tells the stories of the efforts of the major organizations that began to apply the*



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*new concepts and make patient safety a reality. Most of these stories have not been previously told, so this account becomes their histories as well. III. Getting to Work provides in-depth analyses of four key issues that cut across disciplinary lines impacting*

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*patient safety which required special attention. IV. Creating a Culture of Safety looks to the future, marshalling the best thinking about what it will take to achieve the safe care we all deserve. Captivatingly written with an "insider's" tone and a*

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*major contribution to the clinical literature, this title will be of immense value to health care professionals, to students in a range of academic disciplines, to medical trainees, to health administrators, to policymakers and even to lay readers with an*

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*interest in patient safety and in the  
critical quest to create safe care.*

*This best-seller can help anyone  
whose role is to try to find specific  
causes for failures. It provides  
detailed steps for solving problems,  
focusing more heavily on the*

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*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*

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*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;*

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*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*

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*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*



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*example responses to problem situations that the reader can analyze for appropriateness.*

*This book explores the rules and patterns that govern complex systems that, when properly understood and applied, result in more effective*

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*leadership than what is offered from  
traditional leadership models.*

*We've all been fearful or confused  
about what's really causing our  
symptoms. We worry and want to  
know WHY we have chronic illnesses,  
such as back pain, eczema, acne,*

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*diabetes, asthma, high blood pressure  
or cancer. Is it the food we eat, lack  
of exercise, viruses or bacteria? Is it  
our genes? Or could our unresolved  
emotional hurts, limiting beliefs or  
stressful life situations be at fault?*

*Johannes R. Fisslinger, Founder of*

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*the Lifestyle Prescriptions University,  
will introduce you to a revolutionary  
new health paradigm based on the  
Art and Science of Self-Healing. He'll  
help you unlock your body's natural  
healing intelligence by becoming  
aware of your 6 root-cause(s) and*

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*how specific stressors, emotions,  
beliefs and lifestyle habits trigger  
your symptoms.*

*THE PRACTICAL, EASY  
INTRODUCTION TO MODERN  
SUPPLY CHAIN/LOGISTICS  
MANAGEMENT FOR EVERY*

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*PROFESSIONAL AND STUDENT!  
COVERS CORE CONCEPTS,  
PLANNING, OPERATIONS,  
INTEGRATION,  
COLLABORATION, NETWORK  
DESIGN, AND MORE SHOWS HOW  
TO MEASURE, CONTROL, AND*

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*IMPROVE ANY SUPPLY CHAIN  
INCLUDES PRACTICAL ADVICE  
FOR JUMPSTARTING YOUR OWN  
SUPPLY CHAIN CAREER This easy  
guide introduces the modern field of  
supply chain and logistics  
management, explains why it is*

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*central to business success, shows how its pieces fit together, and presents best practices you can use wherever you work. Myerson explains key concepts, tools, and applications in clear, simple language, with intuitive examples that make sense to any*



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*student or professional. He covers the entire field: from planning through operations, integration and collaboration through measurement, control, and improvement. You'll find practical insights on hot-button issues ranging from sustainability to the*

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*lean-agile supply chain. Myerson concludes by helping you anticipate key emerging trends—so you can advance more quickly in your own career. Trillions of dollars are spent every year on supply chains and logistics. Supply chain management is*

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*one of the fastest growing areas of business, and salaries are rising alongside demand. Now, there's an easy, practical introduction to the entire field: a source of reliable knowledge and best practices for students and professionals alike. Paul*

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*A. Myerson teaches you all you'll need to start or move forward in your own supply chain career. Writing in plain English, he covers all the planning and management tasks needed to transform resources into finished products and services, and*

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*deliver them efficiently to customers. Using practical examples, Myerson reviews the integration, collaboration, and technology issues that are essential to success in today's complex supply chains. You'll learn how to measure your supply chain's*

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*performance, make it more agile and sustainable, and focus it on what matters most: adding customer value.*

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**OPERATIONAL BEST PRACTICES**

*Improve procurement, transportation, warehousing, ordering, reverse*

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*logistics, and more* BUILD A  
Improving Processes

*BETTER GLOBAL SUPPLY CHAIN*

*Manage new risks as you improve*

*sustainability STRENGTHEN KEY*

*LINKAGES WITH YOUR*

*PARTNERS AND CUSTOMERS Get*

*supply chains right by getting*

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*collaboration right PREVIEW THE*  
Improving Processes  
*FUTURE OF SUPPLY*

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the puck is headed”—so you can get  
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*organizational structure; required*  
Improving Processes  
*permits and reports; the relationship*  
*between federal and state regulations;*  
*and more.*

*What is RCA? It seems like such an  
easy question to answer, yet from  
novices to veterans and practitioners*

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*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 su*

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*A practical, accessible set of principles and guidelines to improve the quality of patient care in hospitals, this resource helps nursing staff, doctors, and other specialists contain infections and protect themselves and other patients from*

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*their spread. The techniques are invaluable as an excellent reference on every hospital ward—helping workers meet their responsibilities for maintaining sanitary, hygienic health-care environments.*

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[A Step-by-Step Guide to Implementing  
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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

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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

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gaining more knowledge about RCA in healthcare.

This book provides a Root Cause Analysis methodology for process and equipment problems with a unique insight on sources and type of problems that appear in process lines.

For decades, 5S practitioners have

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struggled with exactly how to implement and sustain a 5S program in their workplaces. While there are many books available on the organization methods suggested by 5S, few provide easy-to-understand, step-by-step guidance on how to set up and sustain successful 5S implementations. 5S Made Easy fills this

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need. Written by an expert whose focus for the last decade has been nothing but 5S, the book supplies in-depth guidance on how to implement and sustain each of the 5S pillars—sort, set in order, shine, standardize, and sustain. The book uses an easy-to-follow format that was designed for use during 5S events. It provides color

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images of real-world 5S solutions, including before and after pictures from the field. It also supplies readers with online access to all of the forms and documents needed for an effective 5S program. All the forms and documents are provided in an easily editable format to fit any operation.

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This title is now available under ISBN 9780702052149. CTG Made Easy 4th edition continues the successful format of previous editions, offering a practical guide to all health professionals involved in monitoring the fetal heart rate during labour, and specifically in the interpretation of CTG traces. The

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workbook approach remains, with many new and updated case histories and CTGs, all using current terminology and a recommended proforma for interpretation. The book will aid health professionals to acquire competence and confidence in all aspects of fetal heart rate monitoring during labour, improving the



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care offered to women and babies. In-depth debate on choice of intermittent or continuous electronic fetal heart rate monitoring enables correct identification of the appropriate method Updated references and recommendations from latest national guidelines ensure readers have access to current research-based

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evidence and expert opinion Clear explanation of the physiology of baseline and periodic abnormalities provides vital information for interpretation and assessment of fetal compromise CTG features are described following up-to-date recommendations from NICE Charts describe the classification of CTGs and

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illustrations describe variable decelerations to aid understanding Discussion of current adjuncts to electronic fetal heart rate monitoring give the reader insight into current developments and possible future practice RCOG and NICE proforma and classifications aid consistency in interpretation and use of terminology

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Recent cases of litigation are used to demonstrate the difficulties encountered with monitoring techniques and interpretation of the data, giving the reader an insight into cases that proceed to litigation New to this edition Evidence relating to fetal monitoring in labour updated to current national guidance

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Expanded section debating the issues surrounding intermittent auscultation versus continuous electronic fetal heart rate monitoring Expanded section on the physiological control of the fetal heart rate, fetal blood sampling and acid base balance. Risk management updated, including risks and benefits of current

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methods of fetal heart rate monitoring,  
future developments, and legal issues

References comprehensively reviewed,  
including NICE and RCOG clinical  
guidelines New online resources 20  
additional CTGs and case histories are  
available online

Did being right or left handed influence

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the risk? Have the changes made a difference? Does your diagram capture the root causes you think are important? Will the problem recur if this cause is corrected or eliminated? What is your process for approving due date changes? This one-of-a-kind Root Cause Analysis self-assessment will make you the trusted Root Cause

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Analysis domain authority by revealing just what you need to know to be fluent and ready for any Root Cause Analysis challenge. How do I reduce the effort in the Root Cause Analysis work to be done to get problems solved? How can I ensure that plans of action include every Root Cause Analysis task and that every Root



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Cause Analysis outcome is in place? How will I save time investigating strategic and tactical options and ensuring Root Cause Analysis costs are low? How can I deliver tailored Root Cause Analysis advice instantly with structured going-forward plans? There's no better guide through these mind-expanding questions than

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acclaimed best-selling author Gerard Blokdyk. Blokdyk ensures all Root Cause Analysis essentials are covered, from every angle: the Root Cause Analysis self-assessment shows succinctly and clearly that what needs to be clarified to organize the required activities and processes so that Root Cause Analysis outcomes are

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achieved. Contains extensive criteria grounded in past and current successful projects and activities by experienced Root Cause Analysis practitioners. Their mastery, combined with the easy elegance of the self-assessment, provides its superior value to you in knowing how to ensure the outcome of any efforts in Root Cause

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along with an end to end code in R. Even if you are a novice in Big Data Analytics, you will still be able to understand the concepts explained in this book. If you are already working in Analytics and dealing with Big Data, you will still find this book useful, as it covers exhaustive Data Mining Techniques, which are considered to be



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Advanced topics. It covers Machine Learning concepts and provides in-depth knowledge on unsupervised as well as supervised Learning, which is very important for decision-making. The toughest Data Analytics concepts are made simpler, It features examples from all the domains so that the reader gets

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connected to the book easily. This book is like a personal trainer that will help you master the Art of Data Science.

In no industry is the concept of quality more essential than it is in healthcare, which is why the lean quality principles learned through the example of the Toyota Production System are so

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applicable. Two fundamental principles of Toyota's push for excellence are especially relevant to healthcare: ensuring quality at every step and keeping improvement processes simple enough that they are viable, reproducible, and teachable. Developed with the input of more than 60 healthcare organizations,

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Value Stream Mapping for Healthcare Made Easy introduces healthcare managers to the essential method developed by Toyota known as the Value Stream Map (VSM). The first half of the book provides an introduction to VSMs that shows healthcare workers at all levels how to look at any process with eyes that

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probe all the value-added and non-value-added activities in the delivery of a requested service or product. This will allow all stakeholders the opportunity to evaluate, create, and communicate innovation in their workplace. The second half reviews real value stream maps at real healthcare facilities created by teams of

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administrators, managers, physicians, and staff members. Most participants were not experienced with lean thinking and for many this was their first engagement with lean methods. What becomes clear through these examples is the importance of initiating realistic improvements that can quickly demonstrate successful change

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and encourage even more problem solving. This ability to be involved with creating a better way to work has been exceptionally well received by workers both at Toyota and now throughout the healthcare industry. Lean thinking involves employees in improving work that is meaningful to them, at a level where

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they can see and appreciate the changes they have participated in creating. This satisfaction is essential to retaining good workers, as well as to the everyday improvement of safety, patient satisfaction, and affordability. VSM is a proven high-level view tool that can be used in every aspect of healthcare to identify,



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Information included illustrates the

simplicity and completeness of the tool and describes its applications to staff communication, regulatory documentation, and activities of daily work. The book also highlights simple-to-use data collection and interpretation as

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part of the VSM process.

Root Cause Analysis Handbook: A Guide to Effective Incident Investigation presents a proven system designed for investigating, categorizing, and ultimately eliminating, rootcauses of incidents with safety, health, environmental, quality, reliability, and production-process impacts. Defined as a

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tool to help investigators describe what happened, to determine how it happened, and to understand why it happened, the Root Cause Analysis System enables businesses to generate specific, concrete recommendations for preventing incident recurrences. Using the factual data of the incident, the system also allows quality,

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safety, and risk and reliability managers an opportunity to implement more reliable and more cost-effective policies that result in major, long-term opportunities for improvement. Such process improvements increase a business' ability to recover from and prevent disasters with both financial and health-and-safety implications. Special

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features include a 17 inch by 22 inch pull-out Root Cause Map, a powerful tool for identifying and coding root causes. The book helps readers to understand why root causes are important, to identify and define inherent problems, to collect data for problem solving, to analyze data for root causes, and to generate practical

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recommendations.----- This edition is a reprinting of the 199 edition.-----

-ORGANIZATION OF THE ROOT  
CAUSE ANALYSIS HANDBOOKThe  
focus of this handbook is on the  
application of the Root Cause Map to the  
root cause analysis process. The Root  
Cause Map is used in one of the later steps

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of the root cause analysis process to identify the underlying management systems that caused the event to occur or made the consequences of the event more severe. The first five chapters of this handbook are an overview of the root cause analysis process. These provide the context for use of the Root Cause Map.

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Chapter 6 provides references. Chapter 1, "Introduction to Root Cause Analysis," presents a basic overview of the SOURCE (Seeking Out the Underlying Root Causes of Events) root cause analysis process. Chapter 2, "Collecting and Preserving Data for Analysis," outlines the types of data and data sources that are



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available. Chapters 3, 4, and 5 describe the three major steps in the rootcause analysis process. Chapter 3, "Data Analysis Using Causal Factor Charting," provides a step-by-step description of causal factor charting techniques. Chapter 4, "Root Cause Identification," explains the organization and use of the Root

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Implementation," provides guidance on developing and implementing corrective actions. The references section, Chapter 6, provides additional information for those interested in learning more about specific items contained in the

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handbook. Appendix A, "Root Cause Map  
Node Descriptions," describes each  
segment of the Root Cause Map and  
presents detailed descriptions of the  
individual nodes on the map. Appendix B  
is the Root Cause Map itself.

[The Root Cause Analysis Handbook](#)  
[Root Cause Analysis \(RCA\) for the](#)

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fundamentals of occupational  
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*International Health and Safety  
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frameworks from a range of  
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remains the most effective tool  
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how, why, and when federal  
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*with the April 21, 2000,  
Executive Order. Clear  
explanations, easy-to-follow  
management principles, and  
sample programs and case  
studies help ensure that all  
elements of an EMS are met,*

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*taking the stress and  
guesswork out of this required  
task.*

*"If you wish to visit a new  
place, help is available  
everywhere: maps, guide  
books, Internet sites for trip*

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planning, online reviews and  
personal advice etc. But

*nothing beats finding a local  
guide, someone who lives  
there, and knows the land, its  
people, culture and "how  
things work here".That's*

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*exactly the role that Pat  
Croskerry plays in The  
Cognitive Autopsy - he's our  
guide to the still-emerging  
arena of understanding  
diagnostic error. Pat has spent  
a long career working on the*

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*front lines in emergency  
medicine, also known as the  
emergency room (ER) or the  
emergency department (ED).  
Pat knows this place like the  
back of his hand, and is the  
perfect person to show us*

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*around, and orientate us to what there is to see. The Cognitive Autopsy is a unique and fascinating collection of cases that span the spectrum of diagnostic error types and causes seen in the ED. Each*



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*one is its own self-contained story, with lessons of cognitive and affective biases. Stories are powerful, and it is said that stories may be how our knowledge base is organized. A diagnosis is itself a story - the*

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*medical story that corresponds to and flows from the patient's story"--*

*The answer is root cause analysis, a process that allows you to find the cause of single events/problems in the*

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*workplace. The Root Cause  
Analysis Handbook presents a  
walkthrough example that  
illustrates the method and  
shows how to implement it.  
Because poor initial problem  
definition can (and often does)*

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undermine the problem-solving  
process, Ammerman places  
special emphasis on this area  
to build a solid foundation for  
effective analysis. He also  
provides guidance on  
preparing the final report. The

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*need for clear documentation  
on dealing with problems  
makes this book especially  
valuable for quality managers,  
engineers, safety managers,  
and teams implementing the  
ISO or QS standards. Written in*

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*a simple, user-friendly style,  
you will grasp the core*

*concepts quickly and begin  
applying them to your work.*

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safety with this NEBOSH-  
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*recent examinations at the end  
of each chapter allow you to*

*test your knowledge and  
increase your understanding*

*All relevant legislation is  
summarised for quick*

*reference Introduction to*



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and ends with questions taken  
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60 new diagrams and  
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*to-day issues of health and  
safety and is also of great  
value to those studying for  
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Managing Safely Award. It  
covers all the essential  
elements of health and safety*

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*management, the legal framework, risk assessment and control standards and includes checklists, report forms and record sheets. In addition, useful topics outside the syllabus have been*

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*included and an additional  
chapter to cover other aspects  
of health and safety and  
related topics that many  
readers will find helpful on  
completion of the course -  
construction activities,*

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syllabus Inclusion of a  
summary of the Report on  
Health and Safety 'Common*



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European Classification,  
Packaging and labelling  
regulations A chapter with*

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guidance on searching the  
internet with a range of

*significant Occupational health  
and Safety Websites. There are  
dozens of internet references  
throughout the book Since the  
Practical Application NGC3 has*

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*been significantly revised,  
Chapter 20 includes a sample  
practical application based on  
the new scope and format Phil  
Hughes MBE, MSc, CFIOSH, is a  
former Chairman of NEBOSH  
(1995-2001), former President*

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of IOSH (1990-1991) and runs  
his own consultancy. He  
received an MBE for services to  
health & safety and as a  
director of RoSPA, in the New  
Years Honours List 2005. Ed  
Ferrett PhD, BSc (Hons Eng),

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*CEng, MIMechE, MIET, CMIOSH,  
is a former Vice Chairman of  
NEBOSH (1999-2008) and a  
lecturer on NEBOSH courses at  
Cornwall Business School of  
Cornwall College. He is a  
Chartered Engineer and a*

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*health and safety consultant.  
This updated and expanded  
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different tools for root cause  
analysis and presents them in  
an easy-to-follow structure: a  
general description of the tool,*

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*its purpose and typical applications, the procedure when using it, an example of its use, a checklist to help you make sure it is applied properly, and different forms and templates (that can also*



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*be found on an accompanying CD-ROM). The examples used are general enough to apply to any industry or market. The layout of the book has been designed to help speed your learning. Throughout, the*

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*authors have split the pages into two halves: the top half presents key concepts using brief language—almost keywords—and the bottom half uses examples to help explain those concepts. A roadmap in*

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*the margin of every page  
simplifies navigating the book  
and searching for specific  
topics. The book is suited for  
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type of industry, including*

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*trending, and ultimately eliminating the root causes of incidents. It includes step-by-step instructions, checklists, and forms for performing an analysis and enables users to effectively incorporate the*

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this, effective risk management based on sound science and unbiased information is required by all stakeholders, including the food industry, governments and consumers themselves. In addition, the globalization of the food supply requires the harmonization of policies and standards based on a common

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understanding of food safety among  
authorities in countries around the world.  
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unbiased and concise overviews which  
form in total a comprehensive coverage  
of a broad range of food safety topics,  
which may be grouped under the

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following general categories: History and basic sciences that support food safety; Foodborne diseases, including surveillance and investigation; Foodborne hazards, including microbiological and chemical agents; Substances added to food, both directly and indirectly; Food technologies,



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including the latest developments; Food commodities, including their potential hazards and controls; Food safety management systems, including their elements and the roles of stakeholders. The Encyclopedia provides a platform for experts from the field of food safety and related fields, such as nutrition, food

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science and technology and environment to share and learn from state-of-the art expertise with the rest of the food safety community. Assembled with the objective of facilitating the work of those working in the field of food safety and related fields, such as nutrition, food science and technology and environment - this work

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safety subjects; references for further information, and specialized and general definitions for food safety terminology In maintaining confidence in the safety of the food supply, sound scientific information is key to effectively and efficiently assessing, managing and communicating on food safety risks. Yet,

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professionals and other specialists working in this multidisciplinary field are finding it increasingly difficult to keep up with developments outside their immediate areas of expertise. This single source of concise, reliable and authoritative information on food safety has, more than ever, become a necessity

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Can you articulate the connection(s) you see between the data and our explanation(s)? Does the process run in a controlled environment? Do written procedures describe the potential consequences of deviations? What is the statistical confidence of tests? How do you know you made a difference? This

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Assessment Excel Dashboard to get  
familiar with results generation - In-  
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regulated parties, and compliance and auditing processes of each. In addition to covering air quality management, hazardous materials management, impact assessments, and underground storage tank management, this new edition now also covers homeland security and emergency response, compliance audits,

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books, consultants, and other online resources about the methodologies and tools, or the success stories of Toyota and others. However, it is due to a shortage of knowledge and practice about the most critical success factors of improvement: leadership, sustaining infrastructure, behavioral and cultural transformation,

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and now emerging technology. These factors produce 90 percent of the success with continuous and sustainable improvement; the methodologies and tools represent an irrelevant 10 percent. For decades, most organizations have focused on this quick and easy, irrelevant 10 percent through an endless series of

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fad, in-vogue improvement programs as they attempt to mimic the best-in-class practices of the most successful organizations. Out of the Present Crisis: Rediscovering Improvement in the New Economy is the contemporary version of Deming's famous 1982 book, "Out of the Crisis." The author builds a solid case

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to projects around the world." --From the Foreword by Grady Booch This book is a comprehensive guide to modern software development practices, as embodied in the Rational Unified Process, or RUP. With the help of this book's practical advice and insight, software practitioners will learn how to tackle challenging

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needs of development projects of all types and sizes. Key topics covered include:

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can easily employ the significant power of this process to increase the productivity of your team.

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skills of allied medical and medical students, and other healthcare professionals involved in blood transfusion, empowering them to offer the best possible blood transfusion services to their patients. This book is suitable not only for allied medical and medical students preparing for their

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authors often fail to mention the most important member of an RCA team—the failed part. Root Cause Analysis: A Step-By-Step Guide to Using the Right Tool at the Right Time provides authoritative guidance on how to empirically investigate quality failures using scientific method in the



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form of cycles of plan-do-check-act (PDCA), supported by the use of quality tools. Focusing on the use of proven quality tools to empirically investigate issues, the book starts by describing the theoretical background behind using the scientific method and quality tools for RCA. Next, it supplies

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step-by-step instructions for performing RCA with the tools discussed in the first section. The book 's clear examples illustrate how to integrate PDCA with the scientific method and quality tools when investigating real-world quality failures. This RCA guide provides root cause

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investigators with a tool kit for the quick and accurate selection of the appropriate tool during a root cause investigation. It includes an appendix with a guide to tool selection based on the intended use of the tool. There is also an appendix that defines the terminology used in the book. After

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reading this book, you will understand how to integrate the scientific method, quality tools, and statistics, in the form of exploratory data analysis, to build a picture of the actual situation under investigation that will lead you to the true root cause of an event. The tools and concepts

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presented in the text are appropriate for professionals in both the manufacturing and service industries. Master the After Action Review (AAR) to improve the outcome of any personal or professional activity. From the beginning of time, humans have survived and thrived by learning from

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their experiences – both good and bad – and then tweaked their actions for better results next time. This continual quest for improvement stems from the difference between “ what was ” and “ what could be. ” Even if we're not consciously aware of it, we're constantly seeking improvement in this

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very same way. If we turn to this analysis in a more intentional and methodical way, with an eye towards continuous improvement (CI), then next time around the outcomes can be more rewarding and desirable. After Action Review (AAR) is a continuous improvement approach for reflecting

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on the work of a group or team. Learn how to apply both informal and formal AAR approaches. Along with a complete walkthrough, the book includes resources and materials you can use in your work right now. For example, the Group Insights template will help you distinguish "likes" from



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"wishes," and the Planning Template will show you how to optimize the time spent during the AAR. Chapter 1 covers basic facilitation skills needed to conduct an AAR including active listening, questioning, information gathering and analysis, public speaking, presenting, intervening, and

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managing group dynamics. Chapter 2 explains the AAR in detail including its value proposition and frameworks.

Chapter 3 explores the informal AAR and Chapter 4 the formal AAR.

Implementing the requirements of ISO 9001 can be a daunting task for many organizations. In an attempt to develop

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a system that will pass the registration audit, we are tempted to establish processes with the primary purpose of conforming to the requirements of ISO 9001. In doing so, however, it is easy to lose sight of the primary intent of the standard: to continually improve the effectiveness of the quality

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management system (QMS) implemented at our organization. This book is intended to help managers, quality professionals, internal audit coordinators, and internal auditors implement a practical internal audit process that meets the requirements of ISO 9001:2015 while adding

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significant, measurable value to the organization. The tools, techniques, and step-by-step guidelines provided in this book can also be used by those organizations that have a well-established internal audit process but are looking for easy ways to make that process more effective. The tools in

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the appendices of this book have also been provided on the enclosed CD to facilitate your customizing them to fit the specific needs of your organization.

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process. Have you ever wondered why a problem happened? Discover how to identify the root cause with the book 5 why.

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Business analysis refers to the set of tasks and activities that help companies determine their objectives

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for meeting certain opportunities or addressing challenges and then help them define solutions to meet those objectives. Those engaged in business analysis are charged with identifying the activities that enable the company to define the business problem or opportunity, define what the



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solutions looks like, and define how it should behave in the end. As a BA, you lay out the plans for the process ahead. Business Analysis For Dummies is the go to reference on how to make the complex topic of business analysis easy to understand. Whether you are new or have experience with

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