

Case study

by Heta Jain

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Case: Vaught, a former nurse at Vanderbilt University Medical Center, was indicted in the December 2017 death of Charlene Murphey, whom she injected with the powerful paralyzing drug vecuronium, instead of a dose of a sedative called Versed.

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Introduction

A leader is an individual who possesses the ability to motivate and direct a collection of individuals towards a common goal. People who take for granted the role of a leader is responsible for taking charge, making decisions, and being accountable for the outcomes (Frost, 2022). Effective leadership is critical in all domains, including the healthcare sector. It involves establish a clear direction, mounting a strategic vision, and development a culture of liability and safety for patients.

The responsibility of a complete investigation, identification of the accountable party, and achievement of systemic reforms necessitates effective leadership at Vanderbilt University Medical Centre. In the nonattendance of effective leadership, it is crucial to address the issue at hand, provide support to affected individuals, and implement preventive measures.

Reason for selecting the case

Charlene Murphey's death highlights the healthcare system's patient safety and pharmaceutical error issues. This case was chosen because it included a death, calling Vanderbilt University Medical Center's rules, practice, and responsibility into question. This case study seeks to identify the problem and assess leadership or management failure. The event's impact on patient safety and healthcare organizations' confidence should be examined.

The legal case of Vanderbilt University Medical Centre nurse RaDonda Vaught has sparked a debate about medical mistake penalties. Vaught murdered and neglected 75-year-old Charlene Murphey on March 25 (Coetsee, Wilby, and Brown, 2022). This report presents relevant historical and contextual information and opposing opinions to contextualize the problem under examination. Charlene Murphey was administered vecuronium instead of RaDonda Vaught's prescribed anti-anxiety medication, Versed, on December 26, 2017. Murphey passed away in a tragic manner on the following day. Vaught's job at Vanderbilt University Medical Centre was terminated on January 3, 2018. Vaught was eventually caught on February 4 of this year. On February 4, 2019, the District Attorney's office requested her arrest. According to Kelman (2019), Vaught's multi-count jury trial occurred in March 2023. The court found the defendant guilty of two counts of criminal negligence and one count of extreme carelessness in connection with the death of an incapable adult. The accusation of reckless murder, on the other hand, was dropped. A jury found Vaught guilty of failing to follow safety rules and carrying out activities inconsistent with her nursing qualifications, which led to Murphey's death. The verdict considered

Vaught's divergence from the expected quality of care and her incapacity to discharge her obligations as a competent and careful healthcare provider.

⁶² Vaught's sentence hearing is set for May 13, 2022. The defendant was convicted by the jury of exhibiting serious negligence towards an incapacitated adult, an offence that carries a prison sentence ranging from three to six years (Kelman, 2022). Additionally, the defendant was found guilty of criminal negligence leading to murder, an offence that is punishable by imprisonment for a period of one to two years. The potentiality of Vaught filing an appeal against his sentence remains uncertain. Generating broad attention and ethical deliberation:

Structure of the report

The report below discusses about the case study and the information of the case is analyses with the theoretical aspects and different information's are discussed with the help of theories.

Main Body and Analysis

4P Analysis

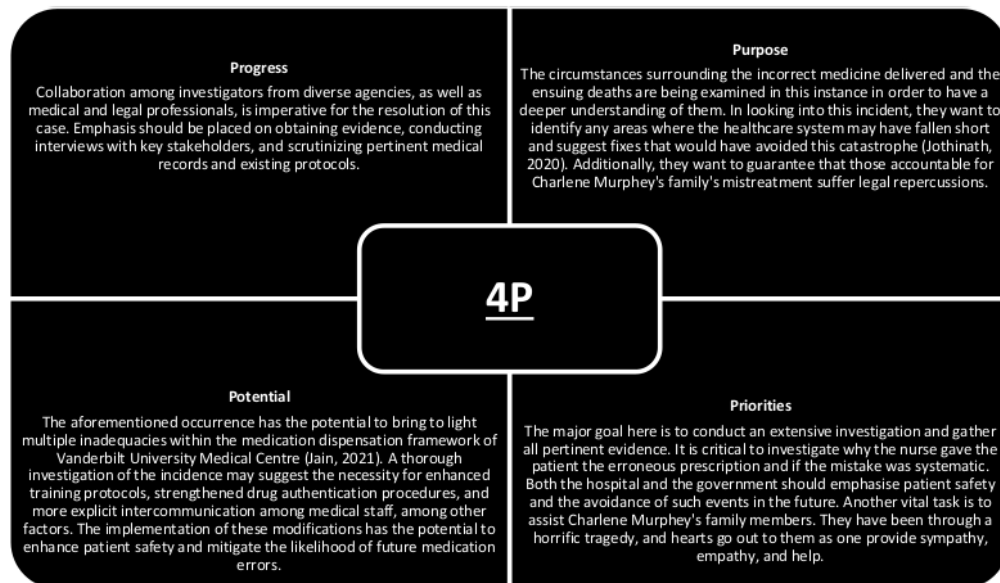


Figure 1:4P Analysis

Source- Self created

Incident and aftermath

RaDonda Vaught started her professional life as a nurse at the Vanderbilt University Medical Centre in December of 2015, when she began her studies in the field. On December 24, 2017, Charlene Murphey, who had reached the age of 75 at the time, was sent to the hospital for the purpose of receiving treatment for a subdural hematoma (Sofer, 2019). After two days, Vaught, who was a registered nurse, was given the directive to provide the sedative Versed (midazolam) to Murphey; nevertheless, she administered the paralyzing drug vecuronium to him instead. Vaught sought to get Versed via an automated drug distribution system, but her attempts were in vain. As a result, she resorted to an override mechanism, giving her access to a broader choice of medications. Vaught failed to obtain Versed via the automatic dispensing cabinet. Vaught entered the code for the automated dispensing cabinet in an attempt to get Versed. A dose of the sedative Versed was supposed to be administered to Murphey before he went in for an MRI scan, which requires patients to maintain complete and utter stillness for periods of at least 15 minutes each. After ingesting the vecuronium, Murphey went into cardiac arrest, but he was able to make a full recovery after being brought back to life. However, she had suffered damage to her brain that was not going to be able to be repaired, and a medical expert concluded that she was no longer aware. Murphey went away the day after having his life support disconnected in order to end his suffering. Vaught was quick to acknowledge the error, and at the end of the investigation conducted internally at the hospital in January 2018, he was fired from his employment there (Kelman and Norman, 2022). In 2019, she was arrested for the murder of Murphey and charged in connection with the crime.

Fish Bone

Fishbone analysis, sometimes called Ishikawa analysis or cause-and-effect analysis, may be used to examine the circumstances behind Vaught's conviction in Charlene Murphey's death.

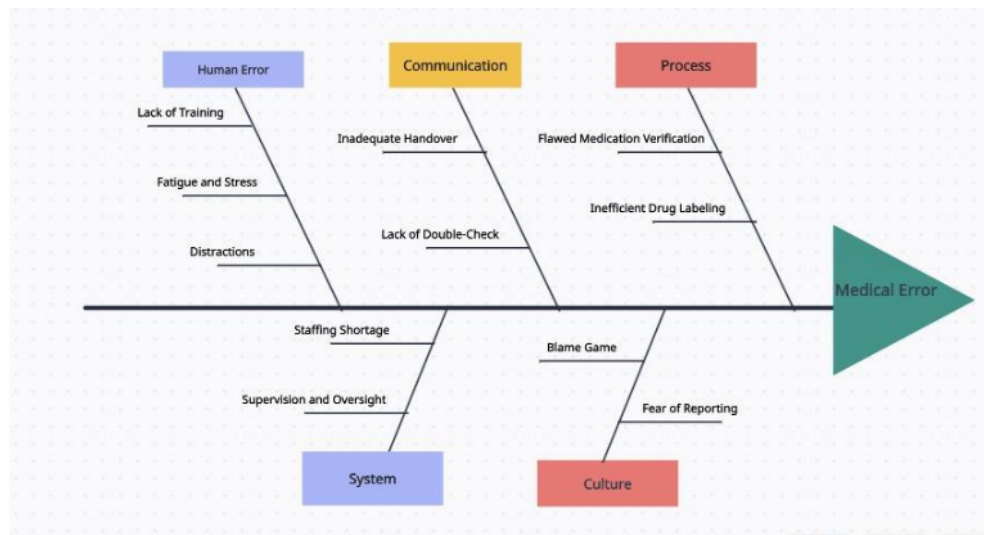


Figure 2: Fish Bone analysis

Source- Self created

Human Error:

- Lack of Training: Vaught may have been confused between Vecuronium and Versed since he was not adequately trained on medication administration standards.
- Fatigue and Stress: Due to fatigue and stress, overworked nurses may make careless decisions (Larsen, 2022).
- Distractions: Vaught's attention may have been distracted from the proper medicine administration by forces outside of his control.

Communication:

- Inadequate Handover: Due to a lack of communication, inaccurate patient data might have been handed along between shifts.
- Lack of Double-Check: Not double-checking with a nurse before giving medicine.

Process:

- Flawed Medication Verification: The hospital's drug verification system had flaws that led to patients receiving erroneous medications.

- Inefficient Drug Labeling: Confusion may arise if pharmaceutical containers need to be clearly labelled.

System:

- Staffing Shortage: Workloads may grow, and patients' treatment quality may need more workers (Minarich, 2019).
- Supervision and Oversight: There needs to be more management and responsibility among the medical staff.

Culture:

- Fear of Reporting: Nurses may be less likely to talk openly about mistakes if they believe they will be punished if they disclose them.
- Blame Game: A society where blame is assigned to specific people rather than systemic causes.

The nurse's mistake in giving Charlene Murphey the incorrect prescription, ultimately leading to her death, is dissected through fishbone analysis in this case study. Human error, faulty systems, and poor communication are just a few of the many causes that may be investigated using this methodical framework. While rich picture analysis helps capture complexity in systemic problems, it is not being employed here because of the emphasis on identifying root causes. Fishbone analysis is the way to go if one wants to find out exactly what went wrong and then take immediate action to avoid it from happening again.

Reason for selecting Fishbone analysis over root cause analysis

Fishbone analysis was selected over root-cause evaluation for the case study as it provides an organized and visual portrayal of likely causes, which is critical in a complicated medical setting like this. Using a fishbone diagram, experts may classify and investigate the causes of the nurse's mistake, such as human error, faulty procedures, poor lines of communication, and faulty infrastructure. It offers a broad perspective on the potential reasons, allowing for a more in-depth comprehension of the situation. However, root cause analysis may emphasize determining the most critical element in what went wrong and hence miss other aspects that might be just as important in averting future mishaps.

The 5 ways

⁶ Vaught, a former nurse at Vanderbilt University Medical Centre, is depicted in this case study because she was charged with murder ⁶ in the December 2017 death of Charlene Murphey.

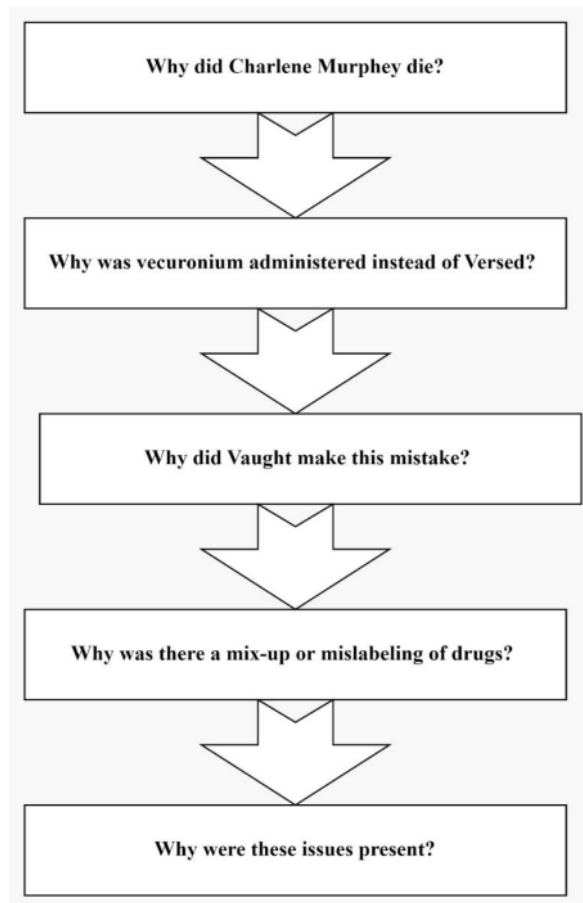


Figure 3 5 Why's

Source- Self created

Using the 5 Whys method, here is a critical examination of this case:

1. Why did Charlene Murphey die?

Charlene Murphey tragically her away after being injected with vecuronium, a potent paralysing medication.

1. Why was vecuronium administered instead of Versed?

According to the inquiry's findings, nurse Vaught intended to give the patient the sedative Versed but gave them vecuronium instead.

1. Why did Vaught make this mistake?

According to the study's findings, the mistake may have resulted from a medicine mix-up or incorrect labelling at the hospital (Patel et al., 2021).

1. Why was there a mix-up or mislabeling of drugs?

Poor inventory management, sloppy labelling practices, or a lack of employee training might all be to blame for the mix-up.

1. Why were these issues present?

At least in part, errors and carelessness may have been caused by systemic issues with the hospital's operations, protocols, and safety precautions.

Figure 4.5 Why's for the Case

Source- Self created

Charlene Murphey's unfortunate death occurred at Vanderbilt University Medical Centre due to a series of mistakes, including possible mismanagement, labelling concerns, and a lack of sufficient training and safety measures.

In this case study, the nurse fatally injected the incorrect medicine into the patient, and the 5 Whys method is utilized to determine what went wrong. To get to the bottom of things like communication breakdowns, insufficient training, or flawed methods, investigators should ask "why" five times in a row. However, Rich Picture analysis isn't used here because it's best suited for depicting systems like organizations and the relationships between their various parts, not for investigating isolated incidents like this one, where the goal is to determine what factors contributed to the tragic outcome.

Reason for selecting the 5 Whys over Rich Picture

The 5 Whys strategy was selected over the Rich Picture approach for the case study because it provides a more focused and systematic way of determining the fundamental reasons for the unfortunate occurrence. The 5 Whys method is helpful in medical investigations because it enables the researcher to ask "why" again, delving further into each probable cause and uncovering underlying difficulties and linkages. It helps in identifying the exact mistakes or system failures that resulted in the improper medication being given. On the other hand, the Rich Picture approach may be more helpful in investigating more general, complex problems that don't need a sequential study of causation.

Connective leadership

The term "connective leadership" pertains to a managerial approach that places emphasis on collaboration by fostering transparent channels of communication and nurturing dependable relationships among employees (O'Donnell and Haldeman, 2022). The behavioral patterns and dispositions exhibited by the subjects under scrutiny in a case study may serve as indicators of the existence or non-existence of interrelated leadership. The following is an illustration of linked leadership being implemented:

Lack of Connective Leadership:

- a. Communication Breakdown: It appears that there is a lack of effective inter-physician communication in the medical management of RaDonda Vaught's case. The failure to effectively communicate the necessity for administering Versed and the subsequent dispensation of an incorrect medication are symptomatic of this breakdown.
- b. Lack of Collaboration: It appears that Vaught made an attempt to obtain Versed through the automated medication dispensing system, but was unsuccessful in doing so. The individual in question utilized an override mechanism without proper authorization or substantiation, rather than pursuing assistance or engaging in discourse with peers or higher-ups. The lack of collaboration and reluctance to solicit assistance may have resulted in the error.

Importance of Connective Leadership:

- a. Collaboration and Teamwork: The concept of "connective leadership" holds significant importance in fostering a collaborative work environment among healthcare professionals (Szalados, 2021). A leader who fosters connectivity would promote transparency, emphasise the importance of seeking aid when necessary, and cultivate an environment in which individuals feel at ease inquiring and verifying data.

b. Building Relationships: A leader who adopts a connected leadership style places a high value on fostering trusting and appreciative relationships. Leaders who prioritize the well-being of their staff are more inclined to establish a conducive environment wherein medical professionals are at ease in voicing their apprehensions and disclosing errors. This fosters transparent communication and knowledge exchange, while also cultivating a culture of safety.

c. Accountability: Effective leaders possess the ability to comprehend and execute their own obligations, as well as those of their constituents. In this scenario, a leader who exhibits connective leadership qualities would acknowledge responsibility for any errors, implement measures to mitigate their consequences, and actively participate in the investigation and remediation procedures.

The absence of cohesive leadership appears to have exacerbated the pharmaceutical error and its catastrophic ramifications. The significance of connective leadership in healthcare contexts lies in its ability to foster transparent communication, collaboration, and a focus on patient-centered care.

Reason for selecting connective leadership over trait theory

The emphasis on Connective leadership over Trait theory was chosen for the case study since it is more equipped to deal with the intricacies of the scenario and possible systemic difficulties. Many things contributed to this sad event, including a breakdown in communication, improper medicine delivery procedures, and maybe even company culture. Relationship building, open lines of communication, and encouraging cross-departmental cooperation are all hallmarks of "connective leadership." This method may be used to identify potential systemic causes of the mistake and implement fixes. Trait theory, on the other hand, is narrower in scope, examining just the personal traits of leaders rather than the contextual, structural, and institutional aspects that may also be at issue.

Henry Mintzberg lens

Henry Mintzberg is a renowned expert in the fields of management and organizational theory on a global scale. By utilizing Mintzberg's framework, it is possible to analyze the issue from multiple perspectives. Taking into account Mintzberg's framework, the following should be considered:

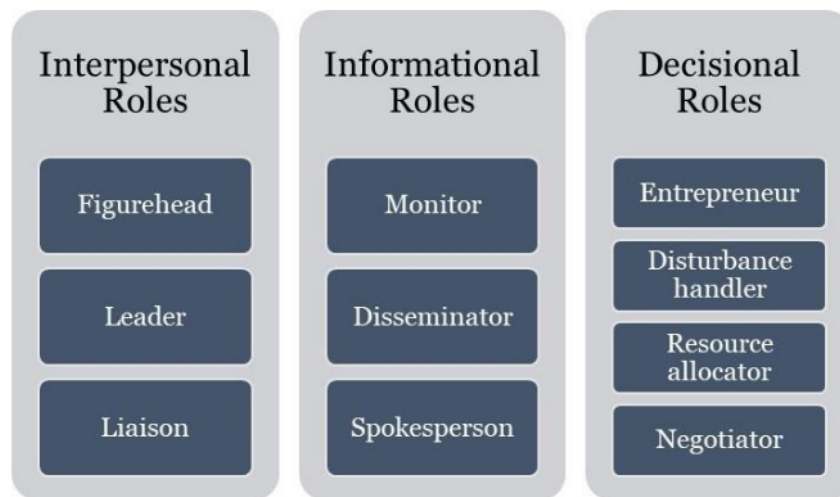


Figure 5: Henry Mintzberg lens

Source- Self created

Interpersonal Roles:

RaDonda Vaught commenced her nursing duties at Vanderbilt University Medical Center, where she assumed responsibility for providing patient care and meeting the expectations imposed upon her. Vaught, a certified nurse, played a pivotal role in the healthcare industry. Nevertheless, she deviated from conventional leadership norms by administering the inaccurate medication.

Informational Roles:

Vaught was responsible for overseeing patient monitoring, conducting examinations, and administering medication. On this occasion, however, she was unsuccessful in carrying out the requisite prescription monitoring and administration of the medication known as Versed.

As a communicator, Vaught was responsible for notifying the appropriate individuals regarding the patient's health status, treatment regimen, and medication needs (Sarat et al., 2021). Nonetheless, it appears that the fundamental cause of the error was inadequate communication of drug-related information.

Decisional Roles:

The automated dispensing device at the pharmacy failed to dispense the tranquilizer Versed to Vaught. The individual in question employed an override mechanism to obtain resources, specifically medications, in the absence of the requisite authorization. During the crisis, Vaught provided significant assistance when a patient experienced cardiac arrest due to a prescription error.

Managerial Perspectives:

Vaught was responsible for overseeing the dispensation of medication and performing routine patient care tasks on a regular basis. The decision to provide an incorrect prescription indicates a deviation from established standard operating procedures. Vaught's conduct was deemed unethical as she neglected to prioritize the patient's well-being and safety by administering the appropriate medication (Montminy, 2022). This behavior exhibits a lack of adherence to established professional ethics and standards of care.

The case's human aspect is noteworthy due to its potential impact on patient confidence, the psychological burden on the patient and their kin, and the occupational consequences for Vaught.

Justification: The management duties framework proposed by Mintzberg provides a comprehensive and established framework for comprehending the numerous roles that managers undertake. The framework provides a comprehensive approach to analyzing the matter from multiple perspectives, encompassing the viewpoints of individuals with responsibilities pertaining to interpersonal interactions, information dissemination, and decision-making.

To know thyself

The philosophy of "To Know Thyself" advocates for the practice of introspection, cultivating a deep understanding of oneself, and valuing one's unique set of attributes. By applying this approach to RaDonda Vaught's situation, they can evaluate her actions and decision-making abilities based on her level of self-awareness and accountability for the prescription error and its consequences.

Self-awareness and Personal Responsibility

•According to the notion, it is imperative to scrutinize Vaught's comprehension of her own assets, limitations, and values within the medical profession. Did she possess a comprehensive comprehension of her own strengths and weaknesses as a purveyor of controlled substances? Was she cognizant of the fact that her adherence to established protocols and thorough drug verification were crucial for ensuring patient safety? The extent to which she comprehends her culpability in the error may vary based on her self-perception and perspective.

Cognitive Biases and Decision Making

•The theory can be employed to examine whether Vaught's cognitive biases or blind spots contributed to her erroneous administration of medication (Lebovics and Mandler, 2020). Can it be argued that the individual in question succumbed to confirmation bias by adhering to her initial assumption that she would not be able to obtain Versed via the automated system? Was the individual not cognizant of the potential ramifications of utilizing the override mechanism to select an alternative medication prior to verifying its safety? The evaluation of cognitive biases in an individual's decision-making process can be achieved through the application of self-awareness.

Personal Growth and Learning

•The approach prioritizes continuous self-enhancement and acquisition of knowledge. Adopting this perspective may provide us with a more comprehensive comprehension of Vaught's conduct and the insights she may have gained from this occurrence. Did she assume accountability for her mistake, analyze its effects on others, and proactively endeavor to improve herself? Assessing her potential for career advancement and error prevention can be achieved by analyzing her response to the mishap and her commitment to ongoing learning.

Ethical Considerations

•The theory can be employed to scrutinize Vaught's ethical reasoning and principles. Did she exhibit a notable level of professionalism and integrity in her capacity as a nurse? Did she give precedence to the safety of the patient over any other consideration? To comprehend an individual's values and morals, it is imperative to examine their decision-making methodology and ethical framework.

Individual Accountability within the System

•In addition to directing attention towards Vaught, it is imperative to examine the entirety of the healthcare system and any potential structural deficiencies that may have contributed to the error (Lambert and Schiff, 2022). An analysis of Vaught's sense of agency and self-awareness may provide a deeper understanding of how the incident was generated through the combination of systemic and personal factors.

Justification: Conducting a case study analysis on "To Know Thyself" would facilitate a deeper comprehension of Vaught's self-awareness, decision-making strategies, ethical dilemmas, and potential for growth and accountability. This research facilitates an examination of the function and impact of individuals within the framework of healthcare provision and the maintenance of patient well-being.

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Maslow's Hierarchy of needs

Maslow's Hierarchy of Needs is a psychological framework that prioritizes various types of needs, ranging from basic physiological provisions to more abstract objective for self-fulfillment. The utilization of Maslow's Hierarchy of Needs in attendance a valuable framework for investigates the case study of RaDonda Vaught and identifies possible stirring factors.

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Maslow's hierarchy of needs

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Figure 6: Maslow's Hierarchy of Needs

Source: (Hopper, 2020)

Physiological Needs:

According to [Maslow's Hierarchy of Needs](#), primary physiological needs such as nourishment, security, and well-being are positioned at the base of the pyramid. As a nurse, Vaught was tasked with providing medical care to her patients and addressing their physiological concern, which may have entail administering medication. Vaught unconsciously administered Versed to the patient as an alternative of vecuronium (Hopper, 2020), ensuing in significant adverse outcomes. In order to ensure patient safety, it is imperative that healthcare personnel are ready with the necessary tools, training, and hold up to meet primary physiological standards.

Safety Needs:

The term "safety need" is usually used to refer to an individual's innate desire or condition to experience a sense of safekeeping. The safety principles of a healthcare facility include the stipulation of a secure setting for both patients and staff. In this scenario, the error in medication administration has the latent to pose a threat to the patient's well-being. The condition of an override mechanism by Vaught, due to her inability to obtain the obligatory medication through the computerized system, highlights a deficiency in the in-progress safety protocols and events. It is very important for healthcare establishments to prioritize patient safety by implement robust systems and as long as ongoing training to make sure the well-being of both patients and staff.

Social Needs:

The concept of "social needs" pertains to the essential human requirements for social acceptance, interpersonal connection, and intimate relationships. Although not explicitly discussed in the case study, it is plausible that the social connections of healthcare provider could exert a collision on their overall state of wellness (Harrington, 2022). Facilitating open message, cooperation, and teamwork can be a viable come up to to ornamental job satisfaction and plummeting errors in the workplace.

Esteem Needs:

Esteem needs refer to the human want for acknowledgement, esteem, and admiration. The potential collision of medical practitioners' sense of self-worth and professional status on their job performance was not clearly examined in the case study (Maher and Cwiek, 2022). The acknowledgement and appreciation of achievements among member of a corporate culture may augment the intelligence of reason and inspiration of healthcare personnel, thereby humanizing the superiority of care provide.

Self-Actualization:

Self-actualization represents the highest level of standards, surrounding the accomplishment of one's complete capability and a feeling of human being pleasure. While not clearly addressed in this particular case study, the ability of healthcare professionals to pursue personal growth (Shi and Lin, 2021), ongoing education, and career progression could potentially enhance their job satisfaction and the caliber of care they offer.

Justification: The utilization of ³³ Maslow's Hierarchy of Needs can facilitate a deeper comprehension of the causal motivations that propelled Vaught's conduct during the aforesaid event. Enhancement of patient safety and healthcare provider well-being can be achieved by address these criteria within the healthcare system. This involves, inter alia, given that opportunities for professional development, ensuring a stable work environment, and upholding a secure ambiance.

Pygmalion effect

The Pygmalion effect, commonly referred to as the self-fulfilling prophecy, is a psychological phenomenon that elucidates the influence of an individual's social environment on their behaviour and performance. The analysis of the Pygmalion effect in the case study sheds light on the impact of external assumptions and presumptions on the behaviour of RaDonda Vaught. As per the case study, Vaught committed a significant prescription error by administering the paralytic agent vecuronium instead of the intended sedative medication, Versed, to Charlene Murphey (Lambert and Schiff, 2022). The patient incurred

severe harm, such as cardiac arrest and permanent cognitive impairment, as a result of the error. Notwithstanding Vaught's benevolent motives, an error resulted in endangering the life of the patient.

Vaught's behaviors and talents may be evaluated using the Pygmalion effect in light of his expectations, beliefs, and working environment. The following factors must be considered:

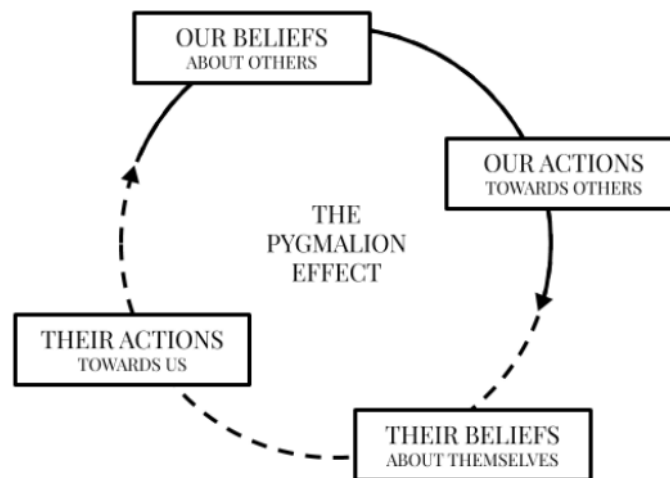


Figure 7: Pygmalion effect

Source- Self created

Self-Perception: It is possible that Vaught's conduct was motivated by her confidence in her nursing skills. The occurrence of an error could be attributed to the presence of self-doubt or a deficiency in self-assurance, which may have impeded her ability to act in a responsible manner.

Organizational Culture and Resources: It is plausible that Vaught's conclusions could have been impacted by the healthcare institution's cultural milieu and resource accessibility (Zhang et al., 2022). The failure of the automated medicine distribution system may have prompted Vaught to make impulsive decisions by utilising the override option, potentially due to insufficient procedures in place.

Communication and Support: Establishing effective channels of communication and garnering the backing of both managerial and personnel factions are pivotal in cultivating a salubrious professional milieu. Vaught's error may have been influenced by issues related to communication, insufficient support, or inadequate monitoring.

Leadership Grid

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The Managerial Grid, also known as the Leadership Grid, was developed by Robert Blake and Jane Mouton to depict various leadership philosophies. The evaluation of leadership attributes such as the consideration for subordinates and the optimization of productivity is conducted. RaDonda Vaught, a nurse with prior experience, can be classified within the Managerial Grid framework as follows:

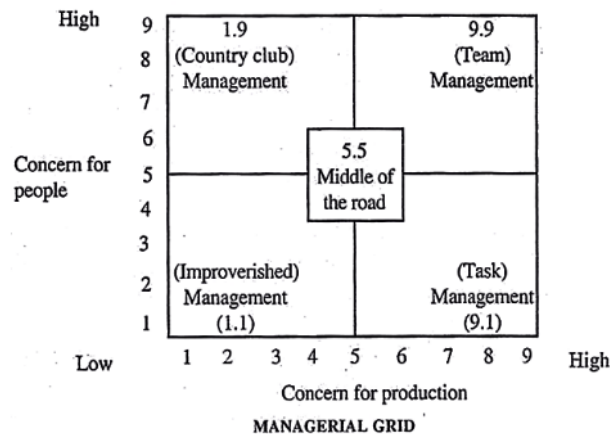


Figure 8 Leadership Grid

Source- (Larsen, 2022)

Impoverished Management (1,1): This approach demonstrates a contemptuous attitude towards both the process of work and the resulting outcomes. However, the data provided indicates that Vaught's actions are incongruent with this particular leadership style.

Country Club Management (1,9): In this operational strategy, priority is given to individuals over production (Mcgraw, 2023). It appears that Vaught has committed a significant error by disregarding established safety protocols, indicating a potential disregard for efficiency rather than a deliberate intention to cultivate a favorable working atmosphere.

Authority-Compliance Management (9,1): This methodology prioritizes the output of goods or services while disregarding the well-being and welfare of individuals involved. The actions of Vaught demonstrated a lack of regard for productivity and individuals, despite the importance of prioritizing the safety and well-being of patients, ultimately leading to an unfavorable outcome.

Middle-of-the-Road Management (5,5): This approach endeavors to achieve a harmonious equilibrium between objectives centered on productivity and those centered on interpersonal dynamics, yet it may not fully meet the requirements of either. Based on the available data, it can be argued that Vaught's actions deviate from the norms typically associated with conventional management strategies.

Team Management (9,9): This aesthetic place equal importance on individuals and their productivity. The task involves cultivating a conducive work environment while simultaneously prioritizing the achievement of exceptional outcomes (Veitch, Lax and Roy, 2022). Vaught's behaviors appear to deviate from a managerial approach that prioritizes collaborative practices.

Due to the limited data available, it is challenging to accurately categorize Vaught's leadership style within the Managerial Grid framework. The adverse outcomes resulting from her actions serve as evidence of her failure to adhere to safety protocols. The Managerial Grid model places significant emphasis on leadership behavior within the context of an organizational structure. It is important to note that the current situation is primarily attributed to the negligence of a single individual, rather than being directly linked to any particular leadership style.

Theory X, Y, Z

The application of McGregor's Theories X, Y, and Z in the context of employee motivation and management styles can be employed in the analysis of the RaDonda Vaught case study. The integration of these hypotheses into one's research can be achieved through the following methods:

Theory X: According to this belief, individuals will go to great lengths to evade attending work. Individuals require rigorous oversight and administration, in addition to extrinsic support and stimulation. Managers who adhere to Theory X hold a pessimistic perception of their employees, perceiving them as lacking motivation and requiring constant supervision (Vizcaya-Moreno and Pérez-Cañaveras, 2020). The actions of RaDonda Vaught are incongruous with the principles of Theory X. No negligence or malevolence was present. The fatal outcome, in this case, was attributed to a pharmaceutical error that led to the patient receiving an incorrect medication.

Theory Y: In contrast to Theory X's prescriptive and authoritarian approach, Theory Y posits that individuals possess the inherent motivation and comprehend the significance of their contributions. The statement suggests that individuals can engage in innovative ideation, address challenges through practical solutions, and take responsibility for their actions. According to Theory Y, managers endorse

employee autonomy, encourage participation, and empower workers to contribute to effective decision-making processes. The act of RaDonda Vaught's miscalculation can be viewed as contradictory to the fundamental notion that humans are inherently responsible and motivated, as per the principles of Theory Y. It is imperative to acknowledge that even individuals who exercise caution and possess self-awareness are not immune to committing errors from time to time.

Theory Z: As per the tenets of Theory Z, it is recommended that businesses establish a conducive environment that fosters employee retention and motivation. This highlights the importance of establishing strong working relationships between employees and management (Frost, 2022). Theory Z's managerial approach prioritizes employees' welfare and development, fostering a work environment that cultivates feelings of recognition and esteem.

The utilization of Theory Z in this case study may entail an examination of the institutional culture and operational procedures. To mitigate medication errors, it is imperative to assess factors such as training protocols, communication strategies, stress levels, and existing systems (Mcgraw, 2023). Mitigating the likelihood of reoccurrence necessitates implementing a proficient strategy and a functional organizational ethos that fosters the assimilation of knowledge from past shortcomings.

McGregor's conceptualizations provide comprehensive frameworks for contemplating employee motivation and management practices (Wright, 2023). When analyzing the cause-and-effect relationship between actions and their outcomes, it is imperative to consider the situation's specific context and complexities.

CATWOE

The utilization of the CATWOE methodology is a beneficial tactic for evaluating intricate matters from multiple perspectives with the aim of identifying optimal solutions (Lim, 2019). The application of the CATWOE framework to RaDona Vaught's situation yields illuminating insights.

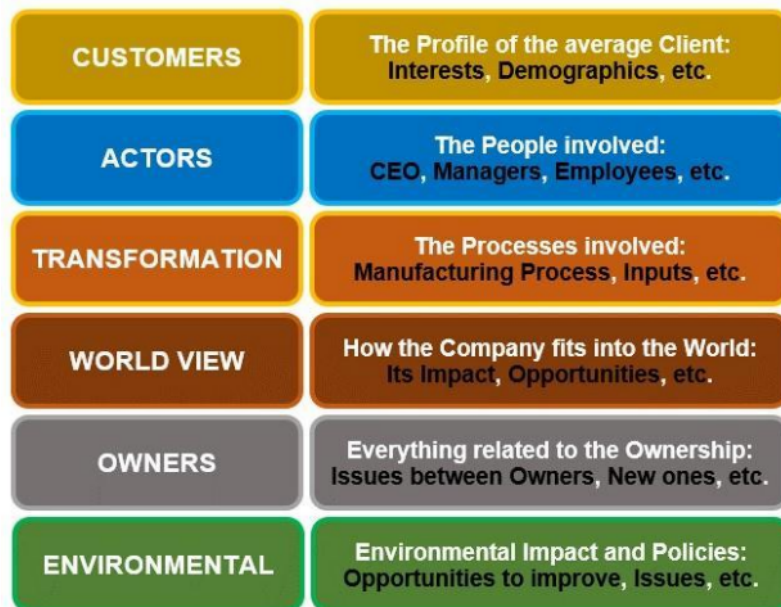


Figure 9: CATWOE Model

Source: (Lim, 2019)

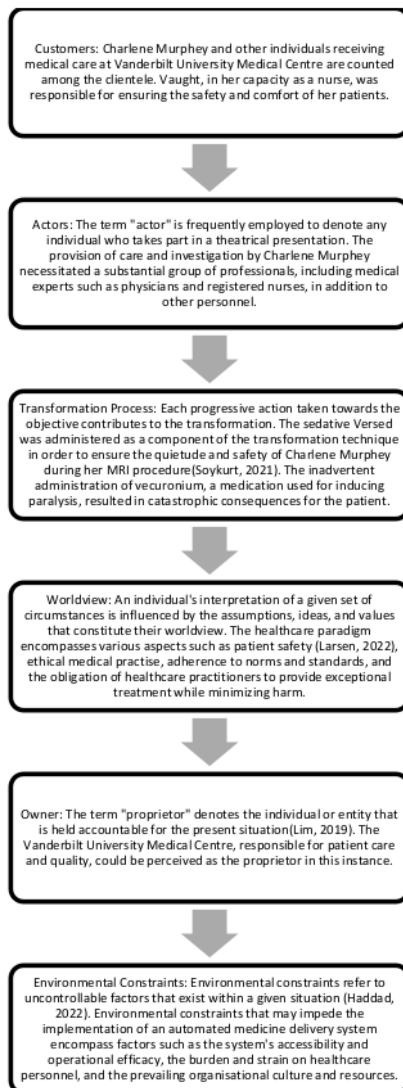


Figure 10:CATWOE

Source- Self created

Justification: The CATWOE paradigm can be employed to conduct a comprehensive analysis of this case and identify all the perspectives and factors that led to RaDonda Vaught's medication error (Adashi and Cohen, 2022). This approach has the potential to reveal potential avenues for enhancing healthcare systems and procedures, and underscores the importance of considering multiple factors when analysing complex situations.

Recommendation

The RaDonda Vaught case sparked considerable discussion about the legal consequences of medical mistakes, leading to an investigation into the role of leadership, team dynamics, and system-oriented thinking in building a safety-oriented culture inside healthcare organizations. Investigating these components in preventing similar catastrophes cannot be overstated.

Leadership Style:

Effective leadership is critical in creating a culture prioritizing patient safety and providing medical workers with the tools they need to provide excellent care. Leaders must create an atmosphere that encourages open communication among workers, prioritizes knowledge development from failed initiatives, and provides the necessary resources and time to complete tasks (Jothinath, 2020). In this situation, leaders must honestly appraise their behavior to create an environment in which safety rules are regularly followed.

Recommendation: The administration of healthcare facilities is responsible for creating a culture free from the punishment that encourages the open disclosure of errors and makes it possible to learn from such occurrences.

Team Dynamics:

Efficient teamwork is critical to guarantee efficient communication and prevention of mistakes in healthcare settings. Interdisciplinary teams that pool their resources and skills may provide the best treatment for patients. Establishing a venue for team members to express concerns and participate in open discourse can reduce the frequency of oversights.

Recommendation: It is suggested that healthcare facilities use techniques that have been shown to improve collaborative efforts, such as interprofessional education, frequent team meetings, and a working atmosphere that prioritizes open communication and mutual respect.

System Thinking:

Errors often occur in the healthcare system due to its complexity. Because of the increased risk of mistakes, a thorough review of a specific configuration at the system level is required (Veitch, Lax and Roy, 2022). Implementing protections such as setting standards, double-checking procedures, and identifying and correcting systemic faults helps reduce mistakes.

Recommendation: Using systems thinking in healthcare facilities' attempts to recognize and treat systemic problems may be beneficial. To attain the goal, it is critical to participate in ongoing quality improvement efforts, undertake detailed root cause analysis after unfavorable incidents, and adopt system-wide upgrades to avoid such failures in the future.

Continuous Learning and Improvement:

Creating a culture prioritizing continual education and improvement may lead to better patient outcomes and fewer medical mistakes. Encouraging doctors to attend professional organization meetings, conferences, and seminars might help them learn new things.

Recommendation: The two approaches that healthcare firms may use to encourage the professional growth of their staff are to establish a learning culture and to provide access to appropriate resources and training courses.

Healthcare facilities may use a variety of approaches to reduce ⁶³the incidence of medical mistakes and improve the safety of their patients. Leadership, teamwork, a system-oriented strategy, and lifelong learning are some of the concepts that govern the execution of such techniques (Jain, 2021). Implementing a safety culture, allocating proper resources and training, and addressing systemic vulnerabilities are all essential steps healthcare organizations may take to reduce mistakes. Applying this technique will allow healthcare practitioners to provide improved treatment while reducing the chance of adverse outcomes.

Conclusion and reflection

Conclusion:

The RaDonda Vaught case has brought attention to the intricate nature of criminalising medical errors. The outcome of Charlene Murphey's actions led to a grave resolution. However, this case underscores the essential factors to consider when responding to such errors and the significance of adopting ³⁷a comprehensive and refined approach. The impact of patient safety and medical error prevention is significantly influenced by leadership style, team dynamics, and systemic thinking. Effective leadership fosters a safe work environment and motivates healthcare personnel to provide exceptional care. It is imperative for leaders to give precedence to the acquisition of knowledge, encourage transparent communication, and establish a non-punitive environment that facilitates the sharing and learning from

mistakes. Leaders can motivate their team members to adhere to safety protocols and regulations by equipping them with the necessary resources and cultivating a positive work atmosphere.

Healthcare collaboration fosters clear communication and eliminates errors. People in a group may work together if they can express their viewpoints and are treated with respect. Organizations should finance interprofessional education, frequent team meetings, and other measures encouraging patient-centered care. Understanding the systemic causes of medical errors necessitates a systems-oriented approach. In healthcare companies, system-wide modifications and root cause analysis may reduce errors and improve patient safety. Education and practice help to reduce errors and enhance patient outcomes. Encourage healthcare staff to participate in training, stay current on best practices, and continue their education. Employee development and patient outcomes may benefit from a culture of continuous learning in healthcare firms.

Reflection:

The module's interactive nature has enhanced my comprehension of the complexities of medical errors and their extensive implications for patient safety, healthcare providers, and the healthcare industry at large. The implementation of a comprehensive approach that encompasses leadership, collaboration, system thinking, and ongoing education and training is necessary for the prevention of errors and the cultivation of a safety culture.

This session underscores the importance of acknowledging both individual accountability and systemic factors that contribute to medical errors. It is imperative to hold individuals accountable for their actions, while simultaneously conducting a thorough examination of the underlying factors contributing to errors and implementing systemic modifications to preclude their recurrence. The interconnection of diverse learning outcomes has facilitated a comprehensive understanding of the prevailing issues. The effective resolution of ⁵⁹ medical errors and the enhancement of patient safety necessitate the interplay of leadership, teamwork, and systems thinking. The module's content has provided a solid foundation regarding the difficulties associated with medical errors and potential remedies for these concerns. The importance of establishing a secure working environment, fostering productive collaboration, and implementing a systems-oriented methodology has been underscored. The aforementioned principles are applicable not only to healthcare practitioners but also extend to other domains. They underscore the importance of fostering transparent communication, ongoing learning, and recognizing the role of systems in tackling complex issues.

In the forthcoming period, it is imperative that I allocate a greater amount of time and exertion towards comprehending and implementing the knowledge I have acquired in these domains. The identification of strengths and areas for growth in one's learning and development approach can enhance one's ability to critically evaluate complex situations and make informed decisions in both personal and professional contexts.

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GENERAL COMMENTS

Engagement with Literature Skills (10/15)

Satisfactory presentation with clear informative structure, headings, and sub-headings. Think of developing your headings better and use the number i.e. 2.1 for 4 p's also instead of using main body as a heading, you should use different words i.e. Case study etc.. You must have at least 2 subheadings under the same heading. Figures are clear, but poorly labelled. Harvard style has not been applied appropriately. Make sure you read more about referencing in Study Skills Plus to learn more about citation and punctuation. SID number is included.

Knowledge and Understanding Skills (15/25)

The problem been formulated using appropriate evidence used extracted from publications and statistics. The problem causes and implications for health care been discussed using relevant theories and concepts. The role of leadership in the creation/magnifying the problem has been discussed.

Cognitive and Intellectual Skills (15/25)

The case study (i.e. organisation) has been identified. The implications on the organisation have been identified. The problem has been identified and has been evidenced using knowledge and literature and adequate theoretical concepts (Rich picture) i.e. **The diagram was present but inadequately described, i.e. a lack of clarity in the explanation.** . Leadership and its implications on the magnifying the problem has been investigated and strengthened using relevant evidence and concepts (MisLeadership). Avoid introducing and describing theories as these do not add any value to submissions. Focus on using these theories to support your arguments and strategies.

Practical Application Skills (09/20)

The solution has been analysed using CATWOE analysis technique. The most relevant leadership styles have been adequately identified using relevant theories and concepts (Leadership Theory) and supported by evidenced arguments from knowledge and literature. The strategy takes into account the complexity of staffing issues motivation and influencing. The submission includes a brief risk mitigation plan.

Transferable Skills for Life and Professional Practice (10/15)

The submission includes a good set of conclusions.

Depth of reflection and introspection regarding what has been learned, what worked well and what needs revision is good. Good to see that you have developed some detailed reflection, about your leadership, but I was hoping to see more about your engagement with the module activities to discover your team role.

For future

Please use the numbering system with sections and sub sections when organizing this document.

need to work on the layout i.e. how to make headings stand out more effectively.

Also you mentioned Behavioural theory leadership in your assignment but there is a gap in your understanding of this type of leadership when it comes to the more complex concepts.

All evidence or claims used in the assignment should also be referenced in order to ensure accuracy

Before you start work on the assignment, always read the assignment brief thoroughly so you know exactly what's expected of you

The report lacked focus as it contained a lot of scattered information that made it difficult to understand.

In addition, some other theories/lenses i.e. Kotter's Change Theory, Catwoe, tannenbaum, behavioural theory etc. can be useful in understanding the complexities of the situation.

Overall, this is a potentially good submission, but unfortunately the approach you took (lack of theory application) and selection of an organisation made your task more challenging. You are highly encouraged to work more with your tutor and colleagues. The work could have been far stronger if you have done so. The above comments should help better future submissions.

Marked by F Khan

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