



# The Co-operative University of Kenya

**END OF SEMESTER EXAMINATION DECEMBER-2019**

**EXAMINATION FOR THE DEGREE OF BACHELOR OF COMMERCE**

**UNIT CODE: HCOB 2334**

**UNIT TITLE: EMPLOYEE RESOURCING**

**DATE: DECEMBER, 2019**

**TIME:**

---

**INSTRUCTIONS:**

- Answer question **ONE (compulsory)** and any other **TWO** questions

**QUESTION ONE**

Explain the following terms using the views of two scholars:

- a) Job Analysis
- b) Human Capital Planning
- c) Employee Recruitment

(10 marks)

**QUESTION TWO**

**Case1**

My son was born after my wife had three miscarriages. Alex was an energetic, curious little boy who went through a long phase of asking me, “Why, Daddy?” It forced me to become creative with my answers, but there was always another “why” waiting in my son’s mind. Alex grew into an athletic young man with a passion for playing the baritone. In his last year of high school, he followed in my footsteps and became a runner, soon beating me in races and greeting me at the finish line with a happy smile and the words, “Good race, Dad.” Just before he turned 18, he became a computer science major at Baylor University. After the events of September 11, 2001, he decided to join ROTC at Baylor and serve in the Air Force after graduation.

On September 15, 2002, a call to my home in Houston changed my life forever. It was late on a Sunday evening, and it came from Dr. Jones in Waco. He said that Alex had collapsed while running. Alex had collapsed in a similar incident a month earlier, but recovered on his own. This time, he was down for some time, and the paramedics had to shock his heart three times to restart it. He was in a deep, unresponsive coma. I drove three hours through the night to be at my son’s bedside.

Alex never recovered from his deep coma. Three days after I drove to see him, Alex died. Words cannot capture the grief experienced by those of us who were closest to Alex — his Mama and me, his little sister, and his much younger little brother. Our faith community and many friends held us in their hearts as we struggled through the process of burying our firstborn son and brother. What had gone wrong? After his first collapse, Alex was hospitalized for five days. He had various cardiac evaluations: numerous electrocardiograms, a cardiac ultrasound, an exercise stress test, and a cardiac MRI. He was also given a cardiac catheterization, which caused a painful hematoma, and an electrophysiology test, which led him to bleed from his groin. During his hospital follow-up visit five days after discharge; his doctor had given him a clean bill of health.

Since there was the possibility of a genetic cause of his death, I asked for his records. I received a quarter inch-thick pile at first, until I pressed for his complete record, which was three inches thick. As I examined his records and studied cardiology literature, I discovered that his cardiologists had failed him. After his first collapse, Alex had three types of heart arrhythmia and low potassium. Two years earlier, a guideline from the National Council on Potassium in Clinical Practice called for potassium replacement in such patients. He never received potassium replacement, even though I had told his lead

cardiologist about his low potassium. (I did not know enough at the time to connect low potassium with heart arrhythmia.)

A communication error was also apparent to me as I pieced together the records. No one warned Alex not to run after the hospitalization after his first collapse. His written discharge instructions specified only that he not drive for 24 hours. There was no record of anyone warning him not to run when he had his follow-up visit, so he didn't realize he shouldn't have resumed running after his groin wounds healed. This was a catastrophic oversight.

In the spring after my son died, I learned of another major mistake. A radiologist at the hospital where my son received treatment got in touch with me. After we exchanged a number of emails, he told me Alex's cardiac MRI was done incorrectly because the technicians had not been trained on new software for the machine. Alex was never told this (I know because I was there), and this information was critical because the cardiac MRI was to be performed *before* any invasive testing.

To be blunt, my son was deceived into signing consent forms for his cardiac catheterization and electrophysiology test. If his cardiologists had only recognized his need for potassium replacement, neither test would have been needed. They should have at least repeated his cardiac MRI with technicians who were properly trained to do the test.

The discovery of these errors led me to a new calling in patient safety. I wrote *A Sea of Broken Hearts* (2007), a book that describes the poor quality of care my son received, the lack of accountability for the system's failings, and the solution I propose: a genuine, national patient bill of rights. The goal would be to protect patients like the laws that protect workers subject to exploitation by powerful employers. To improve patient safety, we must level the playing field between patient and provider

I had the opportunity to talk to the IHI Open School Chapter at Wayne State University Medical School in Detroit. I told the story of what happened to my son and suggested ways to fix the system to make doctors, nurses, and patients happier. I ended by noting that I'm hopeful the next generation can fix the broken health care industry my generation has created. If my son were still alive, he would ask, "Why is it broken, Daddy?" And I would say, "It is mostly selfishness and greed, my son. But sit down, because there is much more."

- I) What were the errors in Alex James's care? What do you think was ultimately the cause of his death? (15 Marks)
  
- II) Do you think that the hospital would have known about the errors in Alex's care if his father hadn't investigated what happened? What does this portend in sharing information in working environment? (15Marks)

### QUESTION THREE

'Human capital planning is the process of determining the required number of workforce in an organization to achieve desired objectives within defined time frame'

Discuss

(15 marks)

### QUESTION FOUR

"Organization Learning is a process of actualizing organization objectives through embracing scientific, viable and logical environment" Discuss

(15 marks)

### QUESTION FIVE

Write short notes on any **Two** of the following:

1. Challenges of Employment in Kenya
2. Training and Development
3. Employee Recruitment
4. Wages Regulations in Kenya.

(15 marks)