

Importance of adherence to the commissions safety goals



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With care-giving as the backbone to the nursing profession, there is a sense of urgency to which we must respond such that patient safety is in no way compromised. For this reason, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) put together the National Patient Safety Goals (NPSGs). Established in 2002, these goals were made to address particular issues regarding patient safety. And like the Constitution of the United States, there have been “ amendments” or, in the Joint Commission’s case, revisions as new cares and concerns have arisen in the process. Whether the goal involves communication between healthcare professionals or interactions between caregivers and clients, these revisions reflect the Joint Commission’s ongoing efforts in ensuring quality care and safety of patients.

For purposes of “ checks and balances” like that of the American government, there is a Patient Safety Advisory Group comprised of various healthcare professionals that collaborates with the Joint Commission about these safety goals, with the best interests of the patient as the highest priority (Sage). Goal #1, which involves the accuracy of patient identification, sounds like a given, but one must first and foremost make sure that the services in question are being given to the correct patient. There are to be at least two forms of patient identifiers to eliminate errors associated with patient misidentification. Goal #2 involves improving effectiveness of communication among caregivers. Though the patient may not necessarily be directly involved in this process, the outcome of this communication between caregivers does directly affect the patient. For instance, since there will be times in which nurses switch out and the patient

is under the care of a “ new” nurse who may not be familiar with the patient, proper charting and documentation is essential such that everyone directly involved in the patient’s care is on the same page. The 3rd safety goal is improving the safety of using medications, whereby all medications, medication containers, and other solutions are properly labeled to reduce the chances of adverse effects associated with taking the wrong medication (i. e. the last thing one wants to happen is for patients who do not need blood-thinning accidentally taking Coumadin or some other anti-coagulant).

Goal #4 covers the “ three rights” (or eliminating the three wrongs)- right site, right patient, and right procedure. It sounds like common sense, but one aspect that may not necessarily come to mind immediately is the fact that people usually have more than one of certain parts of their bodies; therefore, it is crucial that one be more specific when designating such areas for surgery (i. e. If a given patient needs to have an leg amputation to treat cancer, one must specifically designate whether it is the right or left leg to be amputated). Goal #7 seeks to reduce the risk of healthcare-associated infections, formerly known as nosocomial infections. It is of utmost importance that there is full compliance with current guidelines from the Centers for Disease Control (CDC) or the World Health Organization (WHO) with hand-washing on the part of healthcare professionals; additionally, one must see to it that patients take their “ full course” of antibiotics to prevent infections resulting from multi-drug resistant organisms such as Methicillin-resistant Staphylococcus Aureus (MRSA).

Goal #8 aims to accurately and completely reconcile medications across the continuum of care; when a patient is referred from one organization to <https://assignbuster.com/importance-of-adherence-to-the-commissions-safety-goals/>

another, their information pertaining to medication regimen is also to be communicated to the following provider. Goal #14 seeks to prevent healthcare-associated pressure ulcers. Pressure ulcers tend to occur in long-term care settings, particularly geriatric care where residents are, more often than not, less mobile and more sedentary, unwittingly putting extensive pressure on certain areas of their bodies such as the sacral/coccygeal region. For this reason, caregivers are to see to it that such residents are moved and rotated accordingly to lower the chances of this happening. Goal #15 pertains to identifying safety risks inherent in its patient population. Individuals within a given organization must be aware of these risks, such to better care for their clients.

Since the geriatric patient's body generally does not recover quite the same as that of someone in another age group, it would make sense that even more attention to detail is given to this age group with regards to reducing the risk of falls, the aim of goal #9. According to Deanna Gray-Miceli of the Hartford Institute for Geriatric Nursing, the rate of falling increases proportionally with increased number of pre-existing conditions and risk factors (Gray-Miceli, 2007). Essentially, as the body ages, it takes more "hits" and becomes more compromised.

The Hendrich II Fall Risk Model has been an invaluable source for assessing an

in-patient client's risk of falling. In *AJN: the American Journal of Nursing*, Ann Hendrich states that this plan was designed to be administered quickly, focusing on eight independent risk factors- 1) confusion, disorientation,

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impulsivity; 2) symptomatic depression; 3) altered eliminated; 4) dizziness/vertigo; 5) male sex; 6) administration of antiepileptics; 7) administration of benzodiazepines; and 8) poor performance in the “ get-up-and-go” test of rising from a seated position. Each of these risk factors is given a score and, depending on the results of this process, the patient would receive the appropriate precautionary interventions (Hendrich, 2007). Not that there are “ low priority” patients per se, but the higher the score according to that model, the more vigilant caregivers should be of a given patient.

Angela Mankoff of *The Clinical Nurse Specialist: the Journal for Advanced Nursing Practice* presented the findings from Hoag Hospital showing that their inpatient fall rates were initially steady at 40 to 50 falls per quarter or 2. 42 falls per 1000 patient-days. To combat this issue, a pilot tool was developed and implemented in the 1st quarter of 2009, accounting for the patient’s capacity for out-of-bed activity, mobility aids by the bedside, and respective safety cautions and restrictions such as hip fractures. By the 3rd quarter of that same year, the unit had gone four months without a patient fall (Mankoff, 2010, p. 216). The results of this pilot clearly indicated a positive correlation between streamlined communications by the bedside and staff awareness, and in turn, overall improvement in compliance with safety goals.

Times change and people may change, but one thing that will never change is the fact that everyone ages and will need to take appropriate measures in adapting to such changes, assuring safety from falls, and in general, wherever they can. Although one may not necessarily be a geriatric patient <https://assignbuster.com/importance-of-adherence-to-the-commissions-safety-goals/>

just yet, one more often than not has a loved one who was or is one; therefore, the subject of quality care and safety for the geriatric patient is ubiquitously relevant because aging is a natural part of life that everyone experiences.