When the challenge is to get to the heart of a problem, you need a simple and efficient cause investigation methodology. And what would make a real difference would be an interactive map to lead you to the answer every time. Chester Rowe’s Simplifying Cause Analysis: A Structured Approach is your instruction book combined with the included downloadable Interactive Cause Analysis Tool you have been looking for. The author intends this book for professionals like you, who have some familiarity with cause analysis projects and are looking for a simple and efficient cause investigation methodology —is a more effective and insightful way of asking “why?” Introducing his multi-function event investigation tool, Chester Rowe says, “There are already many scientific tools to help us understand the physical causes for machine failures; the challenge now is to find a way of investigating human performance failure modeshumans are often a major source of slips, lapses, and mistakes.” Supporting his instructions with diagrams, charts, and real-world examples from
companies like yours, the author takes you step-by-step through planning, completing, and documenting your investigation: Chapter 1 gives you a process to determine the level of effort that your investigation should encompass, assess the level of effort needed, and determine the rigor needed. Your investigation needs to be as risk-informed as possible. Chapters 2 through 5 presents a new and innovative structure -rigorous yet intuitively easy to remember - to identify the underlying causes for the event (Cause Road Maps) and conduct the investigation. Chapter 6 introduces conceptual human performance models and tells you how to begin focusing on the human behaviors involved. Chapters 7 and 8 present you with methods, tools, and techniques for carefully interviewing personnel. Chapters 9 through 13 “put the pieces together,” showing you how to analyze and model the event, determine corrective action, and document the investigations and findings. Chester Rowe developed the Cause Road Map over many years to provide a comprehensive taxonomy for every cause investigation. However, fully implementing the Cause Road Map requires the use of other tools to organize, analyze, and present the final results of your investigation. To get you started, Rowe includes his downloadable Interactive Cause Analysis Tool - an easy-to-use tool in familiar spreadsheet format - free with your verified purchase of the book.

The answer is root cause analysis, a process that allows you to find the cause of single events/problems in the workplace. The Root Cause Analysis Handbook presents a walkthrough example that illustrates the method and shows how to implement it. Because poor initial problem definition can (and often does) undermine the problem-solving process, Ammerman places special emphasis on this area to build a solid foundation for effective analysis. He also provides guidance on preparing the final report. The need for clear documentation on dealing with problems makes this book especially valuable for quality managers, engineers, safety managers, and teams implementing the ISO or QS standards. Written in a simple, user-friendly style, you will grasp the core concepts quickly and begin applying them to your work.

Offering top-to-bottom coverage of this rapidly developing field; this book encompasses breakthrough techniques and technologies for both components and systems reliability testing; performance evaluation; and liability avoidance. --

This new handbook covers a wide range of engineering skills generally not taught in today's college-level technical programs. New engineers, though technically sound, need to master these other skills upon entering the professional world. Topics covered include teaming, root cause analysis, Lean manufacturing and management, presentation skills, innovation, and change leadership. Based on the author’s 30 years of engineering and leadership experience, this work contains a wealth of practical tips and advice, as well as lessons learned the hard way. Portable and concise, the handbook can
help new engineers thrive in and enjoy the technical world and their professional careers.

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.

A failure or accident brings your business to a sudden halt. How did it happen? What’s at the root of the problem? What keeps it from happening again? Good detective work is needed -- but how do you go about it? In this new book, industry pioneer Fred Forck’s seven-step cause analysis methodology guides you to the root of the incident, enabling you to act effectively to avoid loss of time, money, productivity, and quality. From 30+ years of experience as a performance improvement consultant, self-assessment team leader, and trainer, Fred Forck, CPT, understands what you need to get the job done. He leads you through a clear step-by-step process of root cause evaluation, quality improvement, and corrective action. Using these straightforward tools, you can avoid errors, increase reliability, enhance performance, and improve bottom-line results -- while creating a resilient culture that avoids repeat failures. The key phases of this successful cause analysis include: Scoping the Problem Investigating the Factors Reconstructing the Story Establishing Contributing Factors Validating Underlying Factors Planning Corrective Actions Reporting Learnings At each stage, Cause Analysis Manual: Incident Investigation Method and Techniques gives you a wealth of real-world examples, models, thought-provoking discussion questions, and ready-to-use checklists and forms. The author provides: references for further reading hundreds of illustrative figures, tables, and diagrams a full glossary of terms and acronyms professional index You know that identifying causes and preventing business-disrupting events isn’t always easy. By following Fred Forck’s proven steps you will be able to identify contributing factors, align organizational behaviors, take
corrective action, and improve business performance! Are you a professor or leader of seminars or workshops? On confirmed course adoption of Cause Analysis Manual: Incident Investigation Method and Techniques, you will have access to a comprehensive, professional Instructor’s Manual.

Are you trying to improve performance, but find that the same problems keep getting in the way? Safety, health, environmental quality, reliability, production, and security are at stake. You need the long-term planning that will keep the same issues from recurring. Root Cause Analysis Handbook: A Guide to Effective Incident Investigation is a powerful tool that gives you a detailed step-by-step process for learning from experience. Reach for this handbook any time you need field-tested advice for investigating, categorizing, reporting and trending, and ultimately eliminating the root causes of incidents. It includes step-by-step instructions, checklists, and forms for performing an analysis and enables users to effectively incorporate the methodology and apply it to a variety of situations. Using the structured techniques in the Root Cause Analysis Handbook, you will: Understand why root causes are important. Identify and define inherent problems. Collect data for problem-solving. Analyze data for root causes. Generate practical recommendations. The third edition of this global classic is the most comprehensive, all-in-one package of book, downloadable resources, color-coded RCA map, and licensed access to online resources currently available for Root Cause Analysis (RCA). Called by users "the best resource on the subject" and "in a league of its own." Based on globally successful, proprietary methodology developed by ABS Consulting, an international firm with 50 years' experience in 35 countries. Root Cause Analysis Handbook is widely used in corporate training programs and college courses all over the world. If you are responsible for quality, reliability, safety, and/or risk management, you'll want this comprehensive and practical resource at your fingertips. The book has also been selected by the American Society for Quality (ASQ) and the Risk and Insurance Society (RIMS) as a "must have" for their members.

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® 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.

Medical Device Use Error: Root Cause Analysis offers practical guidance on how to methodically discover and explain the root cause of a use error—a mistake—that occurs when someone uses a medical device. Covering medical devices used in the home and those used in clinical environments, the book presents informative case studies about the use errors.

When the numbers don’t lie, this is your guide to doing what’s right. If your school is faced with a disproportionate rate of suspensions, gifted program enrollment, or special education referrals for students of color, this book shows how you can uncover the root causes and rally your staff to face the challenge head on. You will: Understand how bias creates barriers to the success of students of color Know what questions to ask and what data to analyze Create your own road map for becoming an equity-driven school, with staff activities, data collection forms, checklists, and progress monitoring tools.

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.

A clinically oriented handbook providing up-to-date recommendations for mastering the practical aspects of patient management for venous thromboembolism. Venous thromboembolism (VTE) is associated with high morbidity and mortality both in and out of the hospital setting, and is one of the commonest reasons for hospital attendances and admissions. Designed as a practical resource, the Handbook of Venous Thromboembolism covers the practical aspects of venous thromboembolism management in short and easily followed algorithms and tables. This important text helps physicians keep up-to-date with the latest recommendations for treating venous thromboembolism in clinic-oriented settings. Experts in fields such as the radiological diagnosis of pulmonary embolism and thrombophilia testing, give a succinct summary of the investigation, diagnosis and treatment of venous thromboembolism and include evidence-based guidelines. With contributions from a team of internationally recognized experts, Handbook of Venous Thromboembolism is a source of information that specialists in the field can recommend to non-specialists and which the latter will be able to review to assist in their education and management of this wide-spread condition. This vital resource: Comprises of a clinically focused handbook, useful as a daily resource for the busy physician Offers a handbook written by an international team of specialists offering their experience on the practical aspects of venous thromboembolism management Addresses venous thrombosis prevention, a major focus for healthcare providers Includes coverage on controversies in the management of venous thromboembolism so clinicians can understand how experts are practicing in real scenarios Written for hematology trainees, emergency and acute medicine physicians, junior doctors, and primary care physicians, Handbook of Venous Thromboembolism covers the basics for treating patients with venous thromboembolism and offers guidelines from noted experts in the field.

This team of international experts analyses the possibilities and limitations of preventing or reducing terrorism by addressing the factors that give rise to it and sustain it. The key questions raised include: * what are the main circumstances that provide preconditions for the emergence of various types of terrorism? * what are the typical precipitants that trigger terrorist campaigns? * to what extent is it possible to reduce the problem of terrorism by influencing these causes and circumstances? * should we address those factors that sustain terrorist campaigns rather than root causes? This book is edited by Tore Bjørgo – Senior Research Fellow at the Norwegian Institute of International Affairs (NUPI), Professor and Research Director at the Norwegian Police University College.
Root Cause Failure Analysis provides the concepts needed to effectively perform industrial troubleshooting investigations. It describes the methodology to perform Root Cause Failure Analysis (RCFA), one of the hottest topics currently in maintenance engineering. It also includes detailed equipment design and troubleshooting guidelines, which are needed to perform RCFA on machinery found in most production facilities. This is the latest book in a new series published by Butterworth-Heinemann in association with PLANT ENGINEERING magazine. PLANT ENGINEERING fills a unique information need for the men and women who operate and maintain industrial plants. It bridges the information gap between engineering education and practical application. As technology advances at increasingly faster rates, this information service is becoming more and more important. Since its first issue in 1947, PLANT ENGINEERING has stood as the leading problem-solving information source for America's industrial plant engineers, and this book series will effectively contribute to that resource and reputation. Provides information essential to industrial troubleshooting investigations Describes the methods of root cause failure analysis, a hot topic in maintenance engineering Includes detailed equipment-design guidelines

Handbook of Materials Failure Analysis: With Case Studies from the Construction Industry provides a thorough understanding of the reasons materials fail in certain situations, covering important scenarios including material defects, mechanical failure due to various causes, and improper material selection and/or corrosive environment. The book begins with a general overview of materials failure analysis and its importance, and then logically proceeds from a discussion of the failure analysis process, types of failure analysis, and specific tools and techniques, to chapters on analysis of materials failure from various causes. Failure can occur for several reasons, including: materials defects-related failure, materials design-related failure, or corrosion-related failures. The suitability of the materials to work in a definite environment is an important issue. The results of these failures can be catastrophic in the worst case scenarios, causing loss of life. This important reference covers the most common types of materials failure, and provides possible solutions. Provides the most up-to-date and balanced coverage of failure analysis, combining foundational knowledge and current research on the latest developments and innovations in the field. Offers an ideal accompaniment for those interested in materials forensic investigation, failure of materials, static failure analysis, dynamic failure analysis, and fatigue life prediction. Presents compelling new case studies from key industries to demonstrate concepts and to assist users in avoiding costly errors that could result in catastrophic events.

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.

A comprehensive reference manual to the Certified Reliability Engineer Body of Knowledge and study guide for the CRE exam.

Understanding and improving the CAPA system as a whole is the focal point of this book, the only of its kind dealing exclusively with this critical system within highly regulated industries. Features include: Information about the importance of the CAPA system within the quality system for the medical products regulated industry. Fully updated with current versions of regulations (U.S. FDA, EU, ISO 13485, and so on), and a new section covers the regulatory expectation of customer complaint investigations. Investigation and CAPA elements of the 2015 revision of the ISO 9001 standard. New coverage on the investigation plan and the new U.S. FDA quality metric guidance, as well as a section discussing the tight relationship between CAPAs and FMEA. A new chapter fully devoted to human errors and human factors, and their impact in the investigation and CAPA system. Discussion of a dozen of the most common pitfalls commonly encountered in the investigation and CAPA world of regulated companies. An example of an investigation and CAPA expert certification program being used for many companies. Forms and examples of the different elements (investigation report, root causes checklist, human error investigation, CAPA plan, and so on) covered in the book. Fully usable forms are also included in the companion CD in Microsoft Word format. While the first edition of this book was aimed solely at the FDA-regulated industry, the title of this second edition reflects the importance of the investigation/root cause analysis stage as the necessary preceding step of any effective corrective and preventive action system. Investigation and CAPA are concepts used in many sectors besides the FDA-regulated industry, such as: automotive, electronics, aerospace, telecommunications, process industry, and many more. This book will become an essential reference for those in these other industries.

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

Handbook of Materials Failure Analysis: With Case Studies from the Chemicals, Concrete and Power Industries provides an in-depth examination of materials failure in specific situations, a vital component in both developing and engineering new solutions. This handbook covers analysis of materials failure in the chemical, power, and structures arenas, where the failure of a single component can result in devastating consequences and costs. Material defects, mechanical failure as a result of improper design, corrosion, surface fracture, and other failure mechanisms are described in the context of real world case studies involving steam generators, boiler tubes, gas turbine blades, welded structures, chemical conversion reactors and more. This book is an indispensable reference for engineers and scientists studying the mechanisms of failure in these fields. Introduces readers to modern analytical techniques in materials failure analysis Combines foundational knowledge with current research on the latest developments and innovations in the field Includes many compelling case studies of materials failure in chemical processing plants, concrete structures, and power generation systems

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 rules of business are changing dramatically. The Aspen Institute's Judy Samuelson describes the profound shifts in attitudes and mindsets that are redefining our notions of what constitutes business success. Dynamic forces are conspiring to clarify the new rules of real value creation—and to put the old rules to rest. Internet-powered transparency, more powerful worker voice, the decline in importance of capital, and the complexity of global supply chains in the face of planetary limits all define the new landscape. As executive director of the Aspen Institute Business and Society Program, Judy Samuelson has a unique vantage point from which to engage business decision makers and identify the forces that are moving the needle in both boardrooms and business classrooms. Samuelson lays out how hard-to-measure intangibles like reputation, trust, and loyalty are imposing new ways to assess risk and opportunity in investment and asset management. She argues that "maximizing shareholder value" has never been the sole objective of effective businesses while observing that shareholder theory and the practices that keep it in place continue to lose power in both business and the public square. In our globalized era, she demonstrates how expectations of corporations are set far beyond the company gates—and why employees are both the best allies of the business and the new accountability mechanism, more so than consumers or investors. Samuelson's new rules offer a powerful guide to how businesses are changing today—and what is needed to succeed in tomorrow's economic and social landscape.

All organizations experience unintended variation and its consequences. Such problems exist within a broad range of scope, persistence, and severity across different industries. Some problems cause minor nuisances, others leads to loss of customers or money, others yet can be a matter of life and death. The purpose of this pocket guide is to provide you with easily accessible knowledge about the art of problem solving, with a specific focus on identifying and eliminating root causes of problems. Root cause analysis is a skill that absolutely everybody should master, irrespective of which sector you work in, what educational background you have, and which position in the organization you hold. The content in this little pocket guide can contribute to disseminating this skill a little further in the world.

This book describes the methods and tools used to develop and implement an effective TQM program. It provides a practical explanation of root cause analysis and discusses the proactive use of analysis techniques for the prediction and prevention of problems. It emphasizes the basic concepts, various analysis techniques, and their common purpose in determining the true cause of problems.

This updated and expanded edition discusses many different tools for
root cause analysis and presents them in an easy-to-follow structure: a general description of the tool, its purpose and typical applications, the procedure when using it, an example of its use, a checklist to help you make sure if is applied properly, and different forms and templates (that can also be found on an accompanying CD-ROM). The examples used are general enough to apply to any industry or market. The layout of the book has been designed to help speed your learning. Throughout, the authors have split the pages into two halves: the top half presents key concepts using brief language—almost keywords—and the bottom half uses examples to help explain those concepts. A roadmap in the margin of every page simplifies navigating the book and searching for specific topics. The book is suited for employees and managers at any organizational level in any type of industry, including service, manufacturing, and the public sector.

Loss prevention engineering describes all activities intended to help organizations in any industry to prevent loss, whether it be through injury, fire, explosion, toxic release, natural disaster, terrorism or other security threats. Compared to process safety, which only focusses on preventing loss in the process industry, this is a much broader field. Here is the only one-stop source for loss prevention principles, policies, practices, programs and methodology presented from an engineering vantage point. As such, this handbook discusses the engineering needs for manufacturing, construction, mining, defense, health care, transportation and quantification, covering the topics to a depth that allows for their functional use while providing additional references should more information be required. The reference nature of the book allows any engineers or other professionals in charge of safety concerns to find the information needed to complete their analysis, project, process, or design.

The overwhelming majority of a software system’s lifespan is spent in use, not in design or implementation. So, why does conventional wisdom insist that software engineers focus primarily on the design and development of large-scale computing systems? In this collection of essays and articles, key members of Google’s Site Reliability Team explain how and why their commitment to the entire lifecycle has enabled the company to successfully build, deploy, monitor, and maintain some of the largest software systems in the world. You’ll learn the principles and practices that enable Google engineers to make systems more scalable, reliable, and efficient—lessons directly applicable to your organization. This book is divided into four sections: Introduction—Learn what site reliability engineering is and why it differs from conventional IT industry practices Principles—Examine the patterns, behaviors, and areas of concern that influence the work of a site reliability engineer (SRE) Practices—Understand the theory and practice of an SRE’s day-to-day work: building and operating large distributed computing systems Management—Explore Google's best practices for training,
Root Cause Analysis Handbook: A Guide to Effective Incident Investigation 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. Using the factual data of the incident, the system also allows quality, safety, and risk and reliability managers an opportunity to implement more reliable and more cost-effective policies that result in major, long-term opportunities for improvement. Such process improvements increase a business' ability to recover from and prevent disasters with both financial and health-and-safety implications. Special features include a 17 inch by 22 inch pull-out Root Cause Map, a powerful tool for identifying and coding root causes. The book helps readers understand why root causes are important, to identify and define inherent problems, to collect data for problem solving, to analyze data for root causes, and to generate practical recommendations.

This edition is a reprinting of the 199 edition.

- - - - - ORGANIZATION OF THE ROOT CAUSE ANALYSIS HANDBOOK

The focus of this handbook is on the application of the Root Cause Map to the root cause analysis process. The Root Cause Map is used in one of the later steps of the root cause analysis process to identify the underlying management systems that caused the event to occur or made the consequences of the event more severe. The first five chapters of this handbook are an overview of the root cause analysis process. These provide the context for use of the Root Cause Map. Chapter 6 provides references. Chapter 1, "Introduction to Root Cause Analysis," presents a basic overview of the SOURCE (Seeking Out the Underlying Root Causes of Events) root cause analysis process. Chapter 2, "Collecting and Preserving Data for Analysis," outlines the types of data and data sources that are available. Chapters 3, 4, and 5 describe the three major steps in the root cause analysis process. Chapter 3, "Data Analysis Using Causal Factor Charting," provides a step-by-step description of causal factor charting techniques. Chapter 4, "Root Cause Identification," explains the organization and use of the Root Cause Map. Chapter 5, "Recommendation Generation and Implementation," provides guidance on developing and implementing corrective actions. The references section, Chapter 6, provides additional information for those interested in learning more about specific items contained in the handbook. Appendix A, "Root Cause Map Node Descriptions," describes each segment of the Root Cause Map and presents detailed descriptions of the individual nodes on the map. Appendix B is the Root Cause Map itself.

Typically, root cause analysis is taught by explaining a variety of
tools that require users to gain considerable experience before being able to apply them correctly in the proper settings. What's Your Problem? Identifying and Solving the Five Types of Process Problems simplifies process problem solving and outlines specific techniques to help you.

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.

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

Do you have recurring problems that are costing you time and money? Unresolved problems do more than aggravate. They can increase costs, lower quality, and drive customers away. Plus, quality management processes, such as ISO 9001, require organizations to have a corrective and preventive action process in place. Root cause analysis is integral to the success of any corrective action or problem-solving process. Unfortunately, root cause analysis is an often maligned, misunderstood, and misapplied process. Instead of viewing root cause analysis as an opportunity for improvement, many see it only as an admission that things have gone wrong. Root cause analysis should be seen as an opportunity, not a chore. This practical guide offers proven techniques for using root cause analysis in your organization. Inside you’ll find: What root cause analysis is When (and when not) to use root cause analysis Who should participate in the root cause analysis process How to construct a root cause analysis checklist Examples of how a well-run root cause analysis process works And much more!

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.

Although there are many books on root cause analysis (RCA), most concentrate on team actions such as brainstorming and using quality tools to discuss the failure under investigation. These may be necessary steps during RCA, but authors often fail to mention the most important member of an RCA team—the failed part. Root Cause Analysis: A Step-By-Step Guide to Using the Right Tool at the Right Time provides authoritative guidance on how to empirically investigate quality failures using scientific method in the form of cycles of plan-do-check-act (PDCA), supported by the use of quality tools. Focusing on the use of proven quality tools to empirically investigate issues, the book starts by describing the theoretical background behind using the scientific method and quality tools for RCA. Next, it supplies step-by-step instructions for performing RCA with the tools discussed in the first section. The book’s clear examples illustrate how to integrate PDCA with the scientific method and quality tools when investigating real-world quality failures. This RCA guide provides root cause investigators with a tool kit for the quick and accurate selection of the appropriate tool during a root cause investigation. It includes an appendix with a guide to tool selection based on the intended use of the tool. There is also an appendix that defines the terminology used in the book. After reading this book, you will understand how to integrate the scientific method, quality tools, and statistics, in the form of exploratory data analysis, to build a picture of the actual situation under investigation that will lead you to the true root cause of an event. The tools and concepts presented in the text are appropriate for professionals in both the manufacturing and service industries.

The answer is root cause analysis, a process that allows you to find the cause of single events/problems in the workplace. The Root Cause Analysis Handbook presents a walkthrough example that illustrates the method and shows how to implement it. Because poor initial problem definition can (and often does) undermine the problem-solving process, Ammerman places special emphasis on this area to build a solid foundation for effective analysis. He also provides guidance on preparing the final report. The need for clear documentation on dealing with problems makes this book especially valuable for quality managers, engineers, safety managers, and teams implementing the ISO or QS standards. Written in a simple, user-friendly style, you will grasp the core concepts quickly and begin applying them to your work.