**Root Cause Analysis and System Failure**

Root Cause Analysis is defined as a system used to solve a problem which starts by identifying the origin of the problem. Something is considered a cause if the problem does not reoccur when the factor is isolated. It is one of the best ways of problem-solving since it does not only deal with the effects but prevents future reoccurrence. Individuals trail a situation from its effects, back to the process and then to the ignition of the case. As diseases advance and body systems of individual change due to changes in the environmental conditions, health care provision is slowly becoming complex which affects patient's safety (Kum & Sahin, 2015). New advanced, efficient systems have to be created to reduce errors during healthcare provision which will improve patient's safety.

When addressing the event of the patient safety, essential individuals whom I would invite to the Root Cause analysis for the process to be active are the medical practitioners, a representative from the ministry of health and individuals from the community who receive the health care services. Medical practitioners will help in identifying the treatment procedures employed in different medical firms (Dykes & Schnock, 2016). A representative from the ministry of health gives a description of government investments for better healthcare provision. Individuals who take the role of the patients are made available to state the effects of administered medication and how safe they feel during the treatment process. After the effects, procedures and the start of a treatment method which affects patients has been identified; it becomes easy to determine the cause which is then dealt with for good.

According to research, many medical errors which lead to patient safety problems are not a result of incompetence or lack of enough care from the medical practitioner during the treatment process. Because of the human nature of individuals, despite the efforts made and best intentions at heat a person makes mistakes without knowing. Human nature tempers with the ability to make a perfect decision which increases the rates of making errors (Burrough et al., 2015). Errors which tamper with patient safety can also occur because of the faults in designed systems responsible for the healthcare provision services. Systems produce the correct information they are intended to create which makes it difficult to tackle new diseases caused by the change in environment. Such systems need to be redesigned to allow them to work correctly in providing solutions for the new types of illnesses without posing a danger to the patients.

Improvement in the medical institution's information systems will aid healthcare providers in making the best clinical decisions which do not expose patients to danger. It helps improve diagnosis, record keeping and provide guidance throughout the treatment process. Computers can store information for a long time and deliver the same thing when needed. It is unlike in human beings whereby with time an individual forgets information, and for a health care provider's case, wrong medication is administered (Dykes & Schnock, 2016). Health care systems should, therefore, invest more in electronic information systems for accuracy and patient's information safety.

Health care providers play the most significant role in the wellbeing of a patient and therefore must practice high competence and care level to avoid exposing individuals to danger during the treatment process. Health care providers have to acquire relevant skills in operating information systems and using them efficiently for the benefits of the patients. Health care providers must not depend much on their mental ability to store patient's information. They must ensure each data is recorded correctly in information systems to avoid mix up that can lead to wrong treatment (Kum & Sahin, 2015). The information systems are also to be designed in simple ways easy to understand but efficient with all the needed information included.

Awareness to families who receive medical treatment from the institution has to be created to avoid more errors in medical institutions. They have to be educated about their rights during the treatment processes. The families are shown the proper channels to report any incident they think can cause danger during the treatment process (Burrough et al., 2015). It, therefore, helps create a solution early enough before it affects the safety of the patient.

**References**

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