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# Root Cause Analysis Course Online

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Designing and Implementing Multimodal Curricula and Programs

Knowledge Solutions

Safety Culture

Communities in Action

The PROACT® Root Cause Analysis

Basic Methods of Policy Analysis and Planning -- Pearson eText

Accident Precursor Analysis and Management

Six Sigma Green Belt Certification Project

The Next Generation of Solution Focused Practice

Making Healthcare Safe

Root Cause Analysis

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Collapse of I-35W Highway Bridge, Minneapolis, Minnesota, August 1, 2007

Lean Kaizen

Root Cause Failure Analysis

The PROACT® Root Cause Analysis

Root Cause Analysis Handbook

The Department of Homeland Security's R & D Budget Priorities for Fiscal Year 2009

Hazardous Materials Transportation Incident Data for Root Cause Analysis

The ASQ Certified Quality Improvement Associate Handbook

Exemplars of Assessment in Higher Education

Root Cause Analysis

The ASQ Certified Manager of Quality/Organizational Excellence Handbook

Apollo Root Cause Analysis

Root Cause Analysis and Improvement in the Healthcare Sector

Root Cause Analysis

Root Cause Analysis, Second Edition

Pharmaceutical Practice

The Agile Self-assessment Game

Unifying the Applications and Foundations of Biomedical and Health Informatics

Winning the Battle Within

Root Cause Analysis, Second Edition

The Quality Toolbox

Root Cause Analysis Handbook

TRIZ - The Theory of Inventive Problem Solving

The Theory of the Business (Harvard Business Review Classics)

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The ASQ Quality Improvement Pocket Guide

Healthcare organizations and professionals have long needed a straightforward workbook to facilitate the process of root cause analysis (RCA). While other industries employ the RCA tools liberally and train facilitators thoroughly, healthcare has lagged in establishing and resourcing a quality culture. Presently, a growing number of third-party stakeholders are holding access to accreditation and reimbursement pending demonstration of a full response to events outside of expected practice. An increasing number of exceptions to healthcare practice have precipitated a strong response advocating the use of proven quality tools in the industry. In addition, the industry has now expanded its scope beyond the hospital walls to many ancillary healthcare facilities with little experience in implementing quality tools. This book responds to the demand for a RCA workbook written specifically for healthcare, yet still broad in its definition of the industry. This book contains everything that the typical RCA leader in healthcare requires: A text specific to healthcare, but using the broadest definition of the industry to include not only acute care hospitals, but rehabilitation facilities, long-term care facilities, outpatient surgery centers, ambulatory services, and general office practices. A workbook-style format that walks through the process, step-by-step. Straightforward text without “sidebars,” “tables,” and “tips.” Worksheets are provided at the end of the book to reduce reader distraction within the text. A wide range of real-world examples. Format for use by the most naive of users and most basic of processes, as well as a separate section for more advanced users or more complex issues. Templates, both print and electronic,

included for the reader’s use. Ready-to-use educational materials with scripting to enable the user to train others and garner support for the use of the techniques. Background text for users in leadership to understand the tools in the larger context of healthcare improvement. Up-to-date information on the latest in the use of RCA in satisfying mandatory reporting requirements and slaying the myth that the process is onerous and fraught with barriers. Background text and tools/process are separated to facilitate the readers’ specific needs. Healthcare leaders can appreciate the current context and requirements without wading through the actual techniques; end-users can begin learning the skills without wading through dense administrative text. Language and tone promoting the use of the tools for improvement of processes that have experienced exceptions, as opposed to assigning blame for errors. Attention to process ownership, training, and resourcing. And, most importantly, thorough description of the improvement process as well as the analysis.

[Designing and Implementing Multimodal Curricula and Programs](#) CRC Press

The Next Generation of Solution Focused Practice shows how practitioners help create change by ‘stretching the world’ of their clients. The book brings new ideas from enactive cognition which show how skilled attention on the client and their words is important both practically and conceptually. It provides both a summary of the development of Solution Focused Brief Therapy (SFBT) over time and how the latest developments form a newly coherent form of practice based on developing descriptions. The author has structured the book using simple and easy to understand metaphors to paint a rich,

creative, and visual picture of therapy for the reader, which makes it an accessible read. This book will be of interest to a wide range of SF practitioners internationally, as well as to those involved in coaching, counselling, family therapy, education, social work, healthcare and organisational change.

*Knowledge Solutions Root Cause Analysis, Second Edition*

This pocket guide is designed to be a quick, on-the-job reference for anyone interested in making their workplace more effective and efficient. It will provide a solid initial overview of what "quality" is and how it could impact you and your organization. Use it to compare how you and your organization are doing things, and to see whether what's described in the guide might be useful. The tools of quality described herein are universal. People across the world need to find better, more effective ways to improve the creation and performance of products and services. Since organizational and process improvement is increasingly integrated into all areas of an organization, everyone must understand the basic principles of process control and process improvement. This succinct and concentrated guide can help. Unlike any other pocket guide on the market, included throughout are direct links to numerous free online resources that not only go deeper but also to show these concepts and tools in action: case studies, articles, webcasts, templates, tutorials, examples from the ASQ Service Division's Service Quality Body of Knowledge (SQBOK), and much more. This pocket guide serves as a gateway into the wealth of peerless content that ASQ offers.

[Safety Culture](#) Springer

This unique and engaging open access

title provides a compelling and groundbreaking account of the patient safety movement in the United States, told from the perspective of one of its most prominent leaders, and arguably the movement's founder, Lucian L. Leape, MD. Covering the growth of the field from the late 1980s to 2015, Dr. Leape details the developments, actors, organizations, research, and policy-making activities that marked the evolution and major advances of patient safety in this time span. In addition, and perhaps most importantly, this book not only comprehensively details how and why human and systems errors too often occur in the process of providing health care, it also promotes an in-depth understanding of the principles and practices of patient safety, including how they were influenced by today's modern safety sciences and systems theory and design. Indeed, the book emphasizes how the growing awareness of systems-design thinking and the self-education and commitment to improving patient safety, by not only Dr. Leape but a wide range of other clinicians and health executives from both the private and public sectors, all converged to drive forward the patient safety movement in the US. *Making Healthcare Safe* is divided into four parts: I. In the *Beginning* describes the research and theory that defined patient safety and the early initiatives to enhance it. II. *Institutional Responses* tells the stories of the efforts of the major organizations that began to apply the new concepts and make patient safety a reality. Most of these stories have not been previously told, so this account becomes their histories as well. III. *Getting to Work* provides in-depth analyses of four key issues that cut across disciplinary lines impacting patient safety which required

special attention. IV. Creating a Culture of Safety looks to the future, marshalling the best thinking about what it will take to achieve the safe care we all deserve. Captivatingly written with an “insider’s” tone and a major contribution to the clinical literature, this title will be of immense value to health care professionals, to students in a range of academic disciplines, to medical trainees, to health administrators, to policymakers and even to lay readers with an interest in patient safety and in the critical quest to create safe care.

*Communities in Action* Springer Nature  
The purpose of this book is to share what the author has learned about effective problem solving by exposing the ineffectiveness of conventional wisdom and presenting a principle-based alternative called Apollo Root Cause Analysis that is robust, yet familiar and easy to understand. This book will change the way readers understand the world without changing their minds. One of the most common responses the author has received from his students of Apollo Root Cause Analysis is they have always thought this way, but did not know how to express it. Other students have reported a phenomenon where this material fundamentally re-wires their thinking, leading to a deeply profound understanding of our world. At the heart of this book is a new way of communicating that is revolutionizing the way people all around the world think, communicate, and make decisions together. Imagine a next decision-making meeting where everyone is in agreement with the causes of the problem and the effectiveness of the proposed corrective actions with no conflicts, arguments, or power politics! This is the promise of Apollo Root Cause Analysis.

*The PROACT® Root Cause Analysis*  
Elsevier Health Sciences

The work presented here is generally intended for engineers, educators at all levels, industrialists, managers, researchers and political representatives. Offering a snapshot of various types of research conducted within the field of TRIZ in France, it represents a unique resource. It has been two decades since the TRIZ theory originating in Russia spread across the world. Every continent adopted it in a different manner – sometimes by glorifying its potential and its perspectives (the American way); sometimes by viewing it with mistrust and suspicion (the European way); and sometimes by adopting it as-is, without questioning it further (the Asian way). However, none of these models of adoption truly succeeded. Today, an assessment of TRIZ practices in education, industry and research is necessary. TRIZ has expanded to many different scientific disciplines and has allowed young researchers to reexamine the state of research in their field. To this end, a call was sent out to all known francophone research laboratories producing regular research about TRIZ. Eleven of them agreed to send one or more of their postdoctoral researchers to present their work during a seminar, regardless of the maturity or completeness of their efforts. It was followed by this book project, presenting one chapter for every current thesis in order to reveal the breadth, the richness and the perspectives that research about the TRIZ theory could offer our society. The topics dealt with e.g. the development of new methods inspired by TRIZ, educational practices, and measuring team impact.

Basic Methods of Policy Analysis and

Planning -- Pearson eText National Academies Press

This book presents a proven system designed for investigating, categorizing, and ultimately eliminating root causes of incidents with safety, health, environmental, quality, reliability, and production-process impacts. Defined as a tool to help investigators describe what happened, to determine how it happened, and to understand why it happened, the Root Cause Analysis System enables businesses to generate specific, concrete recommendations for preventing incident recurrences.

**Accident Precursor Analysis and Management** Quality Press

Root Cause Analysis, Second Edition Quality Press

Six Sigma Green Belt Certification

Project Ben Linders Publishing

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

*The Next Generation of Solution Focused Practice* Rothstein Publishing

The Agile Self-Assessment Game is used by teams and organizations to self-assess their agility. Playing the game enables teams to reflect on their own team interworking, discover how agile they are and decide what they can do to increase their agility to deliver more value to their customers and stakeholders. This is the first book specifically about Agile Self-assessments. In this book, Ben Linders explains what self-assessments are and why you would do them, and explores how to do them using the Agile Self-assessment Game. He's also sharing experience stories from people who played the game. This book is based on his experience as a developer, tester, team leader, project manager, quality manager, process manager, consultant,

coach, trainer, and adviser in Agile, Lean, Quality and Continuous Improvement. It takes a deep dive into self-assessments, viewing them from different perspectives and provides ideas, suggestions, practices, and experiences that will help you to do effective agile self-assessments with your teams. The book is aimed at Scrum masters, agile coaches, consultants leading agile transformations, developers and testers, project managers, line managers, and CxOs; basically for anyone who is looking for an effective way to help their agile teams improve and to increase the agility of their organization. With plenty of ideas, suggestions, and practical cases on Agile Self-assessments, this book will help you to apply assessments and help teams to improve. Note: The agile coaching cards needed to play the games described in the book can be downloaded for a nominal fee at [benlinders.com/downloads](http://benlinders.com/downloads).

[Making Healthcare Safe](#) Springer  
Peter F. Drucker argues that what underlies the current malaise of so many large and successful organizations worldwide is that their theory of the business no longer works. The story is a familiar one: a company that was a superstar only yesterday finds itself stagnating and frustrated, in trouble and, often, in a seemingly unmanageable crisis. The root cause of nearly every one of these crises is not that things are being done poorly. It is not even that the wrong things are being done. Indeed, in most cases, the right things are being done—but fruitlessly. What accounts for this apparent paradox? The assumptions on which the organization has been built and is being run no longer fit reality. These are the assumptions that shape any

organization's behavior, dictate its decisions about what to do and what not to do, and define what an organization considers meaningful results. These assumptions are what Drucker calls a company's theory of the business. The Harvard Business Review Classics series offers you the opportunity to make seminal Harvard Business Review articles a part of your permanent management library. Each highly readable volume contains a groundbreaking idea that continues to shape best practices and inspire countless managers around the world—and will have a direct impact on you today and for years to come.

**Root Cause Analysis** CRC Press  
I-35 Minneapolis Bridge (2007).

**TapRoot** Routledge

This best-seller can help anyone whose role is to try to find specific causes for failures. It provides detailed steps for solving problems, focusing more heavily on the analytical process involved in finding the actual causes of problems. It does this using figures, diagrams, and tools useful for helping to make our thinking visible. This increases our ability to see what is truly significant and to better identify errors in our thinking. In the sections on finding root causes, this second edition now includes: more examples on the use of multi-vari charts; how thought experiments can help guide data interpretation; how to enhance the value of the data collection process; cautions for analyzing data; and what to do if one can't find the causes. In its guidance on solution identification, biomimicry and TRIZ have been added as potential solution identification techniques. In addition, the appendices have been revised to include: an expanded breakdown of the 7 M's, which includes more than 50 specific possible

causes; forms for tracking causes and solutions, which can help maintain alignment of actions; techniques for how to enhance the interview process; and example responses to problem situations that the reader can analyze for appropriateness.

**Collapse of I-35W Highway Bridge, Minneapolis, Minnesota, August 1, 2007** Quality Press

This volume presents a comprehensive overview of multimodal approaches to curriculum and programmatic implementation across a diverse range of teaching environments and across geographic and cultural boundaries. Featuring contributions from scholars within and across both disciplines, the book examines the ways in which new technologies link to expanding definitions of literacy and, building on this, how multimodal approaches might most effectively address the unique opportunities and challenges instructors face in contemporary classrooms and professional development programs. Chapters draw on case studies from both existing scholarship and findings from the authors' own experiences in practice, including examples from writing, rhetoric, and composition courses, open online learning courses, and interdisciplinary faculty training programs. The final section of the book showcases how the conversation might be further extended to address increasingly multilingual classrooms by exploring how multimodality has been implemented in transnational settings. Engaging with key questions at the intersection of programmatic and curricular development and multimodal studies, this book is a fundamental resource for graduate students and scholars in multimodality, rhetoric studies, language education, applied

linguistics, and communication studies.

Lean Kaizen Routledge

Intro / prep handbook on basics of the quality field / its philosophies for ASQE's CQIA (Certified Quality Improvement Associate) certification exam.

Root Cause Failure Analysis Routledge

The Quality Toolbox is a comprehensive reference to a variety of methods and techniques: those most commonly used for quality improvement, many less commonly used, and some created by the author and not available elsewhere. The reader will find the widely used seven basic quality control tools (for example, fishbone diagram, and Pareto chart) as well as the newer management and planning tools. Tools are included for generating and organizing ideas, evaluating ideas, analyzing processes, determining root causes, planning, and basic data-handling and statistics. The book is written and organized to be as simple as possible to use so that anyone can find and learn new tools without a teacher. Above all, this is an instruction book. The reader can learn new tools or, for familiar tools, discover new variations or applications. It also is a reference book, organized so that a half-remembered tool can be found and reviewed easily, and the right tool to solve a particular problem or achieve a specific goal can be quickly identified. With this book close at hand, a quality improvement team becomes capable of more efficient and effective work with less assistance from a trained quality consultant. Quality and training professionals also will find it a handy reference and quick way to expand their repertoire of tools, techniques, applications, and tricks. For this second edition, Tague added 34 tools and 18 variations. The "Quality Improvement Stories" chapter has been expanded to

include detailed case studies from three Baldrige Award winners. An entirely new chapter, "Mega-Tools: Quality Management Systems," puts the tools into two contexts: the historical evolution of quality improvement and the quality management systems within which the tools are used. This edition liberally uses icons with each tool description to reinforce for the reader what kind of tool it is and where it is used within the improvement process.

**The PROACT® Root Cause Analysis**  
Quality Press

Root Cause Analysis, or RCA, "What is it?" Everyone uses the term, but everyone does it differently. How can we have any uniformity in our approach, much less accurately compare our results, if we're applying different definitions? At a high level, we will explain the difference between RCA and Shallow Cause Analysis, because that is the difference between allowing a failure to recur or dramatically reducing the risk of recurrence. In this book, we will get down to basics about RCA, the fundamentals of blocking and tackling, and explain the common steps of any investigative occupation. Common investigation steps include: Preserving evidence (data)/not allowing hearsay to fly as fact Organizing an appropriate team/minimizing potential bias Analyzing the events/reconstructing the incident based on actual evidence Communicating findings and recommendations/ensuring effective recommendations are actually developed and implemented Tracking bottom-line results/ensuring that identified, meaningful metrics were attained We explore, "Why don't things always go as planned?" When our actual plans deviate from our intended plans, we usually experience some type of

undesirable or unintended outcome. We analyze the anatomy of a failure (undesirable outcome) and provide a step-by-step guide to conducting a comprehensive RCA based on our 3+ decades of applying RCA as we have successfully practiced it in the field. This book is written as a how-to guide to effectively apply the PROACT(R) RCA methodology to any undesirable outcome, is directed at practitioners who have to do the real work, focuses on the core elements of any investigation, and provides a field-proven case as a model for effective application. This book is for anyone charged with having a thorough understanding of why something went wrong, such as those in EH&S, maintenance, reliability, quality, engineering, and operations to name just a few.

**Root Cause Analysis Handbook**  
Elsevier

To compete successfully in today's economy, organizations need to be as good as or better than their global competitors. This goes not only for quality, but also for costs and cycle times (lead time, processing time, delivery time, set-up time, response time, etc.). Lean addresses these needs in its emphasis on teamwork, continuous training and learning, produce to demand ("pull"), mass customization and batch size reduction, cellular flow, quick changeover, and total productive maintenance. Originally applied in manufacturing settings, lean has now migrated to non-shop floor activities: in business support functions, such as sales, customer service, accounting, human resources, engineering, purchasing; within manufacturing firms; and also in purely service areas like finance, government, and healthcare. The intended audience for this book is

any quality or operational professional who wants to start their lean journey or enhance their career opportunities. After introducing the concepts of lean and kaizen, various building blocks of a lean enterprise are described. After reading this book, any reader will have a foundation of what is understood today as "lean." All the examples of kaizens presented in the book are from the authors' experience associated with real lean transformations. In addition, the forms, figures, and checklists included as part of this book and also on the accompanying CD-ROM can be customized and used in the readers' own lean journey when they perform kaizens.

COMMENTS FROM OTHER CUSTOMERS  
Average Customer Rating: (4 of 5 based on 1 review) "This book gives a great introduction to kaizen, along with a sensible "how to" and several case studies across various industries, including for non-manufacturing applications. It also gives a good introduction to Lean in general, and it places enough emphasis on the "human side" of implementing Lean so that the reader walks away with an understanding that the Lean tools may be fairly simple but the implementation of them requires special attention to human nature and the associated challenges. It is easy to read and comprehend. Plenty of pictures and samples are provided. This could easily be used as a training tool for employees who will be serving on kaizen teams." A reader in Bradenton, Florida

**The Department of Homeland Security's R & D Budget Priorities for Fiscal Year 2009** Quality Press  
Don't jump from problem to solution without first investigating root causes. This book helps you more accurately focus on school improvement issues, so

you can avoid wasting precious time and resources. It is clearly written, contains lots of real examples, and is presented in a style and format designed for the non-expert. It will help you make decisions which will improve learning for all students.

Hazardous Materials Transportation Incident Data for Root Cause Analysis  
Taylor & Francis

This handbook is a comprehensive reference designed to help professionals address organizational issues from the application of the basic principles of management to the development of strategies needed to deal with today's technological and societal concerns. The fifth edition of the ASQ Certified Manager of Quality/Organizational Excellence Handbook (CMQ/OE) has undergone some significant content changes in order to provide more clarity regarding the items in the body of knowledge (BoK). Examples have been updated to reflect more current perspectives, and new topics introduced in the most recent BoK are included as well. This handbook addresses: Historical perspectives relating to the continued improvement of specific aspects of quality management Key principles, concepts, and terminology Benefits associated with the application of key concepts and quality management principles Best practices describing recognized approaches for good quality management Barriers to success, common problems you may encounter, and reasons why some quality initiatives fail Guidance for preparation to take the CMQ/OE examination A well-organized reference, this handbook will certainly help individuals prepare for the ASQ CMQ/OE exam. It also serves as a practical, day-to-day guide for any professional facing various quality

management challenges. About the Editors Sandra L. Furterer is an Associate Professor and Department Chair at the University of Dayton in the Department of Engineering Management, Systems, and Technology. She is an ASQ Certified Manager of Quality/Organizational Excellence, an ASQ Certified Six Sigma Black Belt, an ASQ Certified Quality

Engineer, an ASQ fellow, and a certified Six Sigma Master Black Belt. Douglas C. Wood is President of DC Wood Consulting, LLC and instructor for ASQ. He is an ASQ Certified Manager of Quality/Organizational Excellence, an ASQ Certified Six Sigma Black Belt, an ASQ Certified Quality Engineer, and an ASQ Certified Quality Auditor.

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