**A statement from The Joint Commission**

Earlier this year, The Joint Commission conducted two on-site visits at Southern Nevada Adult Mental Health Services– a routine on-site survey of hospital and behavioral health care programs May 14-17, and an unannounced for-cause survey of the hospital program May 2-3 -- to survey the organization’s compliance with the hospital and behavioral health care accreditation standards.

At the July 18 meeting of The Joint Commission Accreditation Committee, a committee of The Joint Commission Board of Commissioners, the members voted to change the hospital’s accreditation status from “accredited” to “preliminary denial of accreditation,” due to the hospital placing patients at risk for a serious adverse outcome due to significant and pervasive patterns, trends, and/or repeat findings. The accreditation status of the organization’s behavioral health care program is “accredited.”

Preliminary denial of accreditationresults when the Accreditation Committee has determined at its meeting that there is justification to deny accreditation to a health care organization.

Southern Nevada Adult Mental Health Services may appeal any Preliminary Denial of Accreditation decision of the Accreditation Committee before the decision becomes the final decision of The Joint Commission. If the Accreditation Committee denies the appeal, then, the hospital will have one final opportunity to appeal the decision to a different committee of the Board, The Joint Commission Final Appeal and Review Committee. If an organization is unsuccessful in its attempts to appeal a decision it is then denied accreditation. The appeal process takes approximately four to six months.

**The following standard(s) were found to be out of compliance during the for cause survey of the hospital May 2-3, 2013:**

* Before the hospital discharges or transfers a patient, it informs and educates the patient about his or her follow-up care, treatment, and services.
* Medical staff bylaws address self-governance and accountability to the governing body.
* Patients with comparable needs receive the same standard of care, treatment, and services throughout the hospital.
* Staff are competent to perform their responsibilities.
* The governing body is ultimately accountable for the safety and quality of care, treatment, and services.
* The hospital assesses and reassesses the patient and his or her condition according to defined time frames.
* The hospital assesses the needs of patients who receive treatment for emotional and behavioral disorders.
* The hospital discharges or transfers the patient based on his or her assessed needs and the organization’s ability to meet those needs.
* The hospital documents the patient’s discharge information.
* The hospital effectively manages its programs, services, sites, or departments.
* The hospital has a process that addresses the patient’s need for continuing care, treatment, and services after discharge or transfer.
* The hospital has an organization-wide, integrated patient safety program within its performance improvement activities.
* The hospital has policies and procedures that guide and support patient care, treatment, and services.
* The hospital maintains accurate health information.
* The hospital manages the flow of patients throughout the hospital.
* The hospital provides orientation to staff.
* The hospital respects, protects, and promotes patient rights.
* The hospital uses data and information to guide decisions and to understand variation in the performance of processes supporting safety and quality.
* The organized medical staff has a leadership role in organization performance improvement activities to improve quality of care, treatment, and services and patient safety.
* The organized medical staff oversees the quality of patient care, treatment, and services provided by practitioners privileged through the medical staff process.
* The organized medical staff reviews and analyzes all relevant information regarding each requesting practitioner’s current licensure status, training, experience, current competence, and ability to perform the requested privilege.
* Those who work in the hospital are focused on improving safety and quality.
* When a patient is discharged or transferred, the hospital gives information about the care, treatment, and services provided to the patient to other service providers who will provide the patient with care, treatment, or services.

**The following standard(s) were found to be out of compliance during the routine survey of the hospital May 14-17:**

* The hospital manages fire risks.
* The hospital maintains fire safety equipment and fire safety building features. Note: This standard does not require hospitals to have the types of fire safety equipment and building features described below. However, if these types of equipment or features exist within the building, then the following maintenance, testing, and inspection requirements apply.
* The hospital manages risks associated with its utility systems.
* The hospital inspects, tests, and maintains emergency power systems. Note: This standard does not require hospitals to have the types of emergency power equipment discussed below. However, if these types of equipment exist within the building, then the following maintenance, testing, and inspection requirements apply.
* The hospital collects information to monitor conditions in the environment.
* During disasters, the hospital may assign disaster responsibilities to volunteer practitioners who are not licensed independent practitioners, but who are required by law and regulation to have a license, certification, or registration. Note: While this standard allows for a method to streamline the process for verifying identification and licensure, certification, or registration, the elements of performance are intended to safeguard against inadequate care during a disaster.
* The hospital evaluates the effectiveness of its emergency management planning activities.
* Staff are competent to perform their responsibilities.
* The governing body is ultimately accountable for the safety and quality of care, treatment, and services.
* Leaders create and maintain a culture of safety and quality throughout the hospital.
* Leaders use hospital-wide planning to establish structures and processes that focus on safety and quality.
* Those who work in the hospital are focused on improving safety and quality.
* The hospital effectively manages its programs, services, sites, or departments.
* Care, treatment, and services provided through contractual agreement are provided safely and effectively.
* The hospital has an organization-wide, integrated patient safety program within its performance improvement activities.
* The hospital designs and manages the physical environment to comply with the Life Safety Code.
* The hospital protects occupants during periods when the Life Safety Code is not met or during periods of construction.
* The hospital maintains the integrity of the means of egress.
* The hospital provides and maintains building features to protect individuals from the hazards of fire and smoke.
* The hospital provides and maintains operating features that conform to fire and smoke prevention requirements.
* The hospital safely stores medications.
* Medical staff bylaws address self-governance and accountability to the governing body.
* The management and coordination of each patient’s care, treatment, and services is the responsibility of a practitioner with appropriate privileges.
* The organized medical staff has a leadership role in organization performance improvement activities to improve quality of care, treatment, and services and patient safety.
* Identify patients at risk for suicide. Note: This requirement applies only to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.
* The hospital assesses and reassesses the patient and his or her condition according to defined time frames.
* The hospital plans the patient’s care.
* For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital uses restraint or seclusion only when it can be clinically justified or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others.
* For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital initiates restraint or seclusion based on an individual order.
* For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital documents the use of restraint or seclusion.
* The hospital collects data to monitor its performance.
* The hospital improves performance on an ongoing basis.
* The hospital maintains complete and accurate medical records for each individual patient.
* Entries in the medical record are authenticated.
* The patient and his or her family have the right to have complaints reviewed by the hospital.

To view the organization’s Quality Report please visit, [www.QualityCheck.org](http://www.QualityCheck.org).

For more on the hospital accreditation process go here:

<http://www.jointcommission.org/assets/1/18/Hospital_Accreditation_9_17_12.pdf>

For more information about the on-site survey process go here:

<http://www.jointcommission.org/assets/1/18/On-site_Survey_Process1.PDF>

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**Contact:**

Elizabeth Eaken Zhani

Media Relations Manager

The Joint Commission

630.792.5914

[ezhani@jointcommission.org](mailto:ezhani@jointcommission.org)