

Set Phasers On Stun And Other True Tales Of Design Technology And Human Error

New Technology and Human Error
The Field Guide to Understanding 'Human Error'
Human-error Reduction and Safety Management
Behind Human Error
Human Error Reduction in Manufacturing
Safety and Human Error in Engineering Systems
Safety, Reliability, Human Factors, and Human Error in Nuclear Power Plants
Ten Questions About Human Error
Human Error in Aviation
Investigating Human Error
Human Error
Experimental Slips and Human Error
Human Error in Medicine
Advances in Human Error, Reliability, Resilience, and Performance
The Story of Human Error
Investigating Human Error
Human Error, Safety and Systems Development
Human Error
Human Reliability and Error in Medical System
Expiated, by the author of 'Six months hence'. Jens Rasmussen Sidney Dekker Dan Petersen Dr Leila Johannesen José Rodríguez-Pérez B.S. Dhillon B.S. Dhillon Sidney Dekker R. Key Dismukes Barry Strauch Gregory Scott Bernard J. Baars Marilyn Sue Bogner Ronald Laurids Boring Joseph Jastrow Barry Strauch Philippe Palanque George A. Peters Balbir S. Dhillon Herman Ludolph Prior

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covers cognitive aspects of human error as well as errors deriving from affective motivational or environmental factors includes a

taxonomic framework that encompasses both the psychological roots of systematic error forms and the local environmental factors which elicit them

when faced with a human error problem you may be tempted to ask why didn't these people watch out better or how can I get my people more engaged in safety you might think you can solve your safety problems by telling your people to be more careful by reprimanding the miscreants by issuing a new rule or procedure and demanding compliance 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 building on its successful predecessors the third edition of the field guide to understanding human error will help you understand a new way of dealing with a perceived human error problem in your organization it will help you trace how your organization juggles inherent trade offs between safety and other pressures and expectations suggesting that you are not the custodian of an already safe system it will encourage you to start looking more closely at the performance that others may still call human error allowing you to discover how your people create safety through practice at all levels of your organization mostly successfully under the pressure of resource constraints and multiple conflicting goals 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 if you are faced with a human error problem abandon the fallacy of a quick fix read this book

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

for many years we considered human errors or mistakes as the cause of mishaps or problems in the manufacturing industries human error under whatever label procedures not followed lack of attention or simply error was the conclusion of any quality problem investigation the way we look at the human side of problems has evolved during the past few decades now we see human errors as the symptoms of deeper causes in other words human errors are consequences not causes the basic objective of this book is to provide readers with useful information on theories methods and specific techniques that can be applied to control human failure it is a book of ideas concepts and

examples from the manufacturing sector it presents a comprehensive overview of the subject focusing on the practical application of the subject specifically on the human side of quality and manufacturing errors in other words the primary focus of this book is human failure including its identification its causes and how it can be reasonably controlled or prevented in the manufacturing industry setting in addition to including a detailed discussion of human error the inadvertent or involuntary component of human failure a chapter is devoted to analysis and discussion related to voluntary intentional noncompliance written in a direct style using simple industry language with abundant applied examples and practical references this book s insights on human failure reduction will improve individual organizational and social well being

in an approach that combines coverage of safety and human error into a single volume safety and human error in engineering systems eliminates the need to consult many different and diverse sources for those who need information about both topics the book begins with an introduction to aspects of safety and human error and a discussion of mathematical concepts that builds understanding of the material presented in subsequent chapters the author describes the methods that can be used to perform safety and human error analysis in engineering systems and includes examples along with their solutions as well as problems to test reader comprehension he presents a total of ten methods considered useful for performing safety and human error analysis in engineering systems the book also covers safety and human error transportation systems medical systems and mining equipment as well as robots and software nowadays engineering systems are an important element of the world economy as each year billions of dollars are spent to develop manufacture and operate various types of engineering systems around the globe a rise in accidental deaths has put the spotlight on the role human error plays in the safety and failure of these systems written by an expert in various aspects of healthcare engineering management design reliability safety and quality this book provides tools and techniques for improving engineering systems with respect to human error and safety

each year billions of dollars are being spent in the area of nuclear power generation to design construct manufacture operate and maintain various types of systems around the globe many times these systems fail due to safety reliability human factors and human error related problems the main objective of this book is to combine nuclear power plant safety reliability human factors and human error into a single volume for those individuals that work closely during the nuclear power plant design phase as well as other phases thus eliminating the need to consult many different and diverse sources in obtaining the desired information

ten questions about human error asks the type of questions frequently posed in incident and accident investigations people s own practice managerial and organizational settings policymaking classrooms crew resource management training and error research it is one

installment in a larger transformation that has begun to identify both deep rooted constraints and new leverage points of views of human factors and system safety the ten questions about human error are not just questions about human error as a phenomenon but also about human factors and system safety as disciplines and where they stand today in asking these questions and sketching the answers to them this book attempts to show where current thinking is limited where vocabulary models ideas and notions are constraining progress this volume looks critically at the answers human factors would typically provide and compares contrasts them with current research insights each chapter provides directions for new ideas and models that could perhaps better cope with the complexity of the problems facing human error today as such this book can be used as a supplement for a variety of human factors courses

most aviation accidents are attributed to human error pilot error especially human error also greatly effects productivity and profitability in his overview of this collection of papers the editor points out that these facts are often misinterpreted as evidence of deficiency on the part of operators involved in accidents human factors research reveals a more accurate and useful perspective the errors made by skilled human operators such as pilots controllers and mechanics are not root causes but symptoms of the way industry operates the papers selected for this volume have strongly influenced modern thinking about why skilled experts make errors and how to make aviation error resilient

in this book the author applies contemporary error theory to the needs of investigators and of anyone attempting to understand why someone made a critical error how that error led to an incident or accident and how to prevent such errors in the future students and investigators of human error will gain an appreciation of the literature on error with numerous references to both scientific research and investigative reports in a wide variety of applications from airplane accidents to bus accidents to bonfire disasters based on the author s extensive experience as an accident investigator and instructor of both aircraft accident investigation techniques and human factors psychology it reviews recent human factors literature summarizes major transportation accidents and shows how to investigate the types of errors that typically occur in high risk industries it presents a model of human error causation influenced largely by james reason and neville moray and relates it to error investigations with step by step guidelines for data collection and analysis that investigators can readily apply as needed this second edition of investigating human error has been brought up to date throughout with pertinent recent accidents and safety literature integrated it features new material on fatigue distraction eg mobile phone and texting and medication use it also now explores the topics of corporate culture safety culture and safety management systems additionally the second edition considers the effects of the reduction in the number of major accidents on investigation quality the consequences of social changes on transportation safety such as drinking and driving cell phone use etc the contemporary role of accident investigation and the effects of the prosecution of those involved in accidents

accidents happen because of the reduction in adaptable capabilities or because inadaptability takes over adaptability is the failure to adapt according to changed circumstances settings or time the occurrence of human errors in manual assembly lines can be affected by factors such as workplace condition work environment equipment and demographics factors another topic explored in this book is forensic science which is concerned with the application of scientific knowledge to legal problem resolution it is a vital tool in any legal proceeding because it helps the judge and the jury to understand scientific truth also human error in medicine is a major threat to patient safety therefore it is vital to reveal factors that cause performance deficits in medical work environments on the basis of the human error sources identified human factors training programs can be designed as one possible approach to preventing accidents and increasing safety human error has been cited as a common cause in disasters and accidents in diverse high risk industries and in healthcare this book focuses on organizational social and individual causes for the development of conditions behind human errors

whereas most humans spend their time trying to get things right psychologists are pervasively dedicated to error errors are extensively used to investigate perception memory and performance some clinicians study errors like tea leaves for clues to unconscious motives and this volume presents the work of researchers who in an excess of perversity actually cause people to make predictable errors in speech and action some reasons for this oddity are clear errors seem to stand at the nexus of many deep psychological questions the very concept of error presupposes a goal or criterion by comparison to which an error is an error and goals bring in the foundation issues of control motivation and volition baars 1987 1988 wiener 1961 errors serve to measure the quality of performance in learning in expert knowledge and in brain damage and other dysfunctional states and by surprising us they often call attention to phenomena we might otherwise take for granted errors also seem to reveal the natural joints in perception language memory and problem solving revealing units that may otherwise be invisible e g mackay 1981 miller 1956 newell simon 1972 treisman gelade 1980

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

this book brings together studies broadly dealing with human error from different disciplines and perspectives they concern human performance human variability and reliability analysis medical driver and pilot error as well as automation error reports on root cause analyses and the cognitive modeling of human error in addition they highlight cutting edge applications in safety management defense security transportation process controls and medicine as well as more traditional fields of application based on the ahfe 2017 international conference on human error reliability resilience and performance held on july 17 21 2017 in los angeles california usa the book includes experimental papers original reviews and reports on case studies as well as meta analyses technical guidelines best practice and methodological papers it offers a timely reference guide for researchers and practitioners dealing with human error in a diverse range of fields p

in this book the author applies contemporary error theory to the needs of investigators and of anyone attempting to understand why someone made a critical error how that error led to an incident or accident and how to prevent such errors in the future students and investigators of human error will gain an appreciation of the literature on error with numerous references to both scientific research and investigative reports in a wide variety of applications from airplane accidents to bus accidents to bonfire disasters based on the author s extensive experience as an accident investigator and instructor of both aircraft accident investigation techniques and human factors psychology it reviews recent human factors literature summarizes major transportation accidents and shows how to investigate the types of errors that typically occur in high risk industries it presents a model of human error causation influenced largely by james reason and

neville moray and relates it to error investigations with step by step guidelines for data collection and analysis that investigators can readily apply as needed this second edition of investigating human error has been brought up to date throughout with pertinent recent accidents and safety literature integrated it features new material on fatigue distraction eg mobile phone and texting and medication use it also now explores the topics of corporate culture safety culture and safety management systems additionally the second edition considers the effects of the reduction in the number of major accidents on investigation quality the consequences of social changes on transportation safety such as drinking and driving cell phone use etc the contemporary role of accident investigation and the effects of the prosecution of those involved in accidents

recent accidents in a range of industries have increased concern over the design development management and control of safety critical systems attention has now focused upon the role of human error both in the development and in the operation of complex processes human error safety and systems development gathers contributions from practitioners and researchers presenting and discussing leading edge techniques that can be used to mitigate the impact of error both system and human on safety critical systems some of these contributions can be easily integrated into existing systems engineering practices while others provide a more theoretical and fundamental perspective on the issues raised by these kinds of interactive systems more precisely the contributions cover the following themes techniques for incident and accident analysis empirical studies of operator behaviour in safety critical systems observational studies of safety critical systems risk assessment techniques for interactive systems safety related interface design development and testing formal description techniques for the design and development of safety critical interactive systems many diverse sectors are covered including but not limited to aviation maritime and the other transportation industries the healthcare industry process and power generation and military applications this volume contains 20 original and significant contributions addressing these critical questions the papers were presented at the 7th ifip working group 13 5 working conference on human error safety and systems development which was held in august 2004 in conjunction with the 18th ifip world computer congress in toulouse france and sponsored by the international federation for information processing ifip

human error is regularly viewed as an inevitable part of everyday life in many cases the results of human error are harmless and correctable but in cases where injury and death can occur reduction of error is imperative an integration of useful how to do it information human error causes and control covers theories methods and specif

human reliability and error have become a very important issue in health care owing to the vast number of associated deaths each year for example according to the findings of the institute of medicine in 1999 around 100000 americans die each year because of human error this

makes human error in health care the eighth leading cause of deaths in the us moreover the total annual national cost of the medical errors is estimated at between 17 billion and 37 6 billion there are very few books on this subject and none of them covers it at a significant depth the need for a book presenting the basics of human reliability human factors and comprehensive information on error in medical systems is essential this book meets that need contents human reliability and error mathematics human factors basics human reliability and error basics methods for performing human reliability and error analysis in health care system human error in medication human error in anesthesia human error in miscellaneous health care areas and health care human error cost human factors in medical devices mathematical models for predicting human reliability and error in medical system health care human error reporting systems and data appendix bibliography literature on human reliability and error in health care readership health care and safety professionals administrators students human factors psychology specialists biomedical engineers and health care researchers

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