

The Field Guide to Understanding 'Human Error'

Sidney Dekker



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T H I R D E D I T I O N

Field Guide To Understanding Human Error

Steven James Landry



Field Guide To Understanding Human Error:

The Field Guide to Understanding Human Error Sidney Dekker, 2017-04-07 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is basically safe if it were not for those few unreliable people in it This old view of human error is increasingly outdated and will lead you nowhere The new view in contrast understands that a human error problem is actually an organizational problem Finding a human error by any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 [The Field Guide to Understanding 'Human Error'](#) Sidney Dekker, 2017-11-01 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 *The Field Guide to Understanding Human Error* Sidney Dekker,2006 The old Bad Apple Theory of human error promotes the idea that a system is basically safe with the exception of a few unreliable people 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 Sidney Dekker presents the view that human error is an organizational problem and suggests how to apply new theories to your organization handling questions about accountability and constructing meaningful countermeasures **The Field Guide to Human Error Investigations** Sidney Dekker,2017-11-01 This title was first published in 2002 This field guide assesses two views of human error the old view in which human error becomes the cause of an incident or accident or the new view in which human error is merely a symptom of deeper trouble within the system The two parts of this guide concentrate on each view leading towards an appreciation of the new view in which human error is the starting point of an investigation rather than its conclusion The second part of this guide focuses on the circumstances which unfold around people which causes their assessments and actions to change accordingly It shows how to reverse engineer human error which like any other component needs to be put back together in a mishap investigation

Behind Human Error David Woods,Sidney Dekker,Richard Cook,Leila Johannesen,Nadine Sarter,2017-09-18 Human error is cited over and over as a cause of incidents and accidents The result is a widespread perception of a human error problem and solutions are thought to lie in changing the people or their role in the system For example we should reduce the human role with more automation or regiment human behavior by stricter monitoring rules or procedures But in practice things have proved not to be this simple The label human error is prejudicial and hides much more than it reveals about how a system functions or malfunctions This book takes you behind the human error label Divided into five parts it begins by summarising the most significant research results Part 2 explores how systems thinking has radically changed our understanding of how accidents occur Part 3 explains the role of cognitive system factors bringing knowledge to bear changing mindset as situations and priorities change and managing goal conflicts in operating safely at the sharp end of systems Part 4 studies how the clumsy use of computer technology can increase the potential for erroneous actions and assessments in many different fields of practice And Part 5 tells how the hindsight bias always enters into attributions of error so that what we label human error actually is the result of a social and psychological judgment process by stakeholders in the system in question to focus on only a facet of a set of interacting contributors If you think you have a human error problem recognize that the label itself is no explanation and no guide to countermeasures The potential for constructive change for progress on safety lies behind the human error label *Handbook of Human Factors in Air Transportation Systems* Steven James Landry,2017-11-22 One of the primary applications of human factors engineering is in the aviation domain and the importance of human factors has never been greater as U S and European authorities seek to modernize the

air transportation system through the introduction of advanced automation This handbook provides regulators practitioners researchers and educators a comprehensive resource for understanding and applying human factors to air transportation

Risk-Based Thinking Tony Muschara,2017-11-13 Society at large tends to misunderstand what safety is all about It is not just the absence of harm When nothing bad happens over a period of time how do you know you are safe In reality safety is what you and your people do moment by moment day by day to protect assets from harm and to control the hazards inherent in your operations This is the purpose of risk based thinking the key element of the six building blocks of Human and Organizational Performance H OP Generally H OP provides a risk based approach to managing human performance in operations But specifically risk based thinking enables foresight and flexibility even when surprised to do what is necessary to protect assets from harm but also achieve mission success despite ongoing stresses or shocks to the operation Although you cannot prepare for every adverse scenario you can be ready for almost anything When risk based thinking is integrated into the DNA of an organization s way of doing business people will be ready for most unexpected situations Eventually safety becomes a core value not a priority to be negotiated with others depending on circumstances This book provides a coherent perspective on what executives and line managers within operational environments need to focus on to efficiently and effectively control learn and adapt

There Are No Accidents Jessie Singer,2023-02-28 A journalist recounts the surprising history of accidents and reveals how they ve come to define all that s wrong with America We hear it all the time Sorry it was just an accident And we ve been deeply conditioned to just accept that explanation and move on But as Jessie Singer argues convincingly There are no such things as accidents The vast majority of mishaps are not random but predictable and preventable Singer uncovers just how the term accident itself protects those in power and leaves the most vulnerable in harm s way preventing investigations pushing off debts blaming the victims diluting anger and even sparking empathy for the perpetrators As the rate of accidental death skyrockets in America the poor and people of color end up bearing the brunt of the violence and blame while the powerful use the excuse of the accident to avoid consequences for their actions Born of the death of her best friend and the killer who insisted it was an accident this book is a moving investigation of the sort of tragedies that are all too common and all too commonly ignored In this revelatory book Singer tracks accidental death in America from turn of the century factories and coal mines to today s urban highways rural hospitals and Superfund sites The automobile industry popularized the idea of jaywalking to redirect blame away from cars and their drivers Racist planning policies built hazardous highway conditions straight through Black neighborhoods and then blamed Black and Latino victims Drawing connections between traffic accidents accidental opioid overdoses and accidental oil spills Singer proves that what we call accidents are hardly random Rather who lives and dies by an accident in America is defined by money and power She also presents a variety of actions we can take as individuals and as a society to stem the tide of accidents saving lives and holding the guilty to account

Patient Safety and Quality Improvement in Healthcare

Rahul K. Shah, Sandip A. Godambe, 2020-12-15 This text uses a case based approach to share knowledge and techniques on how to operationalize much of the theoretical underpinnings of hospital quality and safety Written and edited by leaders in healthcare education and engineering these 22 chapters provide insights as to where the field of improvement and safety science is with regards to the views and aspirations of healthcare advocates and patients Each chapter also includes vignettes to further solidify the theoretical underpinnings and drive home learning End of chapter commentary by the editors highlight important concepts and connections between various chapters in the text Patient Safety and Quality Improvement in Healthcare A Case Based Approach presents a novel approach towards hospital safety and quality with the goal to help healthcare providers reach zero harm within their organizations [The British National Bibliography](#) Arthur James Wells, 2006 **The Field Guide to Understanding Human Error** Dekker Sidney, 2006 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 **Commercial Aviation Safety, Seventh Edition** Anthony Lawrenson, Clarence C. Rodrigues, Shem Malmquist, Matthew Greaves, Graham Braithwaite, Stephen K. Cusick, 2023-06-02 Your definitive guide to commercial aviation safety fully updated to cover the latest regulations and practices This thoroughly revised guide covers all the principles and practices of commercial aviation safety from human factors and accident investigation to management strategies and regulatory compliance Written by a team of experts Commercial Aviation Safety Seventh Edition delivers comprehensive risk management information both on the ground and in the air You will get plain language explanations of the latest standards from the International Civil Aviation Organization ICAO the Federal Aviation Administration FAA the European Union Aviation Safety Agency EASA and other National Aviation

Authorities NAAs Up to date U S and international accident statistics also are provided Each section of the book includes detailed real world examples as well as analysis and explanations of the core issues This new edition covers The evolution of commercial aviation safety Safety terms theories and models Commercial aviation accidents causes International aviation accident investigation processes Aircraft airport and air traffic safety systems Human fallibility risk mitigation Safety culture assessment and management Safety system theory and practice International and U S aviation safety management systems and data Proactive system safety procedures and protocols Aviation security methods Up to date codes and regulations The role of government in safety Emerging trends in commercial aviation safety

The Controller ,2001

Understanding Patient Safety, Third Edition Robert Wachter,Kiran Gupta,2017-12-01 Now revised and updated the landmark patient safety primer written by the world s leading authorities Medical errors are the unfortunate byproduct of an increasingly complex healthcare system Now more than ever keeping patients safe takes well trained caregivers relevant insights from a range of industries additional investment and a groundbreaking text like Understanding Patient Safety Understanding Patient Safety is must read for those seeking to master the clinical organizational and systems issues of patient safety In this bestselling primer patient safety pioneer Robert Wachter and Kiran Gupta put all the essential tools and principles at your fingertips Engaging and accessible the book is filled with high yield cases analyses tables graphics along with key points and references all designed to help you optimize quality and safety Understanding Patient Safety begins with an introduction to patient safety and medical errors Its second section surveys specific types of medical errors including those related to surgery medications diagnosis transition and handoff and infections The third section covers proven solutions from establishing reporting systems to creating a culture of safety The third edition reflects pivotal new developments in the field including major updates in diagnostic errors information technology and patient safety ambulatory safety and clinician burnout Features Coverage of human factors and errors at the person machine interface Review of workplace issues including supporting caregivers after major errors How to organize an effective safety program Coordination of patient education and training Overview of the malpractice system Discussion of the patient s role

Uranometria 2000.0: Deep sky field guide ,2001

Understanding Policy Success Allen McConnell,2010-08-11 Success and failure are key to any consideration of public policy but there have been remarkably few attempts to assess systematically the various dimensions and complex nature of policy success This important new text fills the gap by developing a systematic framework and offering an entirely new way of introducing students to policy analysis

Bibliographie Mensuelle United Nations Library (Geneva, Switzerland),2010-07

EMBC 2004 IEEE Engineering in Medicine and Biology Society. Conference,2004

OHS Canada ,2003

American Book Publishing Record ,2005

Field Guide To Understanding Human Error Book Review: Unveiling the Magic of Language

In an electronic era where connections and knowledge reign supreme, the enchanting power of language has become more apparent than ever. Its ability to stir emotions, provoke thought, and instigate transformation is really remarkable. This extraordinary book, aptly titled "**Field Guide To Understanding Human Error**," published by a highly acclaimed author, immerses readers in a captivating exploration of the significance of language and its profound effect on our existence. Throughout this critique, we will delve into the book's central themes, evaluate its unique writing style, and assess its overall influence on its readership.

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