Organizational Problems

Order Description

H​‌‍‍‍‌‍‍‍‍‍‌‌‍‍‍‍‌‍‌‌​i, this is a journal assignment that includes thoughts and opinions. Please read the provided rubric in detail and address the key elements. My future career will be in Healthcare Administration and the two topics I am choosing for my final project are insufficient training and communication. No title page nor header is needed for this assignment. If you have any other questions feel free to ask thanks. Please be detailed. One and a half pages will be sufficient. Thanks again. Here's some info you can use. Process of RCA Performing a root cause analysis may involve only one individual; however, often it includes forming a team to conduct the analysis. The team must answer the following questions: What happened? How did it happen? Why did it happen? What should be done to prevent it from happening again? (Mengis &amp; Nicolini, 2010) According to Ross (2014), in a single-event root cause analysis, a patient that receives the wrong medicine will require the individual or team conducting the analysis to ask the “Five Whys” as follows: Question One: Why did the patient receive the wrong medicine? Response One: The prescription was wrong (one of dozens of possible answers) Question Two: Why was the prescription wrong? Response Two: Physician made incorrect pharmaceutical decision. Question Three: Why did the physician make the wrong decision? Response Three: Incomplete patient chart. Question Four: Why was the patient chart incomplete? Response Four: Physician assistant did not record test results. Question Five: Why didn’t the physician assistant record the test results? Response Five: Tests results were phoned to secretary and secre​‌‍‍‍‌‍‍‍‍‍‌‌‍‍‍‍‌‍‌‌​tary did not tell physician assistant The answers to these questions can be simple or complex, depending on the situation or issue presented. Each problem can be seen as an opportunity to collect information that tells the story about what occurred, as well as why and how the incident occurred. In addition to errors, RCA is a tool that can be used to analyze potential errors or adverse events that were caught prior to harm being done to the patient. In RCA, there are three main components that help individual move from problem identification to action: data collection, data analysis, and corrective or preventive action (Ross, 2014). This analysis process is covered more in depth in Chapter Four of the course textbook. Systems Thinking Quality management requires employees to think beyond the scope of their individual work. It provides them with an understanding of how their performance affects the overall system and the satisfaction of patients. All work is a process and, to implement real change in an organization, employees must have an understanding of systems. These systems help mitigate not only the symptoms to a problem, but also the true causes of a problem. This process is systems thinking and is composed of five elements: input, throughput, output, outcome, and feedback (Ross, 2014). It centers its efforts on the interaction, synchronization, and integration of individuals, processes, and technology. By gaining a greater understanding of the dynamics of interaction, synchronization, and integration, systems thinking helps to recognize how to apply interventions ([e.g](https://e.g/)., clinician training or clinical practice) in the system successfully (Trbovich,​‌‍‍‍‌‍‍‍‍‍‌‌‍‍‍‍‌‍‌‌​ 2014).