

Sharp End



Sharp End

Charles Waterton



Sharp End:

The Sharp End David Drake, 1993-11-01 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 **The Field Guide to Understanding**

Human Error Sidney Dekker, 2013-03-28 When faced with a human error problem you may be tempted to ask Why didn t they watch out better How could they not have noticed You think you can solve your human error problem by telling people to be more careful by reprimanding the miscreants by issuing a new rule or procedure These are all expressions of The Bad Apple Theory where you believe your system is basically safe if it were not for those few unreliable people in it This old view of human error is increasingly outdated and will lead you nowhere The new view in contrast understands that a human error problem is actually an organizational problem Finding a human error by any other name or by any other human is only the beginning of your journey not a convenient conclusion The new view recognizes that systems are inherent trade offs between safety and other pressures for example production People need to create safety through practice at all levels of an organization Breaking new ground beyond its successful predecessor The Field Guide to Understanding Human Error guides you through the traps and misconceptions of the old view It explains how to avoid the hindsight bias to zoom out from the people closest in time and place to the mishap and resist the temptation of counterfactual reasoning and judgmental language But it also helps you look forward It suggests how to apply the new view in building your safety department handling questions about accountability and constructing meaningful countermeasures It even helps you in getting your organization to adopt the new view and improve its learning from failure So if you are faced by a human error problem abandon the fallacy of a quick fix Read this book **Iconic Restaurants of Columbia, Missouri** Kerri Linder, 2018-11-26

Columbia s culinary history is chock full of restaurants that not only satisfied appetites but also provided gathering places to build community Gentry s Tavern served wild game along the Boonslick Trail Hungry and broke students could grab a meal on credit from Ralph Morris at the Ever Eat Caf during the Depression During and after World War II Ambrose s Caf required students to give up their seats to men in uniform Segregation didn t stop Annie Fisher from making her fortune serving her famous beaten biscuits These stories and more are as rich as the cinnamon rolls served at Breisch s Join Columbia native Kerri Linder as she shares the stories and memories wrapped around the food of Columbia s iconic restaurants

Knowledge Management in Healthcare Lorri Zipperer, 2016-04-22 Knowledge management goes beyond data and information capture in computerized health records and ordering systems it seeks to leverage the experiences of all who interact in healthcare to enhance care delivery teamwork and organizational learning Knowledge management if envisioned thoughtfully takes a systemic approach to implementation that includes the embodiment of a learning culture Knowledge is

then used to support that culture and the knowledge workers within it to encourage them to share what they know thusly enabling their peers their organizations and ultimately their patients to benefit from their experience to proactively dismantle hierarchy and encourage sharing about what works and what doesn't to focus efforts on improvement Knowledge Management in Healthcare draws on relevant business clinical and health administration literature plus the analysis of discussions with a variety of clinical administrative leadership patient and information experts The result is a book that will inform thinking on knowledge access needs to mitigate potential failures design lasting improvements and support the sharing of what is known to enable work towards attaining high reliability It can be used as a general tool for leaders and individuals wishing to devise and implement a knowledge sharing culture in their institution design innovative activities supporting transparency and communication to strengthen existing programs intended to enhance knowledge sharing behaviours and contribute to high quality safe care

Safety-I and Safety-II Erik Hollnagel, 2018-04-17 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 theoret

Pharmaceutical Care Calvin H. Knowlton, Richard P. Penna, 2003 A collaboration of professional leaders thinkers and seasoned authors introduces the concept of pharmaceutical care a model of health care practice by which pharmacy practitioners and other medical professionals can improve the drug use process and ensure that patients receive full benefit from pharmacotherapy

The Sharp End John Ellis, 1980 In any army it is only a minority of men who end up as combat soldiers at the sharp end

where they have to shoot and be shot at but it is their experiences that are the most intense and reveal most directly what war is actually like John Ellis has drawn together the testimony of men who fought with the British Commonwealth and American armies in all theaters of World War II from Western Europe to Burma and from North Africa to the Pacific He uses these eyewitness accounts to explain how they were trained the different landscapes and climates in which they fought their attitudes and aspirations how they relaxed when they were out of the line and above all how they reacted to the experience of battle

Human Error in Medicine Marilyn Sue Bogner, 2018-02-06 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

Safety at the Sharp End Rhona Flin, Paul O'Connor, 2017-05-15 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 Behind Human Error Dr Leila Johannesen, Dr Nadine Sarter, Dr Richard Cook, Professor Sidney Dekker, Professor David D Woods, 2012-10-01 Human error is so often cited as a cause of accidents There is perception of a human error problem Solutions are thought to lie in changing the people or their role The label human error however is prejudicial and hides more than it reveals about how a system malfunctions This book takes you behind the label It explains how human error results from social and psychological judgments by the system's stakeholders that focus only on one facet of a set of interacting contributors

Risk Management Handbook for Health Care Organizations, 3 Volume Set, 2011-01-06 Continuing its superiority in the health care risk management field this sixth edition of The Risk Management Handbook for Health Care Organizations is written by the key practitioners and consultant in the field It contains more practical chapters and health care examples and additional material on methods and techniques of risk reduction and management It also revises the structure of the previous edition and focuses on operational and organizational structure rather than risk areas and functions The three volumes are written using a practical and user friendly approach *The Field Guide to Understanding 'Human Error'*

Professor Sidney Dekker, 2014-12-28 This latest edition of The Field Guide to Understanding Human Error will help you understand how to move beyond human error how to understand accidents how to do better investigations how to

understand and improve your safety work You will be invited to think creatively and differently about the safety issues you and your organization face In each you will find possibilities for a new language for different concepts and for new leverage points to influence your own thinking and practice as well as that of your colleagues and organization Official Gazette of

the United States Patent and Trademark Office United States. Patent and Trademark Office, 1998 **The Boy's Handy**

Book of Sports, Pastimes, Games and Amusements.., 1863 *Patient Safety* Lorri Zipperer, 2016-05-13 Patient Safety Perspectives on Evidence Information and Knowledge Transfer provides background on the patient safety movement systems safety human error and other key philosophies that support change and innovation in the reduction of medical error The

book draws from multidisciplinary areas within the acute care environment to share models that support the proactive changes necessary to provide safe care delivery The publication discusses how the tenets of safety described in the beginning of the book can be actively applied in the field to make evidence information and knowledge EIK sharing processes reliable effective and safe This is a wide ranging and important book that is designed to raise awareness of the latent risks for patient safety that are present in the EIK identification acquisition and distribution processes structures and systems of many healthcare institutions across the world The expert contributors offer systemic evidence based improvement processes assessment concepts and innovative activities to identify these risks to minimize their potential to adversely impact care These ideas are presented to create opportunities for the field to design and use strategies that enable meaningful implementation and management of EIK Their thoughts will enable healthcare staff to see EIK as a tangible element contributing toward sustainable patient safety improvements

The household encyclopædia; or, Family dictionary of everything connected with housekeeping and domestic medicine, by an association of heads of families and men of science Household encyclopaedia,1858 *High Reliability Organizations, Second Edition* Cynthia A. Oster,Jane S. Braaten,2020-11-02

Patient safety and quality of care are critical concerns of healthcare consumers payers providers organizations health systems and governments Although a strong body of knowledge shows that high reliability methods enable the most efficient safe and effective care these methods have yet to be completely implemented across healthcare According to authors Cynthia Oster and Jane Braaten nurses who are on the frontline of providing safe and effective care are ideally situated to drive high reliability High Reliability Organizations A Healthcare Handbook for Patient Safety Quality Second Edition equips nurses and healthcare professionals with the tools necessary to establish an error detection and prevention system This new edition builds on the foundation of the first book with best practices relevant exemplars and important discussions about cultural aspects essential to sustainability New material focuses on High reliability performance during a pandemic Organizational learning and tiered safety huddles High reliability in infection prevention and ambulatory care The emerging eld of human factors engineering within healthcare Creating a virtual resource toolkit for frontline staff

Essays on Natural History ... Third edition Charles Waterton,1839 **Essays on Natural History, Chiefly Ornithology** Charl Waterton,1844 The Wit and Humor of America, Volume IV. Marshall Pinckney Wilder,

Adopting the Tune of Phrase: An Emotional Symphony within **Sharp End**

In a world used by screens and the ceaseless chatter of quick transmission, the melodic beauty and mental symphony developed by the prepared term often fade into the backdrop, eclipsed by the relentless sound and interruptions that permeate our lives. However, nestled within the pages of **Sharp End** an enchanting fictional prize brimming with raw feelings, lies an immersive symphony waiting to be embraced. Constructed by an outstanding composer of language, that charming masterpiece conducts viewers on an emotional trip, skillfully unraveling the hidden melodies and profound influence resonating within each cautiously crafted phrase. Within the depths of the moving assessment, we can investigate the book is key harmonies, analyze their enthralling writing style, and submit ourselves to the profound resonance that echoes in the depths of readers souls.

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Sharp End Introduction

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