Developing a code of conduct

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Developing a of Conduct A sentinel event is described as an unexpected incidence that occurs randomly and it may involve death or serious psychological or physical injury. A serious physical injury may involve loss of a limb or even loss of function of a particular body part. An injury may also include any incidence that may have a serious effect and outcome in the life of a patient. A sentinel event usually calls for immediate response and investigation to determine its cause and whether it occurred naturally or it was as a result of human error (Joint Commission Resources Inc., 2005).

The Joint Commission has a mandate of ensuring that health care services provided by health care facilities are up to standards. In order for the commission to improve the quality of health care services provided to patients, it has to review the activities of health facilities to identify situations that may inhibit a health facility from providing quality medical services to patients. The Joint Commission carries out its review with reference to sentinel events and it has to ensure that it includes all required accreditation surveys as well as random unannounced surveys. The main purpose of a Sentinel Event Policy is to provide an avenue where events that occur in the organization, both in the private and public health care facilities, will be identified, reported, investigated and managed (Joint Commission Resources Inc., 2005).

Health care facilities are required to work towards meeting the requirements set by Joint Commission. These requirements include: development of effective mechanisms through which sentinel events can be reported and analyzed especially events that involve patient falls, meeting patient-safety goals as well as meeting patient-safety standards. Some health care facilities, however, have not implemented most of the requirements in all

areas of operation. This is seen to have huge impacts on improving communication and increasing leadership knowledge of a hospital. These hospitals are therefore not able to account for the safety of its patients. Health care facilities that do not meet the set standards or do not respond to sentinel alerts as required by the Joint Commission may face consequences such as loss of accreditation. This means that a lot of money from Medicaid programs as well as Medicare will be lost. Hospitals will lack financial resources and they will also lose their patients since no one would want to seek medical services from an institution that provides unsafe care to patients.

A code of conduct policy is in place in the organization where I work. The organization has a standard of conduct through which it is able to communicate its values, its ground rules for behavior as well as the acceptable criteria to be used in decision making. The code of conduct helps the organization to build a value-driven environment and to also deal with its underlying values, the organization’s standards for doing business and its overall relationship with society at large.

I have been oriented on the policy and I therefore know the kind of behavior that is acceptable within the organization. No incidence has been reported since efforts to adhere to the accepted conduct have been heightened within the organization. Leaders of the organization also emphasize on the importance of employees carrying out their daily duties with integrity and in an ethical manner. This has played a great role in increasing the focus of employees and they are able to concentrate on good governance, ethics as well as corporate responsibility.

References

Joint Commission Resources Inc. (2005). Reducing the Risk of Falls in Your Health Care Organization. Improving Health Care Quality and Safety. Illinois: Joint Commission Resources.