

Root cause analysis

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Root cause analysis What factors directly affected the outcome? Some of the factors that had an effect on the outcome, whether directly or indirectly are the hospital guidelines, the nurse's passion and insistence in following the guidelines, the nurse's fervent care for the patient, the anesthesiologist's stubborn behavior, the nurse's persistent badgering or insistence to the anesthesiologist to adhere to the guidelines, and the anesthesiologist's eventual yet hard-pressed willingness to give up.

2. Are they truly beyond the organizations control?

These are the kinds of situations that can go either way for the both the organization and the patient. Had the nurse not notices the negative elements of the situation, the outcome may not have been as good. Another thing to realize is that the nurse insisted on following the organization's guidelines; so much so that she chose those guidelines and went up against a physician. This is something that comes from care and passion, and often cannot be taught or trained. The nurse also showed passionate care towards the patient ; insisting on monitoring the said patient despite the anesthesiologist/physician's assurances that there is no need. Because of the nurse's passion and obedience to the guidelines, the situation was under the organization's control.

3. To what degree are staff members properly qualified and currently competent for their responsibilities?

The anesthesiologist is the most important person to know the risk of making the patient fully sedated. If the patient is under the anesthesia he/she should be closely monitored. There are certain factors that need to be given focus; the respiratory rate, pulse rate and the blood pressure of the patient, especially since the patient is a toddler. The nurse on the other hand must

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also be very responsible in giving care for the patient and it is also the SOP of any hospital or institution to perform sterile technique in handling patient especially during invasive procedure.

Aside from their formal education and training, they must be assessed to obtain a heart of service and dedication to their field. They must be more than just theories and procedure, but they must also have the ability to empathize with their patients and translate that empathy into service and care.

4. Suggest a risk reduction strategy for undermining behaviors

The first step is to disseminate information regarding new risk reduction and undermining behavior procedures and sanctions in order to lessen the chance that any undermining behavior will manifest. The next is to monitor the organization by assigning officers of point people that will check for any undermining behavior. The steps to take for any undermining behavior are as follows: First, make a stern verbal warning and log a report. Next step in case the behavior is persistent is to create a formal written warning. The succeeding offenses will be handled as follows: 1st written warning, suspension for 1 day, 2nd written warning, suspension for a week, the 3rd written instance will merit a month of suspension and the next written instance will merit dismissal from the organization.

References

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