

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, 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 the key area of 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.

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 with your comments and suggestions.

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



Summary of Quality Information

Accreditation Decision

Accredited

Decision Effective Date

August 08, 2008

Accredited Programs	Last Full Survey Date	Last On-Site Survey Date
Critical Access Hospital	8/7/2008	8/7/2008

Accreditation programs recognized by the Centers for Medicare and Medicaid Services (CMS)

Critical Access Hospital

Critical
Access
Hospital

2008National Patient Safety Goals


Compared to other Joint Commission Accredited Organizations


Nationwide


Statewide



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."



Locations of Care




* Primary Location

Locations of Care	Available Services	
Mayo Clinic Health System - Oakridge, Inc. * 13025 8th Street Osseo, WI 54758	<ul style="list-style-type: none"> • Acute Care • Cardiac Unit/Cardiology (Outpatient) • CT Scanner (Inpatient, Outpatient) • EEG/EKG/EMG Lab (Outpatient) • Emergency Room (Outpatient) • Family Practice (Inpatient, Outpatient) • General Medical Services (Inpatient) • Gynecology (Outpatient) • Hematology/Blood Treatment (Inpatient, Outpatient) • Imaging/Radiology (Inpatient, Outpatient) • Infusion Therapy (Outpatient) • Magnetic Resonance Imaging (Outpatient) 	<ul style="list-style-type: none"> • Nuclear Medicine (Outpatient) • Orthopedic Surgery (Outpatient) • Podiatry (Outpatient) • Rehabilitation and Physical Medicine (Inpatient, Outpatient) • Respite Care (Inpatient) • Skilled Nursing Facility (Inpatient) • Sleep Center (Outpatient) • Subacute Care (Inpatient) • Telemetry (Inpatient) • Ultrasound (Outpatient) • Urgent Care/Emergency Medicine (Outpatient) • Wound Care (Inpatient, Outpatient)
MCHS - Oakridge 700 Buffalo St. Mondovi, WI 54755	<ul style="list-style-type: none"> • General Outpatient Services (Outpatient) • Multi Specialty Group Practice (Outpatient) 	


















2008 National Patient Safety Goals

Symbol Key

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Critical Access 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.	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 likelihood of patient harm associated with the use of anticoagulation therapy.	
Reduce the risk of health care-associated infections.	Comply with current World Health Organization (WHO) Hand Hygiene Guidelines or 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.	
Improve recognition and response to changes in a patient's condition.	The organization selects a suitable method that enables health care staff members to directly request additional assistance from	






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Critical Access Hospital

Safety Goals	Organizations Should	Implemented
	a specially trained individual(s) when the patient's condition appears to be worsening.	
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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