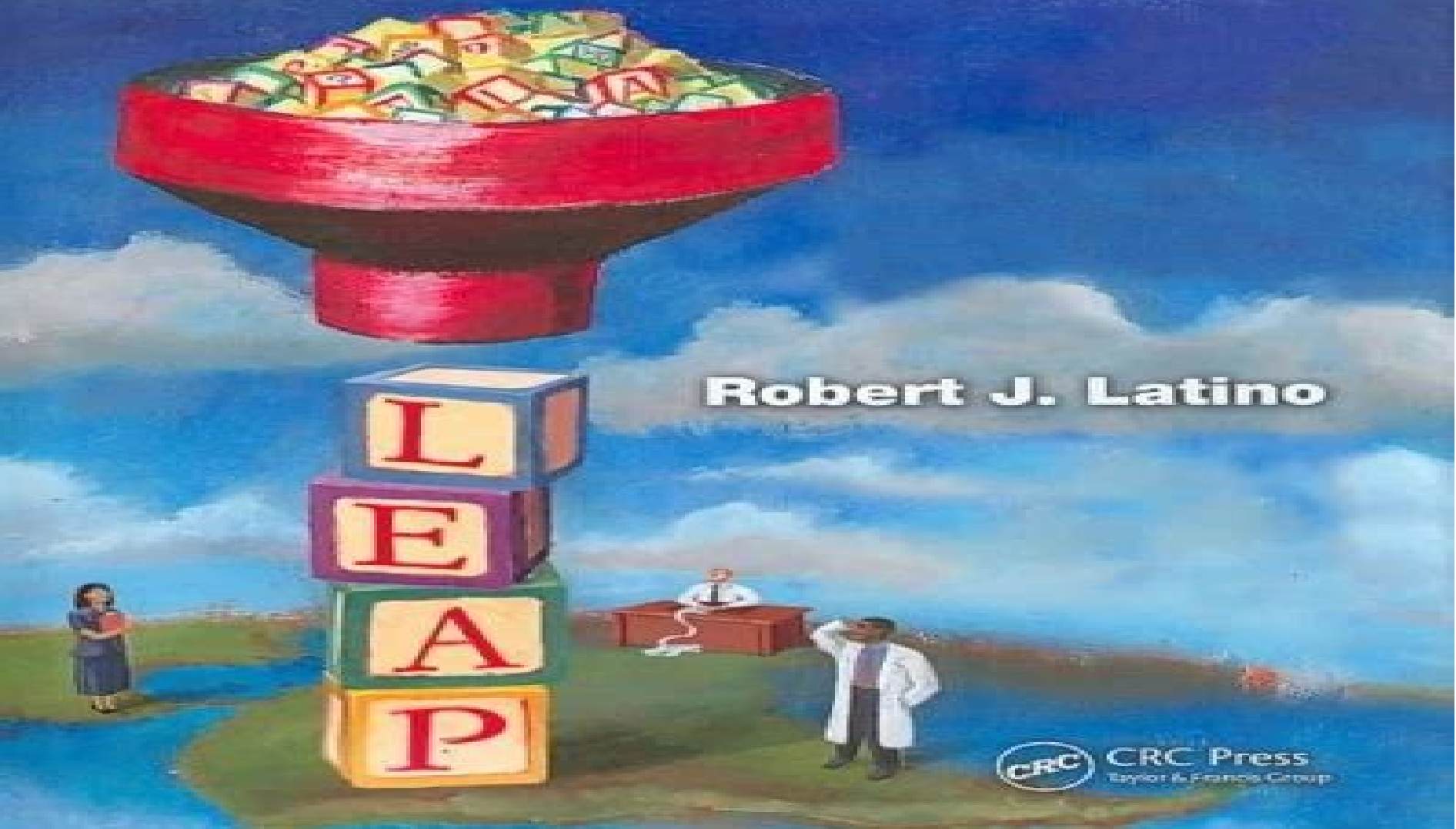


# ***PATIENT SAFETY***

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

**Robert J. Latino**



# Patient Safety The Proact Root Cause Analysis Approach

**Abha Agrawal**



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**Patient Safety** 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 basic failure *Patient Safety* Robert J Latino, 2019-08-30 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 basic failure mode and effects analysis FMEA and opportunity analysis OA are useful in preventing error but in healthcare such tools are often constrained by reticence to share information about mistakes and other problems inherent to the industry well written and extremely applicable to health care Every healthcare professional should have a copy Matthew C Mireles President CEO Community Medical Foundation for Patient Safety Bellaire Texas Patient Safety The PROACT R Root Cause Analysis Approach addresses the proactive methodologies and organizational paradigms that must change in order to support and sustain such activities in the interest of patient safety Written by reliability expert Robert J Latino this book provides a perspective on patient care from outside the health industry and culture It teaches a proven approach that measures its effectiveness based on patient safety results rather than compliance and demonstrates the Return On Investment for using RCA to reduce and or eliminate undesirable outcomes Addressing the contribution of human error to physical consequences Latino explores ways to identify conditions that are more prone to result in human error It also uses FMEA to proactively identify unacceptable risks and then uses the concepts of RCA to prevent risks from materializing Are you ready to be tenacious in your approach and completely honest in your assessment Root Cause Analysis requires courage and honesty When **Root Cause Analysis (RCA) for the Improvement of Healthcare Systems and Patient Safety** David Allison, CPPS, Harold Peters, P.Eng., 2021-08-24 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, 2019-06-26 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

**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 OnDemandSM 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

**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

**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 British National Bibliography* Arthur James Wells, 2009 **Maximize Patient**

**Safety with Advanced Root Cause Analysis** Catherine Corbett (CQM.), Craig Clapper, Kerry M. Johnson, 2004 *AJNR, American Journal of Neuroradiology*, 2009 **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 *Clinical Leadership in Nursing* Judith Rocchiccioli, Mary Sayre Tilbury, 1998 This text provides the leadership and management skills that nurses need to succeed in today's changing healthcare environment

It cultivates proficiency in fiscal management supervision and delegation case management information systems legal and ethical principles cultural diversity group process quality management and much more A focus on the managed care environment equips readers with the particular skills and competencies that it requires And a wealth of learning tools including research boxes learning activities case studies and discussion questions help to promote mastery of the material

**EBOOK: Patient Safety: Research into Practice** Kieran Walshe, Ruth Boaden, 2005-11-16 Winner of the Basis of Medicine Award in the BMA Book Medical Book Competition 2006 In many countries during the last decade there has been a growing public realization that healthcare organisations are often dangerous places to be Reports published in Australia Canada New Zealand United Kingdom and the USA have served to focus public and policy attention on the safety of patients and to highlight the alarmingly high incidence of errors and adverse events that lead to some kind of harm or injury This book presents a research based perspective on patient safety drawing together the most recent ideas and thinking from researchers on how to research and understand patient safety issues and how research findings are used to shape policy and practice The book examines key issues including Analysis and measurement of patient safety Approaches to improving patient safety Future policy and practice regarding patient safety The legal dimensions of patient safety Patient Safety is essential reading for researchers policy makers and practitioners involved in or interested in patient safety The book is also of interest to the growing number of postgraduate students on health policy and health management programmes that focus upon healthcare quality risk management and patient safety Contributors Sally Adams Tony Avery Maureen Baker Paul Beatty Ruth Boaden Tanya Claridge Gary Cook Caroline Davy Susan Dovey Aneez Esmail Rachel Finn Martin Fletcher Sally Giles John Hickner Rachel Howard Amanda Howe Michael A Jones Sue Kirk Rebecca Lawton Martin Marshall Caroline Morris Dianne Parker Shirley Pearce Bob Phillips Steve Rogers Richard Thomson Charles Vincent Kieran Walshe Justin Waring Alison Watkin Fiona Watts Liz West Maria Woloshynowych Improve Patient Safety with Root Cause Analysis Ken Turnbull, Mark Paradies, 2018 *A Socio-cultural Perspective on Patient Safety* Emma Rowley, Justin Waring, 2011 This edited volume of original essays brings together researchers from around the world who are exploring the facets of health care organization and delivery that are sometimes marginal to mainstream patient safety theories and methodologies but offer important insights into the socio cultural and organizational context of patient safety By examining these critical insights or perspectives and drawing upon theories and methodologies often neglected by mainstream safety researchers this collection shows we can learn more about not only the barriers and drivers to implementing patient safety programmes but also about the more fundamental issues that shape notions of safety alternate strategies for enhancing safety and the wider implications of the safety agenda on the future of health care delivery In so doing *A Socio cultural Perspective on Patient Safety* challenges the taken for granted assumptions around fundamental philosophical and political issues upon which mainstream orthodoxy relies *Building Safer Healthcare Systems* Peter Spurgeon, Mark-Alexander Sujan, Stephen

Cross, Hugh Flanagan, 2019-08-21 This book offers a new practical approach to healthcare reform Departing from the priorities applied in traditional approaches it instead assesses both theoretically and practically the successful lessons learned in other safety critical industries and applies them to healthcare settings The authors focus on the importance of human factors and performance measures to establish proactive systematic methods for healthcare system design This approach helps to identify potential hazards before accidents occur enhancing patient safety In addition the book details the new approach on the basis of real world applications in the NHS and insights from NHS staff Case studies and results are presented demonstrating the significant improvements that can be achieved in risk reduction and safety culture Lastly the book outlines what steps healthcare organisations need to take in order to successfully adopt this new approach The approach and experiential learning is brought together through the development of a new holistic patient safety education syllabus

**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 is 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

**Patient Safety Pocket Guide, Version 2.2**, Health Care Errors and Patient Safety Brian Hurwitz, Aziz Sheikh, 2011-08-24 The detection reporting measurement and minimization of medical errors and harms is now a core requirement in clinical organizations throughout developed societies This book focuses on this major new area in health care It explores the nature of medical error its incidence in different health care settings and strategies for minimizing errors and their harmful consequences to patients Written by leading authorities it discusses the practical issues involved in reducing errors in health care for the clinician the health policy adviser and ethical and legal health professionals

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