Safety At The Sharp End A Guide To Non Technical Skills

Providing a practical guide to the training and assessment of non-technical skills within high-risk industries, this book will be of direct interest to safety and training professionals working within aviation, healthcare, rail, maritime, and other high-risk industries. Currently, each of these industries are working to integrate non-technical skills into their training and certification processes, particularly in light of increasing international regulation in this area. However, there is no definitive guidance to assist practitioners within these areas with the design of effective non-technical skills training and assessment programs. This book sets out to fully meet this need. It has been designed as a practically focussed companion to the 2008 book Safety at the Sharp End by Flin, O'Connor and Crichton. While Safety at the Sharp End provides the definitive exploration of the need for non-technical skills training, and examines in detail the main components of non-technical skills as they relate to safe operations, the text does not focus on the "nuts and bolts" of designing training and assessment programs. To this end, Training and Assessing Non-Technical Skills: A Practical Guide provides an extension of this work and a fitting companion text.

Trevor Kletz has had a huge impact on the way people viewed accidents and safety, particularly in the process industries. His ideas were developed from nearly 40 years working in the chemical industry. When he retired from the field, he shared his experience and ideas widely in more than 15 books. Trevor Kletz Compendium: His Process Safety Wisdom Updated for a New Generation introduces Kletz’s stories and ideas and brings them up to date in this valuable resource that equips readers to manage process safety in every workplace. Topics covered in this book include inherent safety, safety studies, human factors and design. Learn the lessons from past accidents to make sure they don’t happen again. Focuses on understanding systems and learning from past accidents Describes approaches to safety that are practical and effective Provides an engineer’s perspective on safety

Wife and mother. Teacher and musician. Marathoner and rock climber. At 66, Dierdre Wolownick-Honnold became the oldest woman to climb El Capitan in Yosemite--and in The Sharp End of Life: A Mother’s Story, she shares her intimate journey, revealing how her climbing achievement reflects a broader story of courage and persistence. Dierdre grew up under the watchful eyes of a domineering mother and realized early on that her parents’ plans for her future weren’t what she wanted for herself. Later, what seemed like a storybook romance brought escape, with new experiences and eye-opening travel, but she quickly discovered that her husband was not the happy-go-lucky man he had first appeared. Adapting as best she could, Dierdre juggled work and raising two young children, encouraging them to be fearlessly confident. She noted with delight how her “little lady” Stasia took it upon herself to look out for her baby brother, and watched in amazement as Alex (Honnold of "Free Solo" fame) started climbing practically before he could crawl. After years of struggle in her marriage and her ultimate divorce, Dierdre found inspiration in her now-adult children’s passions, as well as new depths within herself. At Stasia’s urging, she took up running at age 54 and soon completed several marathons. Then at age 58, Alex led her on her first rock climbs. A world of friendship and support suddenly opened up to her within the climbing “tribe,” culminating in her record-setting ascent of El Cap with her son. From confused

young wife and busy but lonely mother to confident middle-aged athlete, Dierdre brings the reader along as she finds new strength, happiness, and community in the outdoors--and a life of learning, acceptance, and spirit.

The authors believe that a systematic organizational approach to aviation safety must replace the piecemeal approaches largely favoured in the past, but this change needs to be preceded by information to explain why a new approach is necessary. Accident records show a flattening of the safety curve since the early Seventies: instead of new kinds of accident, similar safety deficiencies have become recurrent features in accident reports. This suggests the need to review traditional accident prevention strategies, focused almost exclusively on the action or inaction's of front-line operational personnel. The organizational model proposed by the authors is one alternative means to pursue safety and prevention strategies in contemporary aviation; it is also applicable to other production systems. The model argues for a broadened approach, which considers the influence of all organizations (the blunt end) involved in aviation operations, in addition to individual human performance (the sharp end). If the concepts of systems safety and organizational accidents are to be advanced, aviation management at all levels must be aware of them. This book is intended to provide a bridge from the academic knowledge gained from research, to the needs of practitioners in aviation. It comprises six chapters: the fundamentals, background and justification for an organizational accident causation model to the flight deck, maintenance and air traffic control environments. The last chapter suggest different ways to apply the model as a prevention tool which furthermore enhances organizational effectiveness. The value of the organizational framework pioneered by Professor Reason in analyzing safety in high-technology production systems is felt by his co-authors to have an enduring role to play, both now and in coming decades. Applied now in this book, it has been adopted by ICAO, IFATCA, IMO, the US National Transportation Safety Board, the Transportation Safety B

Rebecca has been captured and awakens alone in the dark, not knowing where she is. She can feel that Llyr is alive, but cannot contact him through the soul link. Chained to a wall and without magic, she must find a way to survive and escape. Llyr was defeated by his brother and witnessed the fall of the tower on Avalon. Being separated from Rebecca has created a problem: the soul link is draining his body of all strength. Despite not being able to stand on his own, he's determined to return to his world and save Rebecca from the Archwizard. Without Havaar to guide him, he must rely on the ghosts of Havaar's school to find a way home.

This is the first textbook designed to introduce the six areas of nursing competencies, as developed by the Quality and Safety Education for Nurses (QSEN) initiative, which are required content in undergraduate nursing programs.

Safety and Reliability – Safe Societies in a Changing World collects the papers presented at the 28th European Safety and Reliability Conference, ESREL 2018 in Trondheim, Norway, June 17-21, 2018. The contributions cover a wide range of methodologies and application areas for safety and reliability that contribute to safe societies in a changing world. These methodologies and applications include: - foundations of risk and reliability assessment and management - mathematical methods in reliability and safety - risk assessment - risk management - system reliability - uncertainty analysis - digitalization and big data - prognostics and system health

management - occupational safety - accident and incident modeling - maintenance modeling and applications - simulation for safety and reliability analysis - dynamic risk and barrier management - organizational factors and safety culture - human factors and human reliability - resilience engineering - structural reliability - natural hazards - security - economic analysis in risk management Safety and Reliability – Safe Societies in a Changing World will be invaluable to academics and professionals working in a wide range of industrial and governmental sectors: offshore oil and gas, nuclear engineering, aeronautics and aerospace, marine transport and engineering, railways, road transport, automotive engineering, civil engineering, critical infrastructures, electrical and electronic engineering, energy production and distribution, environmental engineering, information technology and telecommunications, insurance and finance, manufacturing, marine transport, mechanical engineering, security and protection, and policy making.

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 perspective, Patient Safety: A Human Factors Approach delineates a method that can enlighten and clarify this discourse as well as put us on a better path to correcting the issues. People often think, understandably, that safety lies mainly in the hands through which care ultimately flows to the patient—those who are closest to the patient, whose decisions can mean the difference between life and death, between health and morbidity. The human factors approach refuses to lay the responsibility for safety and risk solely at the feet of people at the sharp end. That is where we should intervene to make things safer, to tighten practice, to focus attention, to remind people to be careful, to impose rules and guidelines. The book defines an approach that looks relentlessly for sources of safety and risk everywhere in the system—the designs of devices; the teamwork and coordination between different practitioners; their communication across hierarchical and gender boundaries; the cognitive processes of individuals; the organization that surrounds, constrains, and empowers them; the economic and human resources offered; the technology available; the political landscape; and even the culture of the place. The breadth of the human factors approach is itself testimony to the realization that there are no easy answers or silver bullets for resolving the issues in patient safety. A user-friendly introduction to the approach, this book takes the complexity of health care seriously and doesn’t over simplify the problem. It demonstrates what the approach does do, that is offer the substance and guidance to consider the issues in all their nuance and complexity.

Sharp Ends is the ultimate collection of award winning tales and exclusive new short stories from the master of grimdark fantasy, Joe Abercrombie. Violence explodes, treachery abounds, and the words are as deadly as the weapons in this rogue's gallery of side-shows, back-stories, and sharp endings from the world of the First Law. The Union army may be full of bastards, but there's only one who thinks he can save the day single-handed when the Gurkish come calling: the incomparable Colonel Sand dan Glokta. Curnden Craw and his dozen are out to recover a mysterious item from beyond the Crinna. Only one small problem: no one seems to know what the item is. Shevedieh, the self-styled best thief in Styria, lurches from disaster to catastrophe

alongside her best friend and greatest enemy, Javre, Lioness of Hoskopp. And after years of bloodshed, the idealistic chieftain Bethod is desperate to bring peace to the North. There's only one obstacle left -- his own lunatic champion, the most feared man in the North: the Bloody-Nine . . .

Pre-Accident Investigations: Better Questions - An Applied Approach to Operational Learning challenges safety and reliability professionals to get better answers by asking better questions. A provocative examination of human performance and safety management, the book delivers a thought-provoking discourse about how we work, and defines a new approach to operational learning. This is not a book about traditional safety. This is a book about creating "real" safety in your organization. In order to predict incidents before they happen, an organization should first understand how their processes can result in failure. Instead of managing the outcomes, they must learn to manage and understand the processes used to create them. Ideal for use in safety, human performance, psychology, cognitive and decision making, systems engineering, and risk assessment areas, this book equips the safety professional with the tools, steps, and models of success needed to create long-term value and change from safety programs.

Gangs rule Cantilucca. Two syndicates dominate the planet. Guns are the only law. Both sides are arming for a bloody showdown that can only end with a handful of survivors sifting for subsistence in the ruins of what could be a rich world. Then the survey team arrives . . . David Drake introduces a new kind of Hammer's Slammer. At the publisher's request, this title is sold without DRM (Digital Rights Management).

Enhancing Surgical Performance: A Primer in Non-Technical Skills explains why non-technical skills are vital for safe and effective performance in the operating theatre. The book provides a full account, with supporting empirical evidence, of the Non-Technical Skills for Surgeons (NOTSS) system and behavioural rating framework, which helps identify the key elements involved in successful operative surgery. The editors spent the last twelve years as part of the team developing and testing the NOTSS system and delivering presentations and workshops across the world. Readers will benefit by having, in one accessible handbook, a description of the NOTSS system and how it can be used for training, assessment, self-reflection and event analysis. The book also examines human error, performance limitations, and global safety initiatives in surgery. Because it encourages surgeons to reflect on their own performance and behaviour, it is suitable for surgeons in all specialties and at all levels.

From the nation’s leading experts in healthcare safety—the first comprehensive guide to delivering care that ensures the safety of patients and staff alike. One of the primary tenets among healthcare professionals is, “First, do no harm.” Achieving this goal means ensuring the safety of both patient and caregiver. Every year in the United States alone, an estimated 4.8 million hospital patients suffer serious harm that is preventable. To address this industry-wide problem—and provide evidence-based solutions—a team of award-winning safety specialists from Press Ganey/Healthcare Performance Improvement have applied their decades of experience and research to the subject of patient and workforce safety. Their mission is to achieve zero harm in the healthcare industry, a lofty goal that some hospitals have already accomplished—which you can, too. Combining the latest advances in safety science, data technology, and high reliability solutions, this step-by-step guide shows you how to implement 6 simple

principles in your workplace. 1. Commit to the goal of zero harm.2. Become more patient-centric.3. Recognize the interdependency of safety, quality, and patient-centricity.4. Adopt good data and analytics.5. Transform culture and leadership.6. Focus on accountability and execution. In Zero Harm, the world's leading safety experts share practical, day-to-day solutions that combine the latest tools and technologies in healthcare today with the best safety practices from high-risk, yet high-reliability industries, such as aviation, nuclear power, and the United States military. Using these field-tested methods, you can develop new leadership initiatives, educate workers on the universal skills that can save lives, organize and train safety action teams, implement reliability management systems, and create long-term, transformational change. You'll read case studies and success stories from your industry colleagues—and discover the most effective ways to utilize patient data, information sharing, and other up-to-the-minute technologies. It's a complete workplace-ready program that's proven to reduce preventable errors and produce measurable results—by putting the patient, and safety, first.

Many 21st century operations are characterised by teams of workers dealing with significant risks and complex technology, in competitive, commercially-driven environments. Informed managers in such sectors have realised the necessity of understanding the human dimension to their operations if they hope to improve production and safety performance. While organisational safety culture is a key determinant of workplace safety, it is also essential to focus on the non-technical skills of the system operators based at the 'sharp end' of the organisation. These skills are the cognitive and social skills required for efficient and safe operations, often termed Crew Resource Management (CRM) skills. In industries such as civil aviation, it has long been appreciated that the majority of accidents could have been prevented if better non-technical skills had been demonstrated by personnel operating and maintaining the system. As a result, the aviation industry has pioneered the development of CRM training. Many other organisations are now introducing non-technical skills training, most notably within the healthcare sector. Safety at the Sharp End is a general guide to the theory and practice of non-technical skills for safety. It covers the identification, training and evaluation of non-technical skills and has been written for use by individuals who are studying or training these skills on CRM and other safety or human factors courses. The material is also suitable for undergraduate and post-experience students studying human factors or industrial safety programmes.

Building on the revolutionary Institute of Medicine reports To Err is Human and Crossing the Quality Chasm, Keeping Patients Safe lays out guidelines for improving patient safety by changing nursesâ€™ working conditions and demands. Licensed nurses and unlicensed nursing assistants are critical participants in our national effort to protect patients from health care errors. The nature of the activities nurses typically perform â€" monitoring patients, educating home caretakers, performing treatments, and rescuing patients who are in crisis â€" provides an indispensable resource in detecting and remedying error-producing defects in the U.S. health care system. During the past two decades, substantial changes have been made in the organization and delivery of health care â€" and consequently in the job description and work environment of nurses. As patients are increasingly cared for as outpatients, nurses in hospitals and nursing homes deal with greater severity of illness. Problems in

management practices, employee deployment, work and workspace design, and the basic safety culture of health care organizations place patients at further risk. This newest edition in the groundbreaking Institute of Medicine Quality Chasm series discusses the key aspects of the work environment for nurses and reviews the potential improvements in working conditions that are likely to have an impact on patient safety.
Strengths-based, solution-focused practice is one of the most exciting areas of contemporary child protection work. The demand for this protection practice has increased faster than the availability of training resources to help students and practitioners, until now. Strengths-Based Child Protection is the first textbook solely dedicated to furthering strengths-based practices in a child protection setting. Carolyn Oliver provides an original, accessible, and practical research-based model that focuses on the key to success in this field: the worker-client relationship. Oliver's long and varied front line experience in child welfare and research based on surveys and interviews with 225 child protection workers provides grounding in the realities of child protection work. Strengths-Based Child Protection contains a rich combination of case studies, reflective questions, and exercises that enable students and practitioners to conceptualize and master implementing strengths-based practices with children.
Safety at the Sharp EndA Guide to Non-Technical SkillsCRC Press
Safety has traditionally been defined as a condition where the number of adverse outcomes was as low as possible (Safety-I). From a Safety-I perspective, the purpose of safety management is to make sure that the number of accidents and incidents is kept as low as possible, or as low as is reasonably practicable. This means that safety management must start from the manifestations of the absence of safety and that - paradoxically - safety is measured by counting the number of cases where it fails rather than by the number of cases where it succeeds. This unavoidably leads to a reactive approach based on responding to what goes wrong or what is identified as a risk - as something that could go wrong. Focusing on what goes right, rather than on what goes wrong, changes the definition of safety from 'avoiding that something goes wrong' to 'ensuring that everything goes right'. More precisely, Safety-II is the ability to succeed under varying conditions, so that the number of intended and acceptable outcomes is as high as possible. From a Safety-II perspective, the purpose of safety management is to ensure that as much as possible goes right, in the sense that everyday work achieves its objectives. This means that safety is managed by what it achieves (successes, things that go right), and that likewise it is measured by counting the number of cases where things go right. In order to do this, safety management cannot only be reactive, it must also be proactive. But it must be proactive with regard to how actions succeed, to everyday acceptable performance, rather than with regard to how they can fail, as traditional risk analysis does. This book analyses and explains the principles behind both approaches and uses this to consider the past and future of safety management practices. The analysis makes use of common examples and cases from domains such as aviation, nuclear power production, process management and health care. The final chapters explain the theoretical and practical consequences of the new perspective on the level of day-to-day operations as well as on the level of strategic management (safety culture). Safety-I and Safety-II is written for all professionals responsible for their organisation's safety, from strategic planning on the executive level to day-to-day operations in the field. It presents the detailed and tested

arguments for a transformation from protective to productive safety management.
This title was first published in 2002: This field guide assesses two views of human error - the old view, in which human error becomes the cause of an incident or accident, or the new view, in which human error is merely a symptom of deeper trouble within the system. The two parts of this guide concentrate on each view, leading towards an appreciation of the new view, in which human error is the starting point of an investigation, rather than its conclusion. The second part of this guide focuses on the circumstances which unfold around people, which causes their assessments and actions to change accordingly. It shows how to "reverse engineer" human error, which, like any other componant, needs to be put back together in a mishap investigation.
Human error is cited over and over as a cause of incidents and accidents. The result is a widespread perception of a 'human error problem', and solutions are thought to lie in changing the people or their role in the system. For example, we should reduce the human role with more automation, or regiment human behavior by stricter monitoring, rules or procedures. But in practice, things have proved not to be this simple. The label 'human error' is prejudicial and hides much more than it reveals about how a system functions or malfunctions. This book takes you behind the human error label. Divided into five parts, it begins by summarising the most significant research results. Part 2 explores how systems thinking has radically changed our understanding of how accidents occur. Part 3 explains the role of cognitive system factors - bringing knowledge to bear, changing mindset as situations and priorities change, and managing goal conflicts - in operating safely at the sharp end of systems. Part 4 studies how the clumsy use of computer technology can increase the potential for erroneous actions and assessments in many different fields of practice. And Part 5 tells how the hindsight bias always enters into attributions of error, so that what we label human error actually is the result of a social and psychological judgment process by stakeholders in the system in question to focus on only a facet of a set of interacting contributors. If you think you have a human error problem, recognize that the label itself is no explanation and no guide to countermeasures. The potential for constructive change, for progress on safety, lies behind the human error label.
He promoted them all: The Who, Eric Clapton, Led Zeppelin, Pink Floyd, David Bowie, Yes, Free, Rod Stewart, Jethro Tull, Deep Purple, The Nice and scores more. Acts that didn't usually play in the North-East played for Geoff Docherty. And this is his incredible story in his own words At The Bay Hotel in Sunderland, Geoff 'Doc of The Bay' Docherty progressed from being doorman and bouncer to self-appointed promoter with a style all of his own. After an upbringing marked by hardship and countless street fights, he brought self-belief and steely determination to getting the big stars to play on his local patch. Sometimes they were on the way up. Sometimes they were already big. Sometimes they didn't show at all. But Docherty was always optimistic, always resolute and always driven by an innate sense of fair play - and he always paid in cash. Rock At The Sharp End - A Promoter's Tale is a unique star-filled memoir of a street-fighting man who became an unforgettable promoter. In the process he also became a folk-hero in his native North-East and one of British rock's most colourful legends.
"Traditional Lead Climbing" is intended to teach rock climbers how to lead with gear. This invaluable book gives step-by-step descriptions of equipment, rope management, and techniques. Dozens of close-up photos and fun yet informative drawings show

situations climbers might encounter and how to deal with them.

Safety suffers from the variety of methods and models that are used to assess human performance. For example, operation is concerned primarily with human error, while design deals with aligning the system to workload or situational awareness, and the gap between the two disassociates safety assessment from design. As a result, system design creates constraints for the operator working at the sharp-end, which will inevitably lead to human error. Accidents and incidents across all industries have demonstrated the safety significance of this gap. Cognition and Safety provides an integrated view of cognitive human issues to better enhance safety. It combines operational with design-related concepts of cognitive performance to provide an approach for safely managing cognitive issues throughout the lifecycle of a system, from operational to senior management levels. The book will be of direct interest to operational managers, designers, training specialists, safety managers and operational staff dealing with human factors and safety issues; scientists in the area of safety, ergonomics and human factors; regulators dealing with safety and human factors, and practitioners in the field of human reliability.

"Nurses play a vital role in improving the safety and quality of patient car -- 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.

How do people cope with having "caused" a terrible accident? How do they cope when they survive and have to live with the consequences ever after? We tend to blame and forget professionals who cause incidents and accidents, but they are victims too. They are second victims whose experiences of an incident or adverse event can be as traumatic as that of the first victims’. Yet information on second victimhood and its relationship to safety, about what is known and what organizations might need to do, is difficult to find. Thoroughly exploring an emerging topic with great relevance to safety culture, Second Victim: Error, Guilt, Trauma, and Resilience examines the lived experience of second victims. It goes through what we know about trauma, guilt, forgiveness, and injustice and how these might be felt by the second victim. The author discusses how to conduct investigations of incidents that do not alienate second victims or make them feel even worse. It explores the importance support and resilience and where the responsibilities for creating it may lie. Drawing on his unique background as psychologist, airline pilot, and safety specialist, and his own experiences with helping second victims from a variety of backgrounds, Sidney Dekker has written a powerful, moving account of the experience of the second victim. It forms compelling reading for practitioners, risk managers, human resources managers, safety experts, mental health workers, regulators, the judiciary, and many other professionals. Dekker provides a strong theoretical background to promote understanding of the situation of the second victim and solid practical advice about how to deal with trauma that continues after an event leading to preventable harm or even avoidable death of a patient, consumer, or colleague. Listen to Sidney Dekker speak about his book

Operating theatres are very private workplaces. There have been few research investigations into how highly trained doctors and nurses work together to achieve safe and efficient

anaesthesia and surgery. While there have been major advances in surgical and anaesthetic procedures, there are still significant risks for patients during operations and adverse events are not unknown. Due to rising concern about patient safety, surgeons and anaesthetists have looked for ways of minimising adverse events. Behavioural scientists have been encouraged by clinicians to bring research techniques used in other industries into the operating theatre in order to study the behaviour of surgeons, nurses and anaesthetists. Safer Surgery presents one of the first collections of studies designed to understand the factors influencing safe and efficient surgical, anaesthetic and nursing practice. The book is written by psychologists, surgeons and anaesthetists, whose contributions combine to offer readers the latest research techniques and findings from some of the leading investigators in this field. It is designed for practitioners and researchers interested in understanding the behaviour of operating theatre team members, with a view to enhancing both training and practice. The material is also suitable for those studying behaviour in other areas of healthcare or in high-risk work settings. The aims of the book are to: a) present the latest research on the behaviour of operating theatre teams b) describe the techniques being used by psychologists and clinicians to study surgeons, anaesthetists and theatre nurses' task performance c) outline the safety implications of the research to date.

While many organizations see the value of creating a just culture they struggle when it comes to developing it. In this Second Edition, Dekker expands his views, additionally tackling the key issue of how justice is created inside organizations. Dekker also introduces new material on ethics and on caring for the' second victim' (the professional at the centre of the incident). Consequently, we have a natural evolution of the author's ideas.

Next Generation Safety Leadership illustrates practical applications that bring theory to life through case studies and stories from the author's years of experience in high-risk industries. The book provides safety leaders and their organisations with a compelling case for change. A key predictor of safety performance is trust, and its associated components of integrity, ability and benevolence (care). The next generation of safety leaders will take the profession forward by creating trust and psychological safety. The book provides safety leaders with actionable goals to enable positive change and translates academic languages into practical applications. It leaves the reader with a clear strategy to move forward in developing a safety plan and utilizes stories, humor, and case studies set in high-risk industries. Written primarily for the safety community and can be used to influence day to day safety operations in high-risk organisations.

This book is a set of new skills written for the managers that drive safety in their workplace. This is Human Performance theory made simple. If you are starting a new program, revamping an old program, or simply interested in understanding more about safety performance, this guide will be extremely helpful.

This book focuses exclusively on the surgical patient and on the perioperative environment with its unique socio-technical and cultural issues. It covers preoperative, intraoperative, and postoperative processes and decision making and explores both sharp-end and latent factors contributing to harm and poor quality outcomes. It is intended to be a resource for all healthcare practitioners that interact with the surgical patient. This book provides a framework for understanding and addressing many of the organizational, technical, and cultural aspects of care to one of the most vulnerable patients in the system, the surgical patient. The first section presents foundational principles of safety science and related social science. The second exposes barriers to achieving optimal surgical outcomes and details the various errors and events that occur in the perioperative environment. The third section contains prescriptive and proactive tools and ways to eliminate errors and harm. The final section focuses on developing continuous quality improvement programs with an emphasis on safety and reliability. Surgical Patient Care: Improving Safety, Quality and Value targets an international audience which

includes all hospital, ambulatory and clinic-based operating room personnel as well as healthcare administrators and managers, directors of risk management and patient safety, health services researchers, and individuals in higher education in the health professions. It is intended to provide both fundamental knowledge and practical information for those at the front line of patient care. The increasing interest in patient safety worldwide makes this a timely global topic. As such, the content is written for an international audience and contains materials from leading international authors who have implemented many successful programs.

The Human Contribution is vital reading for all professionals in high-consequence environments and for managers of any complex system. The book draws its illustrative material from a wide variety of hazardous domains, with the emphasis on healthcare reflecting the author's focus on patient safety over the last decade. All students of human factors - however seasoned - will also find it an invaluable and thought-provoking read.

Communications research in aviation is widely regarded by many in the healthcare community as the 'gold standard' to emulate. Yet healthcare and aviation differ in many ways, as do the vital communications shared among members of clinical teams. Aviation team communication should, then, be understood in terms of what lessons will benefit those who work in healthcare. In Improving Healthcare Team Communication, renowned experts provide insights from 'sharp end' operator research in high-hazard sectors that shed light on the performance of cognitive tasks including resource availability assessment, allocation, anticipation, prediction, trade-off decisions, speculation and negotiation. The book reports on recent field research to address what is known, and what needs to be learned, about team communication among operators. Students, clinicians and healthcare managers can find answers in it to the questions they face daily. How can healthcare information be better shared? What can we expect from its improvement, and how do we get there? Lessons learned from team communication research and experience in aviation and healthcare will point the way to improved patient safety.

Adam Steltzner is no ordinary engineer. His path to leadership was about as unlikely as they come. A child of beatnik parents, he barely made it through school. He blew off college in favour of work at a health food store and playing bass in a band, but after discovering an astonishing gift for maths and physics, he ended up helping a group of scientists land the heaviest rover in the history of space exploration on Mars. This is the story of the teamwork, drama and extraordinary feats of innovation at the Jet Propulsion Lab that culminated in that landing in 2012.

The second edition of a bestseller, Safety Differently: Human Factors for a New Era is a complete update of Ten Questions About Human Error: A New View of Human Factors and System Safety. Today, the unrelenting pace of technology change and growth of complexity calls for a different kind of safety thinking. Automation and new technologies have resu

#1 New York Times Best Seller! "Eleanor & Park reminded me not just what it's like to be young and in love with a girl, but also what it's like to be young and in love with a book."-John Green, The New York Times Book Review Bono met his wife in high school, Park says. So did Jerry Lee Lewis, Eleanor answers. I'm not kidding, he says. You should be, she says, we're 16. What about Romeo and Juliet? Shallow, confused, then dead. I love you, Park says. Wherefore art thou, Eleanor answers. I'm not kidding, he says. You should be. Set over the course of

one school year in 1986, this is the story of two star-crossed misfits-smart enough to know that first love almost never lasts, but brave and desperate enough to try. When Eleanor meets Park, you'll remember your own first love-and just how hard it pulled you under. A New York Times Best Seller! A 2014 Michael L. Printz Honor Book for Excellence in Young Adult Literature Eleanor & Park is the winner of the 2013 Boston Globe Horn Book Award for Best Fiction Book. A Publishers Weekly Best Children's Book of 2013 A New York Times Book Review Notable Children's Book of 2013 A Kirkus Reviews Best Teen Book of 2013 An NPR Best Book of 2013

This edited collection of articles addresses aspects of medical care in which human error is associated with unanticipated adverse outcomes. For the purposes of this book, human error encompasses mismanagement of medical care due to: * inadequacies or ambiguity in the design of a medical device or institutional setting for the delivery of medical care; * inappropriate responses to antagonistic environmental conditions such as crowding and excessive clutter in institutional settings, extremes in weather, or lack of power and water in a home or field setting; * cognitive errors of omission and commission precipitated by inadequate information and/or situational factors -- stress, fatigue, excessive cognitive workload. The first to address the subject of human error in medicine, this book considers the topic from a problem oriented, systems perspective; that is, human error is considered not as the source of the problem, but as a flag indicating that a problem exists. The focus is on the identification of the factors within the system in which an error occurs that contribute to the problem of human error. As those factors are identified, efforts to alleviate them can be instituted and reduce the likelihood of error in medical care. Human error occurs in all aspects of human activity and can have particularly grave consequences when it occurs in medicine. Nearly everyone at some point in life will be the recipient of medical care and has the possibility of experiencing the consequences of medical error. The consideration of human error in medicine is important because of the number of people that are affected, the problems incurred by such error, and the societal impact of such problems. The cost of those consequences to the individuals involved in medical error, both in the health care providers' concern and the patients' emotional and physical pain, the cost of care to alleviate the consequences of the error, and the cost to society in dollars and in lost personal contributions, mandates consideration of ways to reduce the likelihood of human error in medicine. The chapters were written by leaders in a variety of fields, including psychology, medicine, engineering, cognitive science, human factors, gerontology, and nursing. Their experience was gained through actual hands-on provision of medical care and/or research into factors contributing to error in such care. Because of the experience of the chapter authors, their systematic consideration of the issues in this book affords the reader an insightful, applied approach to human error in medicine -- an approach fortified by academic discipline.

#1 NEW YORK TIMES BESTSELLER • ONE OF TIME MAGAZINE'S 100 BEST YA BOOKS OF ALL TIME The extraordinary, beloved novel about the ability of books to feed the soul even in the darkest of times. When Death has a story to tell, you listen. It is 1939. Nazi Germany. The country is holding its breath. Death has never been busier, and will become busier still. Liesel Meminger is a foster girl living outside of Munich, who scratches out a meager existence for herself by stealing when she encounters something she can't resist–books. With the help of her accordion-playing foster father, she learns to read and shares her stolen books with her neighbors during bombing raids as well as with the Jewish man hidden in her basement. In superbly crafted writing that burns with intensity, award-winning author Markus Zusak, author of I Am the Messenger, has given us one of the most enduring stories of our time. "The kind of book that can be life-changing." —The New York Times "Deserves a place on the same shelf with The Diary of a Young Girl by Anne Frank." —USA Today DON'T MISS BRIDGE OF CLAY, MARKUS ZUSAK'S FIRST NOVEL SINCE THE BOOK THIEF.

"A very good book." Sven-Goran Eriksson "This book makes a convincing case that there are good lessons to be learned from the dugout." Management Today " We're not one to gossip, but which manager was spotted in a Monte Carlopool this week ploughing through The 90-Minute Manager only weeks after getting his club relegated? And why, exactly, was he there with Fabien Barthez and international playboy Dave "Barry" Bassett?" The Guardian's Fiver email Football is the setting for one of the purest forms of management - and the most transparent. In an age when club football is more of a business than ever before, suddenly it seems business is getting more and more like football: when talent is at a premium, the ability to attract and retain the very best people - and get the most out of them individually and collectively - is of paramount importance. What better time to learn the lessons from the very best - and worst - of the ultimate man management game. In this book, Brady and Bolchover take each of the key areas of management today, and see what we can learn from football league managers of all levels, their style and methodology. From Shankley to Wenger, from Clough to Mourinho, through Keegan, Venables, Fergusonand O'Neill, strengths and weaknesses are examined to answer classic modern management questions, such as: - what are the best strategies for dealing with brilliant but erratic people? - does the best manger have to be both a great strategist and an inspirational motivator? - what will make top talent want to work for you? - what makes a great manager on a shoestring? - what are the advantages of home grown versus imported talent? - how important is the 'right-hand' man and what qualities make the very best pairing? - should a team ever be built around a single outstanding individual? Now in its 3rd edition, The 90 Minute Manager is the ultimate read for pleasure, read for work book and publishes in the midst of the football fever of World Cup 2006.

Copyright: d7ce94b9ba1f6ade9c2cbd285d3e6bf6