

Good law research proposal example

[Law](#), [Security](#)



According to Carlson and Rice (2014), patient safety advocates have in the recent past called increased regulations on the safety of patients. The advocates lament that the nation's lack of effective measures and regulations aimed at protecting people once they have entered the hospital premises. Medicare watchdog, a body concerned with the monitoring of patient safety situation in the US noted that adverse events within hospitals lead to about 15000 deaths every month. This body further asserts that over 130000 less-severe injuries occur as a result of the adverse events in the hospitals. This means that little has been done by regulatory authorities to assure patients of their safety. The advocates demand for the establishment of an authority which will be able to set rules concerning the management of the safety of patients in the hospital as well as another body whose duty would be to make sure that such laws are enforced to the latter.

The advocates of patient safety have also been calling upon providers of medical services to accept the fact that they are not perfect and hence support a national system that would ensure the accountability of medical practitioners. Hospitals have made several attempts to improve the safety of patients. For instance, the management is inculcating in employees the culture of safety which would then result into renewed commitment on maintaining safety of patients. Hospitals are also required to carry out root-cause analysis in order to identify the causes of serious failures that occur within the premises. Despite such efforts, there has been little improvement in the manner in which the safety of patients is taken care of. When hospital management realised that their failures could result into increased costs in terms of dock charges and patient readmissions compelled the management

to make efforts in improving patient healthcare.

The safety of patients is governed by the Patient Safety and Quality Improvement Act of 2005. This article was written in response to the fact that few medical practitioners were paying attention to patient safety rules espoused in the Patient Safety and Quality Improvement Act of 2005. This Act seeks to improve the safety of patients by requiring every medical practitioner to report on voluntary basis any events within the provision of healthcare that may negative affect the health of patients. One of the requirements of this Act is for healthcare practitioners to develop patient safety programs through which data on patient safety is collected and analyzed. The analysis of adverse events affecting patient safety is important as it enables healthcare practitioners to identify events that may undermine patient safety in order to maintain safety. According to the article written by Carlson and Rice (2014), healthcare practitioner has not made necessary efforts to abide by these laws. The authors also note that only 13% of the events affecting the safety of patients are recorded and acted upon. This has significantly jeopardised efforts aimed at improving the safety of patients.

The function of this law is to make sure that the safety of patients is maintained. Unfortunately, very few healthcare practitioners have undertaken necessary actions required by the Patient Safety and Quality Improvement Act of 2005. The failure of healthcare practitioners to adhere to this law has led to an increase in the number of infections arising poor patient safety practices. Such healthcare infections have caused many patients to return back to hospital for treatment owing to the failure of

medical practitioner to maintain their safety within the hospital. If this law were to be fully adhered to by all medical practitioners, there would be few cases of patient infection among other adverse events like patient falls. The Patient Safety and Quality Improvement Act of 2005 also require the healthcare practitioners to maintain make confidential reports of any events that occur within the premises that threaten the safety of patients. The reports could then be used to identify, evaluate and manage such risks. Unfortunately, as Carlson and Rice (2014) note, such measures have not been taken by many healthcare practitioners within the US. Some patients try to report such adverse events when they occur. Despite this, no measures have been undertaken to improve the safety of patients. Although patients report such cases, very few healthcare practitioners are willing to make a follow-up and hence, bring forth an improvement patient safety. According to the article, the hospital accreditation process which is managed by the Joint Commission has not effectively conducted an oversight on the maintenance of patient safety in healthcare organizations. According to the law, it is important for the hospital accreditation to make sure that frequent compliance assessments are carried out to ensure that healthcare practitioners maintain high quality patient safety. The law also calls for healthcare practitioners to carry out frequent self assessments to make sure that the hospitals and other premises housing patients are managed in a manner that supports the safety of patients. It is important for the healthcare practitioners to make sure that patients are safe. Some of the risks that could be avoided include patient falls as well as infection with diseases due to negligence on the part of healthcare practitioners.

The use of patient safety evaluations is also important as outlined in the Act. Healthcare practitioners will only be considered to be adhering to the patient safety regulations if they consistently carried out patient safety evaluations. The evaluations enable healthcare to identify risks that may bring forth patient falls, infections among other adverse events.

References

Agency for Healthcare Research and Quality (2014) Patient Safety Organization (PSO) Program. Available at: <https://www.pso.ahrq.gov/legislation> (Accessed 5th November 2014)

Carlson, J. & Rice, S. (2014). Patient-safety advocates issue call for regulation Available at: <http://www.modernhealthcare.com/article/20140614/MAGAZINE/306149779> (Accessed 5th October 2014)