Chapter 104
An Exploratory Content Analysis of Human Resources Management in Healthcare Organizations

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ABSTRACT

Human resource experts suggest unveiling future trends should invite practitioners to focus on evolving human resource management (HRM) roles, target deficiencies, and present solutions leveraging abilities to converge, employees, leaders, and stakeholders committed to advance opportunities for professional development. This chapter provides a detailed analysis of human resources management (HRM) roles that affect employee management changes to explore human resource (HR) accountability, competency management, employee abilities, and organizational capabilities around treatment effectiveness and reduction of errors in healthcare delivery. Explorations on HRM's future impact on career development, succession and replacement planning, and development provoked examinations on goals and future career aspirations in healthcare.

INTRODUCTION

Medical errors happen and are a result of numerous causes, but patient safety is necessary for all healthcare stakeholders, including accrediting and credentialing agencies, and educational institutions (Wachter, Pronovost, & Shekelle, 2013). A gap exists between current hospital practices and the perceived importance of varying approaches to improve patient safety Wachter, Pronovost, & Shekelle, 2013). Healthcare organizations in the United States seek ways to reduce medical errors and adverse events that hamper patient safety (Frese & Keith, 2015). Medical errors are among the primary causes of death in

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the United States (James et al., 2014). The annual cost of preventable medical errors, not including the cost of loss of human life, is $17- $29 billion (James et al., 2014). Reducing these errors and improving patient safety has become a global concern (James et al., 2014). Organizational performance may improve when staff and human resource (HR) personnel use a more coherent strategic approach to reduce errors improving patient safety (Mohmmad, 2019; Smith, 2013).

The challenge in finding the causes of failure in healthcare is to find the issue and focus on the redesign process to promote change. The origins of medical errors may have critical factors, such as failure because of barriers within the organization. Longenecker and Longenecker (2014) acknowledged that ten key factors caused hospital improvement and change efforts to fail. Longenecker and Longenecker (2014) noted over 160 frontline leaders who contributed to focus groups from among four community hospitals. The participants in this study consisted of 60% females and 38% males of about 40 years in age and represented the hospitals' functional areas. 66% were clinicians, and over 30% were from business operations. The results of the ten key factors of failure included

poor implementation and unreasonable timelines;
a lack of engagement and ownership of the personnel;
poor leadership and a lack of trust in management;
planning errors;
communication difficulties;
no change, focus or improvement;
lack of teamwork;
failure to provide measurements, lack of accountability, and limited feedback;
lack of clear goals, roles, and performance expectations; and
a lack of resources, time, and the support of upper management.

The identification of these primary obstacles suggested that hospitals do not foster an organizational culture that holds and endorses essential critical practices such as organizational change and improvement with expertise and desire (Longenecker & Longenecker, 2014).

Problem Statement

The problem is understanding the role the human resources can play in improving the culture, staff, and effectiveness of healthcare organizations. At least 50% of hospital-acquired infections (HAIs) account for a large proportion of the harm caused by inappropriate healthcare and are estimated to cost approximately 18.2 billion dollars annually (Zimlichman et al., 2013). With little evidence of improved quality care, thousands of additional deaths are associated with preventable medical errors (Wachter et al., 2013). James (2013) found from their research that 400,000 patients die annually due in some respect to medical errors, making it the third leading cause of death in the United States. Employees and effective ways to engage them play a significant role in addressing healthcare delivery, patient care, and organizational effectiveness (Mohmmad, 2019; Smith, 2013).