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Topic: The Shrewsbury
and Telford Hospital case
study



INFERTILITY

Introduction

Shrewsbury and Telford NHS Trust ignored their mistakes, and over 300 babies died as a result of their long-term maternity care inadequacies. This study will look at the maternity care center's quality shortcomings.

Aim

It will discover the underlying reasons.

Analyze all policy issues.

This report will look at the influence on service delivery.

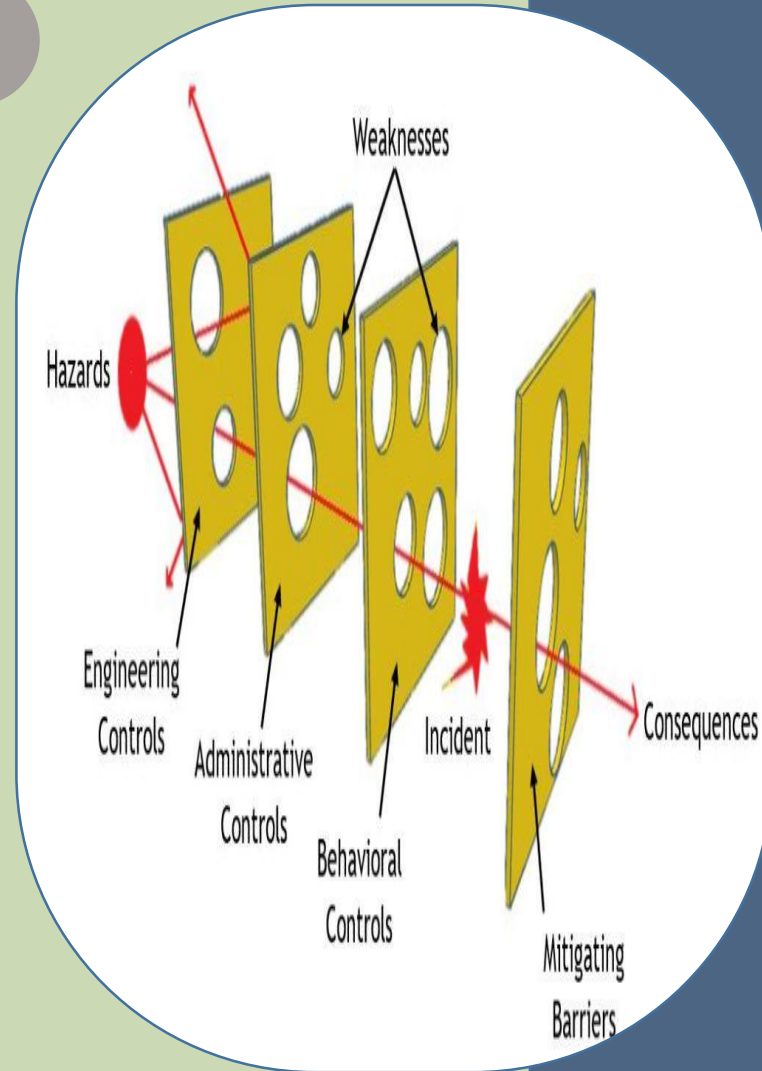


Overview on the case study

The Shrewsbury and Telford Hospital case study described how, from the 1970s to 2019, the hospital failed to provide adequate care to babies and mothers, resulting in the deaths of hundreds of babies (Dyer, 2022).

Swiss cheese model

This model is commonly used to understand the root cause and safety efforts. According to Reason, accidents within most complex systems, such as healthcare, are caused by a breakdown or absence of safety barriers across four levels within a sociotechnical system (Wiegmann, *et al.*, 2022). The healthcare system has multiple layers of defense, and in each layer there is a hole just like Swiss cheese. These holes represent the weaknesses, and if these holes align, the industry face difficulties.



Application of the Swiss cheese model

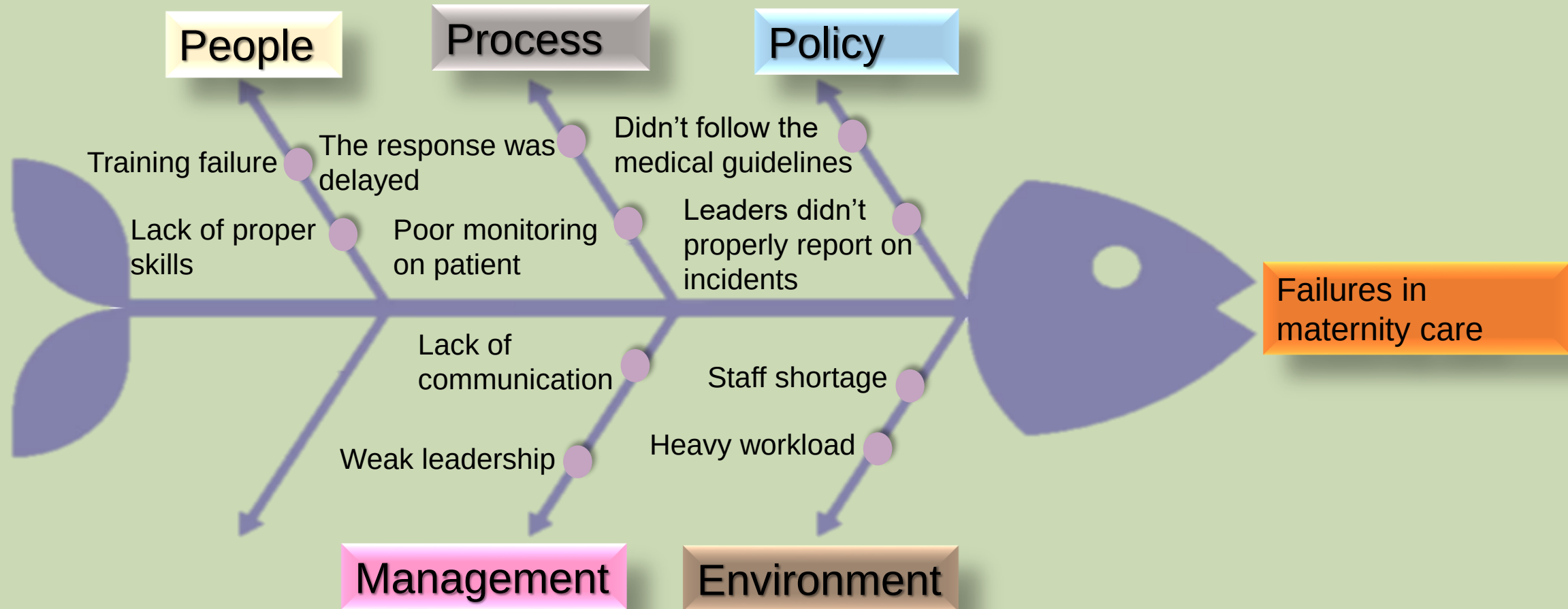


This technique is ideal for determining the root cause, allowing investigators to comprehend the factors that contributed to big errors.

This model describes the numerous levels of protection required for infection prevention during surgery (Reason et al., 2006).

This paradigm can be utilized to provide effective pharmaceuticals since it facilitates the implementation of pharmacy checks as well as pharmacist consultation layers.

Fishbone (Ishikawa) Diagram



Donabedian model

This model has three interconnected components, which are structure, process and outcomes (Tossaint-Schoenmakers et al., 2021)



Structure

The hospital has a personnel shortfall and bad leadership.

Process

First of all, there is poor communication among the staff, and the leader did not monitor the staff properly.

Outcomes

100 babies died, causing long-term injury.

Root cause of failures

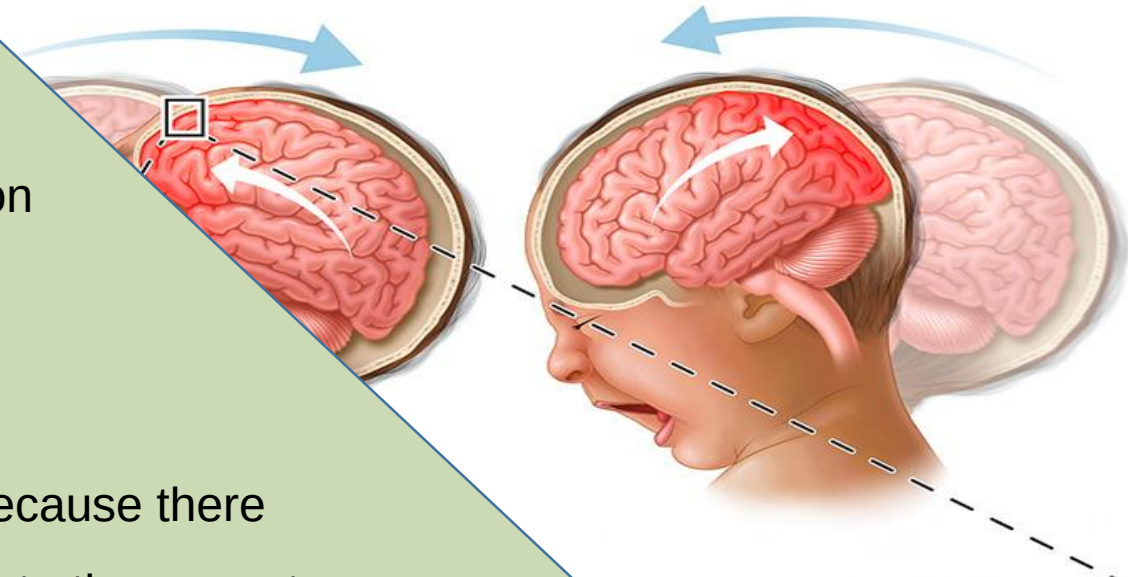
The organizational culture at this institution is protective, and employees are discouraged from speaking up.

The governance also failed because there is no adequate investigation into the current fatality episodes (Dyer, 2022).

The hospital did not give adequate training in fetal monitoring.

There is a lack of efficient communication and collaboration.

Shaken baby syndrome (abusive head trauma)



Subdural hematoma

Subarachnoid hemorrhage

Root cause analysis

The issue here is a high rate of maternal mortality, which is mostly the result of inadequate surveillance (Dyer, 2020).

However, due to an ineffective governance framework, the hospital was unable to provide enough staff training.





Policy issues

This company fails to follow the national maternity guidelines because they cause several deaths and improper mother care (Kronenfeld, 2013).

Even they failed to report about the incidents effectively.

The leaders failed to oversee the implementation of regulatory

Impact on service provision



Impact on quality

This hospital is totally unsafe and low quality.



Impact on efficiency

They do not diagnose and give treatment on time.
The resources here are totally wasted (Dyer, 2020).



Impact on trust and reputation

Due to these incidents, people lose their confidence in taking services from this company, which damaged the NHS's reputation.

Recommendation to enhance QA

The hospital has to conduct regular audits and effectively monitor worker performance.

The authorities must ensure that such instances are adequately investigated.

Plan training specifically for fetal monitoring.



Structure of the report

Introduction
case analysis
theoretical framework
Root cause analysis
policy analysis
impact assessment
Recommendation
conclusion



Conclusion

Finally, the instance of Shrewsbury and Telford Hospital demonstrated a significant failure in healthcare services.

The primary reason is ineffective monitoring and risk assessment. Several models demonstrated that this issue has multiple layers, not simply one. Some recommendations are made to improve their QA.

Reference

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