[Books] The Near Miss Management Of Operational Risk

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Near Miss Reporting as a Safety Tool-T.W. van der Schaaf 2013-10-22 Near Miss Reporting as a Safety Tool arises from a meeting of safety professionals, academicians, and consultants from Western-Europe and Canada held in Eindhoven, the Netherlands, in September 1989. The book deals with near-miss reporting in various systems, mostly in the context of errors and accidents. The book begins by discussing the effects of bad management decisions in the design phase and a framework that will describe or manage these near misses through reporting, description, analysis, interpretation, and suggestions. Seven modules that compose this framework, called the Near Miss Management System (NMMS), along with pertinent cases, are explained. The book notes that near misses are ignored because of technical myopia, action-oriented organizations, event-focused organizations, consequence driven, and variables in quality of reporting. The organizational and management aspects of the NMMS are then analyzed within the commonly accepted culture and experience of the company. The book also presents comparative application of near miss information systems covering a wide range of industrial and transport environment. Such presentation allows differences and similarities to come into view more easily. The text will prove valuable for safety professionals in the nuclear and chemical industry and in road, railway, and air traffic management. Professors and students in safety management will likewise appreciate this book.
Safety Management-Ron C. McKinnon 2012-02-27 Close calls, narrow escapes, or near hits. History has shown repeatedly that these "near-miss" incidents often precede loss producing events, but are largely ignored or go unreported because nothing (no injury, damage or loss) happened. Thus, many opportunities to prevent the accidents that the organization has not yet had are lost. Recognizing and
Patient Safety-Institute of Medicine 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 â€" 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.
Encyclopedia of Financial Models-Frank J. Fabozzi 2012-09-20 Volume 3 of the Encyclopedia of FinancialModels The need for serious coverage of financial modeling has neverbeen greater, especially with the size, diversity, and efficiencyof modern capital markets. With this in mind, the Encyclopediaof Financial Models has been created to help a broad spectrumof individuals—ranging from finance professionals toacademics and students—understand financial modeling and makeuse of the various models currently available. Incorporating timely research and in-depth analysis, Volume3 of the Encyclopedia of Financial Models covers bothestablished and cutting-edge models and discusses their real-worldapplications. Edited by Frank Fabozzi, this volume includescontributions from global financial experts as well as academicswith extensive consulting experience in this field. Organizedalphabetically by category, this reliable resource consists offorty-four informative entries and provides readers with a balancedunderstanding of today’s dynamic world of financialmodeling. Volume 3 covers Mortgage-Backed Securities Analysisand Valuation, Operational Risk, Optimization Tools, ProbabilityTheory, Risk Measures, Software for Financial Modeling, StochasticProcesses and Tools, Term Structure Modeling, Trading CostModels, and Volatility Emphasizes both technical and implementation issues, providingresearchers, educators, students, and practitioners with thenecessary background to deal with issues related to financialmodeling The 3-Volume Set contains coverage of the fundamentals andadvances in financial modeling and provides the mathematical andstatistical techniques needed to develop and test financialmodels Financial models have become increasingly commonplace, as wellas complex. They are essential in a wide range of financialendeavors, and the Encyclopedia of Financial Models willhelp put them in perspective.
Accident Precursor Analysis and Management-National Academy of Engineering 2004-09-16 In the aftermath of catastrophes, it is common to find prior indicators, missed signals, and dismissed alerts that, had they been recognized and appropriately managed before the event, could have resulted in the undesired event being averted. These indicators are typically called "precursors." Accident Precursor Analysis and Management: Reducing Technological Risk Through Diligence documents various industrial and academic approaches to detecting, analyzing, and benefiting from accident precursors and examines public-sector and private-sector roles in the collection and use of precursor information. The book includes the analysis, findings and recommendations of the authoring NAE committee as well as eleven individually authored background papers on the opportunity of precursor analysis and management, risk assessment, risk management, and linking risk assessment and management.
The Value of Close Calls in Improving Patient Safety-Albert W. Wu 2011-01-01 Because close calls, often termed near misses, don't raise the same concerns about malpractice liability and may be less emotionally charged than errors that cause serious harm, they are a unique source of learning for individuals and organizations striving to keep patients safe. This book tells how to take advantage of these lessons to prevent today's close call from turning into tomorrow's catastrophic event. Special Features: * Foreword by human error expert James Reason, Ph.D. * Authoritative tutorials on what the literature tells us about the concept of close calls and their identification, relationship with errors, and use in assessing and improving the safety and reliability of health care. * 15 detailed case studies from a variety of clinical disciplines and specialties to show how health care organizations use close calls to identify and solve patient safety problems
Software Failure Investigation-Jan Eloff 2017-09-07 This book reviews existing operational software failure analysis techniques and proposes near-miss analysis as a novel, and new technique for investigating and preventing software failures. The authors provide details on how near-miss analysis techniques focus on the time-window before the software failure actually unfolds, so as to detect the high-risk conditions that can lead to a major failure. They detail how by alerting system users of an upcoming software failure, the detection of near misses provides an opportunity to collect at runtime failure-related data that is complete and relevant. They present a near-miss management systems (NMS) for detecting upcoming software failures, which can contribute significantly to the improvement of the accuracy of the software failure analysis. A prototype of the NMS is implemented and is discussed in the book. The authors give a practical hands-on approach towards doing software failure investigations by means of near-miss analysis that is of use to industry and academia
ECCWS2014-Proceedings of the 13th European Conference on Cyber warefare and Security-Andrew Liaropoulos 2014-03-07
Safety Management-Ron C. McKinnon 2012-02-27 Close calls, narrow escapes, or near hits. History has shown repeatedly that these "near-miss" incidents often precede loss producing events, but are largely ignored or go unreported because nothing (no injury, damage or loss) happened. Thus, many opportunities to prevent the accidents that the organization has not yet had are lost. Recognizing and
Risk-based, Management-led, Audit-driven, Safety Management Systems-Ron C. McKinnon 2016-11-25 Risk-based, Management-led, Audit-driven, Safety Management Systems, explains what a safety management system (SMS) is, and how it reduces risk in order to prevent accidental losses in an organization. It advocates the integration of safety and health into the day-to-day management of the enterprise as a value, rather than an add-on, and emphasizes that the safety movement must be initiated, led and maintained by management at all levels. The concepts of safety authority, responsibility and accountability are described as the key ingredients to safety system success. Safety system audits

are expounded in simple terms, and leading safety performance indicators are suggested as the most important measurements, in preference to lagging indicators. McKinnon highlights the importance of the identification and control of risk as a key basis for a SMS, with examples of a simple risk matrix and daily task risk assessment, as well as a simplified method of assessing, analyzing, and controlling risks. The book refers to international Guidelines on SMS, as well as the proposed International Organization for Standardization (ISO) 45001, which could soon become the international safety benchmark for organizations worldwide. Using clear, approachable examples, the chapters give a complete overview of an SMS and its components. Confirming to most of the safety management system Guidelines published by leading world authorities, this volume will allow organizations to structure their own world-class SMS.

Near Misses in Cardiac Surgery-Myles Edwin Lee 2008-11-26 Historian Daniel J. Boorstin has said, "Trying to plan for the future without a sense of the past is like trying to plant cut flowers." This reissue of Near Misses in Cardiac Surgery, endorsed by today's experts and with a new preface by Denton A. Cooley, M.D., Surgeon-in-Chief, Texas Heart Institute, is especially timely in this era of transition to interventional and hybrid procedures. No matter what the technical advances are, the same principles that facilitate successful outcomes in surgery (teamwork, communication, vigilance, simplicity and standardization of techniques, anticipation of the next step) will apply equally to today's hybrid procedures and to those who perform them. A best-seller in its field when first issued, Near Misses in Cardiac Surgery has since become a resource for the Cardiothoracic Surgery Network's safety reporting system (www.CTSNet.org) and has become the template used by CTSNet as a teaching tool for the anonymous reporting of near-disasters in the field by cardiac surgeons from around the world. Written in the second person present tense so that the reader becomes the surgeon on the spot, this reissue of Near Misses in Cardiac Surgery, although it reads like a medical thriller, is really a textbook of cardiac surgical complications, their management, and prevention. With its cogent analyses, discussions, and pertinent references, Near Misses in Cardiac Surgery will introduce a new generation of cardiac surgical residents and fellows, as well as more experienced surgeons, cardiologists, interventionalists, anesthesiologists, medical students, and nurses, to principles that are as timeless as they are essential.

Risk Intelligent Supply Chains-Çağrı Haksöz 2016-07-22 The Turkish economy is very dynamic and growing at phenomenal speeds. For instance, Turkey’s first quarter GDP growth rate was 11 percent in 2011. This growth brings its own risks and benefits. The lessons learned from surviving and thriving in such an environment can be applied to supply chains in any country. Packed with interesting and timely examples from industries such as automotive, airline, and manufacturing, Risk Intelligent Supply Chains: How Leading Turkish Companies Thrive in the Age of Fragility presents strategic insights from various leading Turkish companies regarding their management of supply chain risks. Çağrı Haksöz brings the risk intelligent supply chain (RISC) concept to life for the first time. It answers the question of how to become a risk intelligent supply chain. He proposes the I-Quartet Model with four essential roles "Integrator, Inquirer, Improviser, and Ingenious," that any supply chain network must play to become risk intelligent. The book also presents never-before-published cases and practices of leading Turkish companies that thrive globally in the age of fragility with their supply chain risk intelligence. While providing real-life examples, the book also shares insights obtained in various scientific disciplines. It provides not only an industry focus but also details numerous industry approaches, analyzing their similarities and differences in a manner that allows each industry to learn from the other.

Prevention of Accidents and Unwanted Occurrences-Urban Kjellen 2017-03-07 This new edition comes after about 15 years of development in the field of safety science and practice. The book addresses the question of how to improve risk assessments, investigations, and organizational learning inside companies in order to prevent unwanted occurrences. The book helps the reader in analyzing the subject from different scientific perspectives to demonstrate how they contribute to an overall understanding. It also gives a comprehensive overview of different methods and tools for use in safety practice and helps the reader in analyzing their scope, merits, and shortcomings. The book raises a number of critical issues to be addressed in the improvement process.

Operational Risk-Anna S. Chernobai 2007-06-15 Operational Risk While operational risk has long been regarded as a mere part of "other" risks—outside the realm of credit and market risk—it has quickly made its way to the forefront of finance. In fact, with implementation of the Basel II Capital Accord already underway, many financial professionals—as well as those preparing to enter this field—must now become familiar with a variety of issues related to operational risk modeling and management. Written by the experienced team of Anna Chernobai, Svetlozar Rachev, and Frank Fabozzi, Operational Risk: A Guide to Basel II Capital Requirements, Models, and Analysis will introduce you to the key concepts associated with this discipline. Filled with in-depth insights, expert advice, and innovative research, this comprehensive guide not only presents you with an abundant amount of information regarding operational risk, but it also walks you through a wide array of examples that will solidify your understanding of the issues discussed. Topics covered include: The main challenges that exist in modeling operational risk The variety of approaches used to model operational losses Value-at-Risk and its role in quantifying and managing operational risk The three pillars of the Basel II Capital Accord And much more

From Accidents to Zero-Andrew Sharman 2016-05-20 As leaders increasingly understand the importance of good safety practice to support their business objectives, safety and health practitioners develop better tools and solutions. However, there is still a gulf between these two groups where engagement, communication and shared understanding can be found lacking. From Accidents to Zero opens up the field of safety culture and breaks it down into bite-sized pieces to facilitate new, critical thought and inspire practical action. Based on the concept of creating safety, as opposed to just preventing accidents, each of the 26 chapters in this user-friendly book includes explanation, commentary, reflections and practical activities designed to systematically and sustainably improve workplace safety culture. Core topics range from behaviour to values, daily rituals to unsafe acts, felt leadership to trust. Andrew Sharman's practical guide blends current academic thinking with authoritative guidance and sets up the opportunity for all parts of the organization to close the gap by providing very clear steps to thinking and acting differently. It sparks insight into how both traditional methods and novel approaches can be brought to life in real world situations. From Accidents to Zero offers a clear route to culture change through over one hundred pragmatic ideas to motivate and lead people, influence behaviour and drive a positive evolution in workplace safety.

Safety Management-John Davies 2003-05-15 Professionals striving for accident reduction must deal with systems in which both technical and human elements play equal and complementary roles. However, many of the existing techniques in ergonomics and risk management concentrate on plant and technical issues and downplay human factors and "subjectivity." Safety Management: A Qualitative Systems Approach describes a body of theories and data that addresses safety by drawing on systems theory and applied psychology, stressing the importance of human activity within systems. It explains in detail the central roles of social consensus and reliability and the nature of verbal reports and functional discourse. This text presents a new approach to safety management, offering a path to both greater safety and to economic savings. It presents a series of methodological tools that have proven to be reliable through extensive use in the rail and nuclear industries. These methods allow organizational and systems failures to be analyzed much more effectively in terms of quantity, precision, and usefulness. The concepts and tools described in this book are particularly valuable for reliability engineers, risk managers, human factors specialists, and safety managers and professionals in safety-critical organizations.

The Design, Implementation, and Audit of Occupational Health and Safety Management Systems-Ron C. McKinnon 2019-11-20 This book covers the design, implementation, and auditing of structured occupational health and safety management systems (SMS), sometimes referred to as safety programs. Every workplace has a form of SMS in place as required by safety regulations and laws. The Design, Implementation, and Audit of Occupational Health and Safety Management Systems describes some of the elements that constitute an SMS, the implementation process, and the auditing of the conformance to standards. It covers more than 60 processes, programs, or standards of a system, and gives important background information on each element. Guidelines and examples show how to design and implement the risk-based processes, programs and standards, and how to audit them against standards. The text is based on actual SMS implementation experiences across a wide range of industries. It offers a roadmap to any organization which has no structured SMS. It will guide them through the process of upgrading their health and safety processes to conform to local and international standards. It will lead them away from relying on reactive safety measures such as injury rates, to proactive actions which are measured by the audit of the system. Features Covers more than 60 elements of a safety management system (SMS) Provides practical examples of how to design, implement, and audit a structured SMS Based on actual SMS implementation experience across a wide range of industries Presents the integration of an SMS into the day-to-day functions of the organization

Changing the Workplace Safety Culture-Ron C. McKinnon 2013-07-15 Despite the fact that workplaces have implemented and followed new safety innovations and approaches, the majority of them have seen little, if any, significant progress in the reduction of accidental deaths and injuries. Changing the Workplace Safety Culture demonstrates that changing the way an organization views and practices safety will impact the behavior of all employees including executive and line managers. It delineates how safety culture change can be implemented and defines the roles of everyone in the safety culture, including management, employees, and unions and their members. Rather than focus on behavior-based safety measures, this book provides step-by-step procedures on how to establish a long-lasting integrated safety management system in any organization. It explores how to change the safety personality of an organization. The author covers the management principles and functions that need to be applied to bring about safety culture change and includes many real-life examples. He goes on to explain the activities needed to implement safety change and the benefits of getting others involved in the safety management system. The only way to ensure that accidents and their consequences are tackled at the source is to identify and eliminate the workplace risks before,

rather than after, the event. To be truly effective, safety activities must be integrated into the day-to-day business and become a way of life for management and employees of the organization. This book provides a blueprint for creating an active safety culture that prevents accidents before they occur and becomes the key component in ongoing safety success.
Proceedings of the ... Annual Loss Prevention Symposium- 2003
Near Misses in Pediatric Anesthesia-John G. Brock-Utne 2013-05-28 Authored by “a superb clinician and award-winning teacher,”* Near Misses in Pediatric Anesthesiology, Second Edition is a thorough updating and significant expansion of this popular case book in the newest anesthesiology subspecialty to be approved by the American Board of Medical Specialties. The book comprises 87 true-story clinical “near misses,” including 40 cases that are brand new. Recommendations, references, and discussion accompany each case. The cases provide an ideal basis for problem-centered learning and also model how to learn from experience and to maintain professionalism during the lifelong development of clinical expertise. Dr. Brock-Utne’s latest case book provides a pediatric complement to his bestselling Case Studies of Near Misses in Clinical Anesthesia (Springer, 2012) and Clinical Anesthesia: Near Misses and Lessons Learned (Springer, 2008). * Jay B. Brodsky, MD, from the Foreword.
Workplace Violence-Kim Kerr 2010-05-21 Workplace violence in all its forms is becoming more prevalent and pervasive every year. Workplace Violence: Planning for Prevention and Response gives a comprehensive account of the problem using a multi-faceted approach to the issues surrounding workplace violence incidents, addressing how the topic affects victims, witnesses, the workforce, family members, and management. A series of chapters helps organizations to form action and response plans to manage incidents both large and small. The focus also includes organizations that are forced to address violent individuals in settings where law enforcement may not be immediately available. Kerr speaks first-hand about complex issues like corporate liability for violent or threatening acts committed by employees, as well as issues of privacy, and he includes chapters written by experts on legal issues, cyberthreats, and anger in the workplace. This book belongs on the desk of every security manager and HR professional, and offers solid advice to all managers regardless of the size of their organization. Details the problem from all angles to help the reader design a comprehensive strategy for all constituent groups Provides proven, detailed support for creating policies and procedures, awareness, and response training Discuses real-life case studies to help readers understand how to apply strategies discussed in the book
The Near-miss Experience-Doward Gerrit Douwsma 1991 Recommendations include the continued collection and codification of near-miss experiences, experimentation using full-mission simulation, and research into the potential for near-misses under the one-person bridge organization structure.
Year Book of Anesthesiology and Pain Management 2012 - E-Book-David H. Chestnut 2012-06-06 The Year Book of Anesthesiology and Pain Management brings you abstracts of the articles that reported the year's breakthrough developments in anesthesiology, carefully selected from more than 500 journals worldwide. Expert commentaries evaluate the clinical importance of each article and discuss its application to your practice. Topics included are: Anesthesia-Related Pharmacology and Toxicology, Anesthesia Techniques and Monitors, Cardiothoracic and Vascular Anesthesia, Pediatric Anesthesia, Obstetric Anesthesia, Pain Management, and Geriatric Medicine. The Year Book of Anesthesiology and Pain Management is published annually in June.
Close Calls-C. Macrae 2014-03-05 Drawing on extensive and detailed fieldwork within airlines-an industry that pioneered near-miss analysis- this book develops a clear set of practical implications and theoretical propositions regarding how all organizations can learn from 'near-miss' events and better manage risk and resilience.
Steps to Safety Culture Excellence-Terry L. Mathis 2013-01-10 Provides a clear road map to instilling a culture of safety excellence in any organization Did you know that accidental injury is among the top ten leading causes of death in every age group? With this book as your guide, you'll learn how to help your organization develop, implement, and sustain Safety Culture Excellence, vital for the protection of and improvement in the quality of life for everyone who works there. STEPS to Safety Culture Excellence is based on the authors' firsthand experience working with international organizations in every major industry that have successfully developed and implemented ongoing cultures of safety excellence. Whether your organization is a small regional firm or a large multinational corporation, you'll find that the STEPS process enables you to instill Safety Culture Excellence within your organization. STEPS (Strategic Targets for Excellent Performance in Safety) demystifies the process of developing Safety Culture Excellence by breaking it down into small logical, internally led tasks. You'll be guided through a sequence of STEPS that makes it possible to: Create a culture of excellence that is reinforced and empowered at every level Develop the capability within the culture to identify, prioritize, and solve safety problems and challenges Maintain and continuously improve the performance of your organization's safety culture Although this book is dedicated to safety, the tested and proven STEPS process can be used to promote excellence in any aspect of organizational performance. By optimizing the safety culture in your organization, you will give the people you work with the skills and knowledge to not only minimize the risk of an on-the-job accident, but also to lead safe, healthy lives outside of work.
Alive and Well at the End of the Day-Paul D. Balmert 2011-09-20 Proven strategies and tactics that you can use to lead workers to safety Industrial facilities supervisors, from front-line managers to CEOs, can depend on Alive and Well at the End of the Day for tested and proven management and leadership practices that ensure the safety of their workers. With more than thirty years of hands-on experience in the chemical industry, including front-line management, author Paul Balmert understands the challenges facing supervisors in industrial facilities. His advice, based on firsthand experience, shows you how to identify and correct flaws in industrial practices. Moreover, he shows you how to lead by example, overcoming all obstacles that interfere with safety. Rather than focus on theory, this book offers concrete strategies and tactics that enable you to: Recognize and capitalize on the moments when workers are most receptive to learning safety Discover what's really going on when you tour and inspect plant operations Engage in a helpful discussion with someone who is not following safety guidelines Understand the various types of risk involved in an industrial operation Implement a comprehensive strategy to manage and minimize risk Throughout the book, plenty of case studies and examples illustrate key challenges alongside step-by-step solutions. You'll also learn how to understand and leverage the psychology and motivations of your staff in order to fully implement safety practices and procedures. In short, with this book as your guide, you will be equipped and ready to lead your staff to safety.
E-Health and Telemedicine: Concepts, Methodologies, Tools, and Applications-Management Association, Information Resources 2015-09-23 Advances in medical technology increase both the efficacy and efficiency of medical practice, and mobile technologies enable modern doctors and nurses to treat patients remotely from anywhere in the world. This technology raises issues of quality of care and medical ethics, which must be addressed. E-Health and Telemedicine: Concepts, Methodologies, Tools, and Applications explores recent advances in mobile medicine and how this technology impacts modern medical care. Three volumes of comprehensive coverage on crucial topics in wireless technologies for enhanced medical care make this multi-volume publication a critical reference source for doctors, nurse practitioners, hospital administrators, and researchers and academics in all areas of the medical field. This seminal publication features comprehensive chapters on all aspects of e-health and telemedicine, including implementation strategies; use cases in cardiology, infectious diseases, and cytology, among others; care of individuals with autism spectrum disorders; and medical image analysis.
Physical Management for Neurological Conditions E-Book-Maria Stokes 2011-04-19 The third edition of this popular textbook - formerly Physical Management in Neurological Rehabilitation and now renamed Physical Management for Neurological Conditions - maintains its scientific and research base with extensive use of references and case studies. It is the only book for physiotherapists that offers a comprehensive overview of the basic principles of neurological rehabilitation, specific neurological / neuromuscular conditions and the related physiotherapy treatment approaches used. Important areas which feature throughout are discussed in relation to the different neurological conditions and include: a non-prescriptive, multidisciplinary, problem-solving approach to patient management involvement of the patient and carer in goal-setting and decision-making (client-centred practice) use of outcome measures to evaluate the effects of treatment in everyday practice use of case studies to illustrate clinical practice scientific evidence of treatment effectiveness Additional specialist editor – Dr Emma Stack Refined content but with the inclusion of 4 brand new chapters: an introductory chapter on rehabilitation in practice one on respiratory management and two covering self management and falls under the section entitled Skill Acquisition and Learning 11 new expert contributors join the reduced contributor team of 31
Safety Differently-Sidney Dekker 2014-06-23 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
Lees' Loss Prevention in the Process Industries-Frank Lees 2012-11-05 Safety in the process industries is critical for those who work with chemicals and hazardous substances or processes. The field of loss prevention is, and continues to be, of supreme importance to countless companies, municipalities and governments around the world, and Lees’ is a detailed reference to defending against hazards. Recognized as the standard work for chemical and process engineering safety professionals, it provides the most complete collection of information on the theory, practice, design elements, equipment, regulations and laws covering the field of process safety. An entire library of alternative books

(and cross-referencing systems) would be needed to replace or improve upon it, but everything of importance to safety professionals, engineers and managers can be found in this all-encompassing three volume reference instead. The process safety encyclopedia, trusted worldwide for over 30 years Now available in print and online, to aid searchability and portability Over 3,600 print pages cover the full scope of process safety and loss prevention, compiling theory, practice, standards, legislation, case studies and lessons learned in one resource as opposed to multiple sources

Command and Control-Eric Schlosser 2014 Presents a minute-by-minute account of an H-bomb accident that nearly caused a nuclear disaster, examining other near misses and America's growing susceptibility to a catastrophic event.

HBR's 10 Must Reads on Making Smart Decisions (with featured article "Before You Make That Big Decision..." by Daniel Kahneman, Dan Lovallo, and Olivier Sibony)-Harvard Business Review 2013-03-05 Learn why bad decisions happen to good managers—and how to make better ones. If you read nothing else on decision making, read these 10 articles. We've combed through hundreds of articles in the Harvard Business Review archive and selected the most important ones to help you and your organization make better choices and avoid common traps. Leading experts such as Ram Charan, Michael Mankins, and Thomas Davenport provide the insights and advice you need to: Make bold decisions that challenge the status quo Support your decisions with diverse data Evaluate risks and benefits with equal rigor Check for faulty cause-and-effect reasoning Test your decisions with experiments Foster and address constructive criticism Defeat indecisiveness with clear accountability

Refurbishing Occupied Buildings-Bev Nutt 1998 A significant proportion of the construction industry is currently involved with the refurbishment of occupied premises. This easy and concise reference guide aims to assist clients, planning supervisors, designers and contractors in this area to be aware of their obligations under the existing regulations. Based around the CDM regulations, it draws information from Health and Safety Executive data and case study research to develop a profile of construction activities which will enable readers to identify and prioritise significant health and safety risks during the refurbishment of occupied buildings.

How Could This Happen?-Jan U. Hagen 2018-07-26 The first comprehensive reference work on error management, blending the latest thinking with state of the art industry practice on how organizations can learn from mistakes. Even today the reality of error management in some organizations is simple: "Don't make mistakes. And if you do, you're on your own unless you can blame someone else." In most, it has moved on but it is still often centered around quality control, with Six Sigma Black Belts seeking to eradicate errors with an unattainable goal of zero. But the best organizations have gone further. They understand that mistakes happen, be they systemic or human. They have realized that rather than being stigmatized, errors have to be openly discussed, analyzed, and used as a source for learning. In How Could This Happen? Jan Hagen collects insights from the leading academics in this field – covering the prerequisites for error reporting, such as psychological safety, organizational learning and innovation, safety management systems, and the influence of senior leadership behavior on the reporting climate. This research is complemented by contributions from practitioners who write about their professional experiences of error management. They provide not only ideas for implementation but also offer an inside view of highly demanding work environments, such as flight operations in the military and operating nuclear submarines. Every organization makes mistakes. Not every organization learns from them. It's the job of leaders to create the culture and processes that enable that to happen. Hagen and his team show you how.

Operational Risk Management-Ariane Chapelle 2019-02-04 OpRisk Awards 2020 Book of the Year Winner! The Authoritative Guide to the Best Practices in Operational Risk Management Operational Risk Management offers a comprehensive guide that contains a review of the most up-to-date and effective operational risk management practices in the financial services industry. The book provides an essential overview of the current methods and best practices applied in financial companies and also contains advanced tools and techniques developed by the most mature firms in the field. The author explores the range of operational risks such as information security, fraud or reputation damage and details how to put in place an effective program based on the four main risk management activities: risk identification, risk assessment, risk mitigation and risk monitoring. The book also examines some specific types of operational risks that rank high on many firms' risk registers. Drawing on the author's extensive experience working with and advising financial companies, Operational Risk Management is written both for those new to the discipline and for experienced operational risk managers who want to strengthen and consolidate their knowledge.

Severe Acute Maternal Morbidity-Arulmozhi Ramarajan 2011-11-01 Severe Acute Maternal Morbidity presents a collection of cases describing various conditions in obstetrics and gynaecology that can result in maternal morbidity. The book begins with an overview of severe acute maternal morbidity - incidence, issues and challenges in diagnosis, standard of care, near miss audit, communication and medico-legal implications. The following chapters discuss different obstetric conditions, including haemorrhage, hypertension and eclampsia, sepsis, obstructed labour and embolism.

Improving the Continued Airworthiness of Civil Aircraft-National Research Council 1998-09-11 As part of the national effort to improve aviation safety, the Federal Aviation Administration (FAA) chartered the National Research Council to examine and recommend improvements in the aircraft certification process currently used by the FAA, manufacturers, and operators.

A Physician's Guide to Pain and Symptom Management in Cancer Patients-Janet L. Abrahm 2015-01-01 This comprehensive guide to managing pain and other symptoms for people with cancer has helped tens of thousands of patients and families. Designed for busy practicing clinicians, A Physician's Guide to Pain and Symptom Management in Cancer Patients provides primary care physicians, advanced practice nurses, internists, and oncologists with detailed information and advice for alleviating the stress and pain of patients and family members alike. Drawing on the work of experts who have developed revolutionary approaches to symptom management and palliative care, as well as on the lessons learned from patients and their families during her thirty years as a teacher and clinician, Dr. Janet L. Abrahm shows how physicians and other caregivers can help patients and families heal emotionally even as the disease progresses. The third edition includes updates to medications and clinical stories, and features two new chapters: "Working with Patients' Families" and "Sexuality, Intimacy, and Cancer." New lessons from palliative care and hospice care can help patients, their professional caregivers, and their families support each other every step of the way.

Vignettes in Patient Safety-Stanislaw P. Stawicki 2018-09-05 Over the past decade it has been increasingly recognized that medical errors constitute an important determinant of patient safety, quality of care, and clinical outcomes. Such errors are both directly and indirectly responsible for unnecessary and potentially preventable morbidity and/or mortality across our healthcare institutions. The spectrum of contributing variables or "root causes" - ranging from minor errors that escalate, poor teamwork and/or communication, and lapses in appropriate protocols and processes (just to name a few) - is both extensive and heterogeneous. Moreover, effective solutions are few, and many have only recently been described. As our healthcare systems mature and their focus on patient safety solidifies, a growing body of research and experiences emerges to help provide an organized framework for continuous process improvement. Such a paradigm - based on best practices and evidence-based medical principles- sets the stage for hardwiring "the right things to do" into our institutional patient care matrix. Based on the tremendous interest in the first two volumes of The Vignettes in Patient Safety series, this third volume follows a similar model of case-based learning. Our goal is to share clinically relevant, practical knowledge that approximates experiences that busy practicing clinicians can relate to. Then, by using evidence-based approaches to present contemporary literature and potential contributing factors and solutions to various commonly encountered clinical patient safety scenarios, we hope to give our readers the tools to help prevent similar occurrences in the future. In outlining some of the best practices and structured experiences, and highlighting the scope of the problem, the authors and editors can hopefully lend some insights into how we can make healthcare experiences for our patients safer.

Macondo Well Deepwater Horizon Blowout-National Research Council 2012-03-02 The blowout of the Macondo well on April 20, 2010, led to enormous consequences for the individuals involved in the drilling operations, and for their families. Eleven workers on the Deepwater Horizon drilling rig lost their lives and 16 others were seriously injured. There were also enormous consequences for the companies involved in the drilling operations, to the Gulf of Mexico environment, and to the economy of the region and beyond. The flow continued for nearly 3 months before the well could be completely killed, during which time, nearly 5 million barrels of oil spilled into the gulf. Macondo Well-Deepwater Horizon Blowout examines the causes of the blowout and provides a series of recommendations, for both the oil and gas industry and government regulators, intended to reduce the likelihood and impact of any future losses of well control during offshore drilling. According to this report, companies involved in offshore drilling should take a "system safety" approach to anticipating and managing possible dangers at every level of operation -- from ensuring the integrity of wells to designing blowout preventers that function under all foreseeable conditions-- in order to reduce the risk of another accident as catastrophic as the Deepwater Horizon explosion and oil spill. In addition, an enhanced regulatory approach should combine strong industry safety goals with mandatory oversight at critical points during drilling operations. Macondo Well-Deepwater Horizon Blowout discusses ultimate responsibility and accountability for well integrity and safety of offshore equipment, formal system safety education and training of personnel engaged in offshore drilling, and guidelines that should be established so that well designs incorporate protection against the various credible risks associated with the drilling and abandonment process. This book will be of interest to professionals in the oil and gas industry, government decision makers, environmental advocacy groups, and others who seek an understanding of the processes involved in order to ensure safety in undertakings of this nature.

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