Root Cause Analysis

Name

Institution

Root Cause Analysis

Root Cause Analysis team is the group of members in a health facility whose role is to identify the causes of a problem experienced in the organization. In this perspective, an error occurred during the healthcare activities, and the team had a role in identifying the root causes of the problems. The team also focuses on identifying the changes that need to take place to improve the performance in the healthcare facility (Spath, 2012). The team is made of the leadership of the healthcare facility who designates the individual who facilitates the group of root cause analysis. The number of team members for the root cause analysis highly depends on the objective of the investigation. The RCA team is therefore made of the leadership of the company, the facilitator and other team members selected based on the skills and knowledge of the individuals.

The knowledge used by the leadership as members of the team to contribute to RCA is through teambuilding and coaching. In this perspective, the leaders use the leadership knowledge to bring together the team so that the objectives of identifying the problem can be achieved (Charles, et al., 2016). The facilitator can use the experience to the benefit of the Root Cause Analysis by ensuring that the ideas of every member of the team are heard. The facilitator also should apply the knowledge on Root Cause Analysis methodology like creating a precise and clear definition of the problem which ensures that the goals of the process are achieved. The team members know the healthcare systems and how the methods can be applied for the growth of the facilities (Latino, et al., 2016). The team members should also portray effective communication in their role in Root Cause Analysis for their contribution to help in the achievement of the objectives. The team members of the Root Cause Analysis should show teamwork in their role for better results to be achieved in identifying the problems, causes and solutions to the issues.

References

Charles, R., Hood, B., Derosier, J. M., Gosbee, J. W., Li, Y., Caird, M. S., ... & Hake, M. E. (2016). How to perform a root cause analysis for workup and future prevention of medical errors: a review. *Patient safety in surgery*, *10*(1), 20.

Latino, R. J., Latino, K. C., & Latino, M. A. (2016). *Root cause analysis: improving performance for bottom-line results*. CRC press.

Spath, P. L. (2012). Error reduction in health care: a systems approach to improving patient safety. *Journal of Nursing Regulation*, *2*(4), 60.