

# Accreditation Quality Report





Welcome to the Joint Commission's Quality Report. We know how important reliable information is to you and your family when making health care decisions. This Quality Report will help you make the right decisions to meet your needs. Since 1951, the Joint Commission has been the national leader in setting standards for health care organizations. When a health care organization seeks accreditation, it demonstrates commitment to giving safe, high quality health care and to continually working to improve that care.

The Quality Report is only one way to determine whether a health care organization can meet your needs. Discuss this report with your doctor or with other professional acquaintances before making a care decision. In addition to the accreditation status of the organization, the Quality Report uses checks, pluses, and minuses in each of the following key areas to help you compare a health care organization with similar accredited organizations.

- National Patient Safety Goals - safety guidelines that target the prevention of medical errors such as surgery on the wrong side of the body and safe medication use.
- National Quality Improvement Goals - measures the care of patients with specific conditions such as heart failure or pregnancy.




Not all measures are relevant to or available for all types of health care organizations. The Joint Commission will add relevant measures of health care quality as more measures become available. Your comments are just as important to us. The content and format of the Quality Report will be updated from time to time based on changes in the health care industry and your suggestions. Please call Customer Service at 630-792-5800 or e-mail the Joint Commission at [qualityreport@jointcommission.org](mailto:qualityreport@jointcommission.org) with your comments and suggestions.

Mark R. Chassin, MD, MPP, MPH  
President of the Joint Commission












## Summary of Quality Information

### Symbol Key

-  The organization has met the National Patient Safety Goal.
-  The organization has not met the National Patient Safety Goal.
-  The Goal is not applicable for this organization.

For further information and explanation of the Quality Report contents, refer to the "Quality Report User Guide."

Accreditation Programs	Accreditation Decision	Effective Date	Last Full Survey Date	Last On-Site Survey Date
 Behavioral Health Care	Accredited	6/30/2007	8/20/2010	8/20/2010
 Hospital	Accredited	6/30/2007	8/20/2010	8/20/2010
 Pathology and Clinical Laboratory	Accredited	1/10/2009	1/9/2009	1/9/2009

		Compared to other Joint Commission Accredited Organizations	
		Nationwide	Statewide
Behavioral Health Care	<b>2007 National Patient Safety Goals</b>		 *
Hospital	<b>2007 National Patient Safety Goals</b>		 *
Pathology and Clinical Laboratory	<b>2009 National Patient Safety Goals</b>		 *



## Locations of Care




### \* Primary Location

Locations of Care	Available Services
<p><b>Richmond State Hospital *</b> 498 Northwest 18th Street Richmond, IN 47374</p>	<ul style="list-style-type: none"> <li>• Behavioral Health (Residential / Group Homes - Adult) (24-hour Acute Care/Crisis Stabilization - Adult)</li> <li>• Chemical Dependency (24-hour Acute Care/Crisis Stabilization - Adult)</li> <li>• General Laboratory Tests</li> <li>• Toxicology</li> </ul>
















## 2007 National Patient Safety Goals

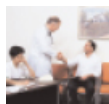
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### Behavioral Health Care

Safety Goals	Organizations Should	Implemented
Improve the accuracy of client identification.	Use at least two client identifiers when providing care, treatment or services.	
Improve the effectiveness of communication among caregivers.	For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the information record and "read-back" the complete order or test result.	
	Standardize a list of abbreviations, acronyms, symbols, and dose designations that are not to be used throughout the organization.	
	Measure, assess and, if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values.	
	Implement a standardized approach to "hand off" communications, including an opportunity to ask and respond to questions.	
Improve the safety of using medications.	Standardize and limit the number of drug concentrations used by the organization.	
	Identify and, at a minimum, annually review a list of look-alike/sound-alike drugs used by the organization, and take action to prevent errors involving the interchange of these drugs.	
Reduce the risk of health care-associated infections.	Comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines when providing services to a high-risk population, or administering physical care.	
	Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care-associated infection.	
Accurately and completely reconcile medications across the continuum of care.	There is a process for comparing the client's current medications with those ordered for the client while under the care of the organization.	
	A complete list of the client's medications is communicated to the next provider of service when a client is referred or transferred to another setting, service, practitioner or level of care within or outside the organization. The complete list of medications is also provided to the client on discharge from the facility.	
Encourage clients' active involvement in their own care as a client safety strategy.	Define and communicate the means for clients and their families to report concerns about safety and encourage them to do so.	
The organization identifies safety risks inherent in its client population.	The organization identifies clients at risk for suicide.	


















## 2007 National Patient Safety Goals

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### Hospital

Safety Goals	Organizations Should	Implemented
Improve the accuracy of patient identification.	Use at least two patient identifiers when providing care, treatment or services.	
Improve the effectiveness of communication among caregivers.	For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the information record and "read-back" the complete order or test result.	
	Standardize a list of abbreviations, acronyms, symbols, and dose designations that are not to be used throughout the organization.	
	Measure, assess and, if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values.	
	Implement a standardized approach to "hand off" communications, including an opportunity to ask and respond to questions.	
Improve the safety of using medications.	Standardize and limit the number of drug concentrations used by the organization.	
	Identify and, at a minimum, annually review a list of look-alike/sound-alike drugs used by the organization, and take action to prevent errors involving the interchange of these drugs.	
	Label all medications, medication containers (for example, syringes, medicine cups, basins), or other solutions on and off the sterile field.	
Reduce the risk of health care-associated infections.	Comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.	
	Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care-associated infection.	
Accurately and completely reconcile medications across the continuum of care.	There is a process for comparing the patient's current medications with those ordered for the patient while under the care of the organization.	
	A complete list of the patient's medications is communicated to the next provider of service when a patient is referred or transferred to another setting, service, practitioner or level of care within or outside the organization. The complete list of medications is also provided to the patient on discharge from the facility.	
Reduce the risk of patient harm resulting from falls.	Implement a fall reduction program including an evaluation of the effectiveness of the program.	
Encourage patients' active involvement in their own care as a patient safety strategy.	Define and communicate the means for patients and their families to report concerns about safety and encourage them to do so.	
The organization identifies safety risks inherent in its patient population.	The organization identifies patients at risk for suicide. [Applicable to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.]	






## 2007 National Patient Safety Goals

### Hospital

Safety Goals	Organizations Should	Implemented
Universal Protocol	Conduct a pre-operative verification process.	
	Mark the operative site.	
	Conduct a "time out" immediately before starting the procedure.	

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## 2009 National Patient Safety Goals

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### Pathology and Clinical Laboratory

Safety Goals	Organizations Should	Implemented
Improve the accuracy of patient identification.	Use of Two Patient Identifiers	
	Conducting a Verification Process Before Starting Procedures	
Improve the effectiveness of communication among caregivers.	Reading Back Verbal Orders	
	Creating a List of Abbreviations Not to Use	
	Timely Reporting of Critical Tests and Critical Results	
	Managing Hand-Off Communications	
Reduce the risk of health care-associated infections	Meeting Hand Hygiene Guidelines	
	Sentinel Events Resulting from Infection	
Encourage patients' active involvement in their own care as a patient safety strategy.	Patient and Family Reporting of Safety Concerns	