

To Be Credible An Rca Must Be Internally Consistent

Kerm Henriksen

Root Cause Analysis and Improvement in the Healthcare Sector Bjorn Andersen, Martha Ellen Keyes Beltz, Tom Natland Fagerhaug, 2009-11-09 Healthcare organizations and professionals have long needed a straightforward workbook to facilitate the process of root cause analysis (RCA). While other industries employ the RCA tools liberally and train facilitators thoroughly, healthcare has lagged in establishing and resourcing a quality culture. Presently, a growing number of third-party stakeholders are holding access to accreditation and reimbursement pending demonstration of a full response to events outside of expected practice. An increasing number of exceptions to healthcare practice have precipitated a strong response advocating the use of proven quality tools in the industry. In addition, the industry has now expanded its scope beyond the hospital walls to many ancillary healthcare facilities with little experience in implementing quality tools. This book responds to the demand for a RCA workbook written specifically for healthcare, yet still broad in its definition of the industry. This book contains everything that the typical RCA leader in healthcare requires: A text specific to healthcare, but using the broadest definition of the industry to include not only acute care hospitals, but rehabilitation facilities, long-term care facilities, outpatient surgery centers, ambulatory services, and general office practices. A workbook-style format that walks through the process, step-by-step. Straightforward text without “sidebars,” “tables,” and “tips.” Worksheets are provided at the end of the book to reduce reader distraction within the text. A wide range of real-world examples. Format for use by the most naive of users and most basic of processes, as well as a separate section for more advanced users or more complex issues. Templates, both print and electronic, included for the reader’s use. Ready-to-use educational materials with scripting to enable the user to train others and garner support for the use of the techniques. Background text for users in leadership to understand the tools in the larger context of healthcare improvement. Up-to-date information on the latest in the use of RCA in satisfying mandatory reporting requirements and slaying the myth that the process is onerous and fraught with barriers. Background text and tools/process are separated to facilitate the readers’ specific needs. Healthcare leaders can appreciate the current context and requirements without wading through the actual techniques; end-users can begin learning the skills without wading through dense administrative text. Language and tone promoting the use of the tools for improvement of processes that have experienced exceptions, as opposed to assigning blame for errors. Attention to process ownership, training, and resourcing. And, most importantly, thorough description of the improvement process as well as the analysis.

Healthcare Safety for Nursing Personnel James T. Tweedy, 2014-12-10 Nursing personnel play an integral role in healthcare and medical delivery organizations. Nurses not only work to keep patients safe, but must also contend with a number of safety and health risks. Illustrating the occupational risks nurses face, *Healthcare Safety for Nursing Personnel: An Organizational Guide to Achieving Results* addresses healthcare safety as related to nursing personnel risks, hazards, and responsibilities in hospitals and healthcare facilities. The book begins with an introduction to nursing safety that supplies a fundamental understanding of patient, nursing, and facility safety. Next, it delves into the range of safety issues that nurses must contend with. Topics covered include administrative area safety, bloodborne pathogens, workplace violence, infection control and prevention, emergency management, fire safety, and radiation hazards. Examining the concepts and principles of patient safety as related to organizational dynamics, culture, system methods, and key patient safety initiatives, the book supplies essential knowledge of healthcare safety risks, challenges, and controls. It includes information on leadership, management, communication skills, and understanding accidents. The book includes helpful resources in the appendices, such as a nurse safety perception survey, an accident causal factor chart, sample ergonomics symptoms report, sample TB exposure control plan, and a model respirator plan for small organizations. Complete with review exercises in each chapter, this book is ideal for certification training in nursing programs and as a reference for developing nursing in-service safety sessions.

Patient Safety and Hospital Accreditation Sharon Ann Myers, RN, MSN, MSB, FACHE, FAIHQ, CPHQ, CPHRM, 2011-12-20 Improving the culture of safety in our health care institutions is an essential component of preventing or reducing errors as well as improving overall health care quality. This book presents the clinically tested Myer's Patient Safety Model for health care system leaders, middle managers, and administrators to build their patient safety program and to help sustain, renew, or obtain accreditation. The author provides detailed explanations of why medical errors still occur in accredited hospitals, and provides the much needed organization-wide steps to prevent these errors and enhance patient safety for improved outcomes. Current patient safety challenges are discussed with an emphasis on the concept of reliability. The Myers Model is examined in detail, along with current evidence for its three interrelated levels of organizational structure-the leadership (system) level, the unit (microsystem) level, and the individual level. The text includes interviews about key aspects of patient safety with three leaders of major health care accreditation programs in the U.S., Canada, and Australia. Additionally, it provides an overview of reporting systems within the U.S. and covers two essential tools for patient safety-root cause analysis and failure mode and effect analysis. The book links all aspects of patient safety with accreditation standards at the national level, and also discusses efforts to globalize accreditation criteria and procedures. Key Features: Presents a clinically tested model for building a patient safety program and helping to sustain, renew, or obtain accreditation Provides tools for use in ensuring patient safety and accreditation, including root cause analysis and failure mode and effect

analysis Discusses how aggregate data inform patient safety documentation and accreditation through integrated perspectives Offers a global view of accreditation and patient safety Includes techniques to improve communication among members of health care teams

Healthcare Hazard Control and Safety Management, Third Edition James T. Tweedy, MS, CHSP, CPSO, CHEP, 2014-03-12 Comprehensive in scope, this totally revamped edition of a bestseller is the ideal desk reference for anyone tasked with hazard control and safety management in the healthcare industry. Presented in an easy-to-read format, *Healthcare Hazard Control and Safety Management, Third Edition* examines hazard control and safety management as proactive functions of an organization. Like its popular predecessors, the book supplies a complete overview of hazard control, safety management, compliance, standards, and accreditation in the healthcare industry. This edition includes new information on leadership, performance improvement, risk management, organizational culture, behavioral safety, root cause analysis, and recent OSHA and Joint Commission Emergency Management requirements and regulatory changes. The book illustrates valuable insights and lessons learned by author James T. Tweedy, executive director of the International Board for Certification of Safety Managers. In the text, Mr. Tweedy touches on the key concepts related to safety management that all healthcare leaders need to understand. Identifies common factors that are often precursors to accidents in the healthcare industry Examines the latest OSHA and Joint Commission Emergency Management Requirements and Standards Covers facility safety, patient safety, hazardous substance safety, imaging and radiation safety, infection control and prevention, and fire safety management Includes references to helpful information from federal agencies, standards organizations, and voluntary associations Outlining a proactive hazard control approach based on leadership involvement, the book identifies the organizational factors that support accident prevention. It also examines organizational dynamics and supplies tips for improving organizational knowledge management. Complete with accompanying checklists and sample management plans that readers can immediately put to use, this text is currently the primary study reference for the Certified Healthcare Safety Professional Examination.

Medical Errors United States. Congress. Senate. Committee on Health, Education, Labor, and Pensions, 2000

Medical Mistakes United States. Congress. Senate. Committee on Appropriations. Subcommittee on Departments of Labor, Health and Human Services, Education, and Related Agencies, United States. Congress. Senate. Committee on Health, Education, Labor, and Pensions, United States. Congress. Senate. Committee on Veterans' Affairs, 2001

Patient Safety Institute of Medicine, Board on Health Care Services, Committee on Data Standards for Patient Safety, 2003-12-20 Americans should be able to count on receiving health care that is safe. To achieve this, a new health care delivery system is needed — a system that both prevents errors from occurring, and learns from them when they do occur. The development of such a system requires a commitment by all stakeholders to a culture of safety and to the development of

improved information systems for the delivery of health care. This national health information infrastructure is needed to provide immediate access to complete patient information and decision-support tools for clinicians and their patients. In addition, this infrastructure must capture patient safety information as a by-product of care and use this information to design even safer delivery systems. Health data standards are both a critical and time-sensitive building block of the national health information infrastructure. Building on the Institute of Medicine reports *To Err Is Human* and *Crossing the Quality Chasm*, Patient Safety puts forward a road map for the development and adoption of key health care data standards to support both information exchange and the reporting and analysis of patient safety data.

Anesthesia Outside the Operating Room Richard D. Urman, Wendy L. Gross, Beverly K. Philip, 2018-08-10 *Anesthesia Outside of the Operating Room* is a comprehensive, up-to-date textbook that covers all aspects of anesthesia care in OOR settings, from financial considerations to anesthetic techniques to quality assurance. With increasing numbers of procedures such as cardiac catheterization and imaging taking place outside of the main OR, anesthesia providers as well as non-anesthesia members of the patient care team will find this book critical to their understanding of the principles of anesthesia care in unique settings which may have limited physical resources. The book includes chapters on patient monitoring techniques, pre-procedure evaluation and post-procedure care, and procedural sedation performed by non-anesthesia providers. Its authors address problems of anesthesia that have unique answers in OOR settings, such as patient transport and cardiac arrest, and discuss technological progress and considerations for the future. The text also covers surgical procedures and anesthetic considerations by procedure location, such as radiology, infertility clinics, field and military environments, and pediatric settings, among many others. Select guidelines from the American Society of Anesthesiologists (ASA) are provided as well. Edited by the senior faculty from Harvard Medical School and with contributions from other academic institutions, *Anesthesia Outside of the Operating Room* provides a unique and convenient compendium of expertise and experience.

The Patient Safety Committee Handbook Sandra L. Patterson, 2003

Advances in Patient Safety Kerm Henriksen, 2005 v. 1. Research findings -- v. 2. Concepts and methodology -- v. 3. Implementation issues -- v. 4. Programs, tools and products.

Public Health Behind Bars Robert B. Greifinger, 2021-10-25 *Public Health Behind Bars From Prisons to Communities* examines the burden of illness in the growing prison population, and analyzes the impact on public health as prisoners are released. This book makes a timely case for correctional health care that is humane for those incarcerated and beneficial to the communities they reenter.

Patient Safety Sidney Dekker, 2016-04-19 Increased concern for patient safety has put the issue at the top of the agenda of practitioners, hospitals, and even governments. The risks to patients are many and diverse, and the complexity of the

healthcare system that delivers them is huge. Yet the discourse is often oversimplified and underdeveloped. Written from a scientific, human factors

Patient Safety and Quality: section 1, Patient safety and quality ; section 2, Evidence-based practice ; section 3, Patient-centered care Ronda Hughes,2008 Nurses play a vital role in improving the safety and quality of patient care -- not only in the hospital or ambulatory treatment facility, but also of community-based care and the care performed by family members. Nurses need know what proven techniques and interventions they can use to enhance patient outcomes. To address this need, the Agency for Healthcare Research and Quality (AHRQ), with additional funding from the Robert Wood Johnson Foundation, has prepared this comprehensive, 1,400-page, handbook for nurses on patient safety and quality -- Patient Safety and Quality: An Evidence-Based Handbook for Nurses. (AHRQ Publication No. 08-0043). - online AHRQ blurb, <http://www.ahrq.gov/qual/nurseshdbk/>

The Measurement and Monitoring of Safety Charles Vincent,Susan Burnett,Jane Carthey,2013

Improving Healthcare Quality in Europe Characteristics, Effectiveness and Implementation of Different Strategies OECD,World Health Organization,2019-10-17 This volume, developed by the Observatory together with OECD, provides an overall conceptual framework for understanding and applying strategies aimed at improving quality of care. Crucially, it summarizes available evidence on different quality strategies and provides recommendations for their implementation. This book is intended to help policy-makers to understand concepts of quality and to support them to evaluate single strategies and combinations of strategies.

Maldives Asian Development Bank,2015-08-01 The Maldives has propelled itself to middle-income status despite its geographic constraints and the risks it faces as a small island economy. The economy has been growing in the last 5 years, but development challenges remain formidable. How can the Maldives sustain and improve the pace of its economic growth and reduce poverty and inequality? This report identifies the critical constraints to inclusive growth and discusses policy options to overcome such constraints.

The Physical Environment of the Health Care Facility Adam Coutts,1978

Methodology for Impact Assessment of Free Trade Agreements Michael G. Plummer,David Cheong,Shintaro Hamanaka,2011-02-01 This publication displays the menu for choice of available methods to evaluate the impact of Free Trade Agreements (FTAs). It caters mainly to policy makers from developing countries and aims to equip them with some economic knowledge and techniques that will enable them to conduct their own economic evaluation studies on existing or future FTAs, or to critically re-examine the results of impact assessment studies conducted by others, at the very least.

The Growth Report Commission on Growth and Development,2008-07-23 The result of two years work by 19 experienced policymakers and two Nobel prize-winning economists, 'The Growth Report' is the most complete analysis to

date of the ingredients which, if used in the right country-specific recipe, can deliver growth and help lift populations out of poverty.

Mobilising the Diaspora Alexander Betts, Will Jones, 2016-11-17 This book shows how diasporas are mobilised to challenge authoritarian governments - by whom, for what purposes, and with what consequences.

Decoding **To Be Credible An Rca Must Be Internally Consistent**: Revealing the Captivating Potential of Verbal Expression

In a time characterized by interconnectedness and an insatiable thirst for knowledge, the captivating potential of verbal expression has emerged as a formidable force. Its ability to evoke sentiments, stimulate introspection, and incite profound transformations is genuinely awe-inspiring. Within the pages of "**To Be Credible An Rca Must Be Internally Consistent**," a mesmerizing literary creation penned by a celebrated wordsmith, readers set about an enlightening odyssey, unraveling the intricate significance of language and its enduring impact on our lives. In this appraisal, we shall explore the book's central themes, evaluate its distinctive writing style, and gauge its pervasive influence on the hearts and minds of its readership.

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