Sentinel Event Statistics for First Half of 2013

From the January 1995 implementation of The Joint Commission's Sentinel Event Database through June 30, 2013, The Joint Commission has reviewed 9,981 reports of sentinel events and included de-identified information about them in the Sentinel Event Database. The Sentinel Event Database is designed “to increase the general knowledge about sentinel events, their contributing factors, and strategies for prevention”—a key goal of the enterprise's Sentinel Event Policy. Database content includes data collected and analyzed from the review of sentinel events, root cause analyses (RCA), action plans, and follow-up activities, as tracking this aggregate information may help guide local efforts to prevent future occurrences.

The Joint Commission recently updated its summary data of sentinel events statistics for the first six months of 2013. Sentinel event outcomes from 2004 through the first half of 2013 show that a total of 7,440 patients have been affected by these events, with 4,476 (59.6%) resulting in the patient’s death, 700 (9.3%) resulting in loss of function, and 2,335 (31.1%) resulting in unexpected additional care and/or psychological impact. The Joint Commission reviewed a total of 446 sentinel events during the first half of 2013; the 10 most frequently reported types are shown in the first box on page 3.

Sentinel events are voluntarily self-reported to The Joint Commission by an accredited organization or non–self-reported via the complaint process or the media. When the Joint Commission Sentinel Event Unit (SEU) in the Office of Quality Monitoring receives information about a self- or non–self-reported event, the SEU discusses the event with the organization to determine if it meets Joint Commission reviewability criteria.* If it does, a

* See the “Sentinel Events” chapter in the accreditation (SE) and certification (SENT) manuals for a description of sentinel events subject to review by The Joint Commission.

Continued on page 3
New and revised requirements for Advanced Disease-Specific Care Certification for Comprehensive Stroke Center (CSC) requirements in the disease-specific care program (field review ends October 1, 2013)

Proposed revisions to Advanced Disease-Specific Care Certification for Primary Stroke Center (PSC) requirements in the disease-specific care program (field review ends October 9, 2013)

Proposed Patient Blood Management certification option for the hospital program (field review ends October 10, 2013)

Proposed Memory Care certification option for the nursing and rehabilitation center program (field review ends October 16, 2013)

Note: To participate in or read more about field reviews, please visit The Joint Commission website at http://www.jointcommission.org/standards_information/field_reviews.aspx.

CURRENTLY IN DEVELOPMENT

STANDARDS

- Proposed revisions to Advanced Disease-Specific Care Certification for CSC requirements in the disease-specific care program
- Proposed revisions to Advanced Disease-Specific Care Certification for PSC requirements in the disease-specific care program
- Proposed Patient Blood Management certification option for the hospital program
- Proposed Memory Care certification option for the nursing and rehabilitation center program
- Proposed new memory care standards for the nursing and rehabilitation center program
- Proposed revisions to requirements related to diagnostic imaging services for the ambulatory care, critical access hospital, and hospital programs
- Proposed revisions to requirements regarding sample medications for the ambulatory care, behavioral health care, critical access hospital, home care, hospital, and office-based surgery programs
- Proposed revisions to Advanced Disease-Specific Care Certification for Chronic Obstructive Pulmonary Disease (COPD) requirements in the disease-specific care program
- Revisions to the Primary Care Medical Home certification option for the ambulatory care program
- Proposed new and revised standards for the laboratory program
- Proposed new perinatal care certification for the health care staffing services program
- Proposed revision to the “Human Resources” (HR) chapter for the behavioral health care program
- Proposed 2015 National Patient Safety Goal (NPSG) on transitions of care for the ambulatory care, behavioral health care, critical access hospital, home care,
specially trained Joint Commission clinician then collaborates with the organization to review its RCA and to create an action plan with strategies for reducing the risk that similar events might occur in the future. The majority of events are a result of multiple root causes; the ten most frequently identified root causes (spanning several types of events) for the first half of 2013 are shown in the box at right.

“While sentinel events are infrequent, they may serve as signals of system vulnerability,” says Ronald Wyatt, MD, MHA, DMS(HON), medical director, Healthcare Improvement, The Joint Commission. “Rapid retrospective diagnosis of these mega-events is a key to achieving greater reliability and responsiveness. The analysis of sentinel events enables organizations to see and solve micro-breaks in the system, which can help prevent future occurrences of similar mega-events.

“In aviation, ‘blame-free’ reporting allows the system to see the problem, learn from it, and remove the causal factor(s) before another failure occurs,” Wyatt adds. “It is through this mechanism that a system can maintain its equilibrium. Simply working harder and performing acts of heroism are not enough.”

It is estimated that fewer than 2% of all sentinel events are reported to The Joint Commission and that only about two-thirds of these are voluntarily reported (4,977 of the 7,440 events reported since 2004 have been voluntarily reported). As these data are not an epidemiologic data set, no conclusions should be drawn about the actual relative frequency of events or trends in events over time. For more information about sentinel events, visit The Joint Commission website at http://www.jointcommission.org/sentinel_event.aspx.

<table>
<thead>
<tr>
<th>Most Frequently Reported Sentinel Events, January 1–June 30, 2013</th>
</tr>
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<tbody>
<tr>
<td>Wrong-patient, wrong-site, or wrong-procedure—60</td>
</tr>
<tr>
<td>Unintended retention of a foreign object—56</td>
</tr>
<tr>
<td>Delay in treatment†—56</td>
</tr>
<tr>
<td>Falls†—48</td>
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<tr>
<td>Other unanticipated events†—40</td>
</tr>
<tr>
<td>Operative/postoperative complication†—37</td>
</tr>
<tr>
<td>Suicide—35</td>
</tr>
<tr>
<td>Criminal event (assault/rape/homicide)—26</td>
</tr>
<tr>
<td>Medication error†—20</td>
</tr>
<tr>
<td>Perinatal death/injury†—15</td>
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</tbody>
</table>

† Resulting in death or permanent loss of function
‡ Includes asphyxiation, burns, choking, drowning, and being found unresponsive

<table>
<thead>
<tr>
<th>Most Frequently Identified Root Causes for Sentinel Events, January 1–June 30, 2013</th>
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<tbody>
<tr>
<td>Human factors (such as fatigue or distraction)—314</td>
</tr>
<tr>
<td>Communication (such as among staff, across disciplines, or with patients)—292</td>
</tr>
<tr>
<td>Leadership (regarding, for example, lack of performance improvement infrastructure or community relations)—276</td>
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<tr>
<td>Assessment (such as patient observation processes or its documentation)—246</td>
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<tr>
<td>Information management (such as patient identification or confidentiality)—101</td>
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<tr>
<td>Physical environment (such as emergency management or hazardous materials)—70</td>
</tr>
<tr>
<td>Care planning (planning and/or interdisciplinary collaboration)—49</td>
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<tr>
<td>Continuum of care (includes transfer and/or discharge of patient)—48</td>
</tr>
<tr>
<td>Medication use (such as storage/control or labeling)—48</td>
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<tr>
<td>Operative care (such as blood use or patient monitoring)—45</td>
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<th>In Sight (continued)</th>
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<tr>
<td>Continued from page 2</td>
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<tr>
<td>hospital, nursing and rehabilitation center, and office-based surgery programs</td>
</tr>
<tr>
<td>Proposed 2015 revision to NPSG.15.02.01 on home oxygen use for the home care program</td>
</tr>
</tbody>
</table>

POLICIES AND PROCEDURES
- Proposed revision to criteria for inclusion of physician practices in surveys of hospitals and critical access hospitals
- Revisions to the Sentinel Event Policy for all programs
In mid-September, The Joint Commission launched a Customer Inquiry Volume Study to determine the process changes needed to ensure that inquiries about standards from accredited customers are answered in a time frame that meets their needs. The goal of the study is to more readily identify—and prioritize—inquiries received from accredited customers, thereby facilitating faster response times.

To assist in the study, customers contacting The Joint Commission with standards inquiries should follow these guidelines:

- Complete the online form available on the Joint Commission Connect™ extranet site. This is the most efficient way for customers to send questions to The Joint Commission. As a secure website intended only for Joint Commission–accredited and –certified organizations, the extranet automatically identifies and tracks the accredited and certified organizations submitting the inquiries.

LAUNCHED: Monthlong Study to Improve Customer Inquiry Response Time

The Joint Commission recently appointed Tracy Griffin Collander, LCSW, as executive director of the Behavioral Health Care Accreditation Program. In this role, Griffin Collander will lead the program's operations, development and strategic planning and serve as the Joint Commission liaison to national behavioral health professional and provider organizations.

Griffin Collander has more than 21 years of experience as an executive director and a clinician focusing on residential, day treatment, therapeutic day school, foster care, in-home, and outpatient treatment programs. Griffin Collander most recently served as an executive director for the Gateway Foundation, where she directed a suburban Chicago program that provides residential and outpatient treatment services for adults and youth with substance abuse issues and/or mental health disorders. A licensed clinical social worker in the state of Illinois, she holds a master's degree in social service administration from the University of Chicago.

“Tracy’s leadership experience in a variety of behavioral health settings gives her the practical perspective on both the opportunities and challenges that providers face on a daily basis,” said Charles Mowll, FACHE, executive vice president, Business Development, Government and External Relations, The Joint Commission. “Her firsthand knowledge and insight makes her well equipped to lead The Joint Commission’s Behavioral Health Care Accreditation Program forward in its mission to help and inspire organizations to achieve ever higher levels of safety and quality in the care they provide.”

The Joint Commission has been active in behavioral health care accreditation since 1969, when it began accrediting organizations providing services for persons with intellectual and developmental disabilities. In 1972 The Joint Commission began evaluating and accrediting organizations providing mental health and chemical dependency services, and today it accredits more than 2,000 behavioral health care organizations ranging from two-person organizations to the largest providers in the industry. Next year The Joint Commission will launch a Behavioral Health Home (BHH) certification product to recognize organizations that have successfully coordinated and integrated behavioral and primary physical health care (see September 2013 Perspectives, page 3). Organizations accredited under the Behavioral Health Care Accreditation Program may pursue this optional certification beginning January 1, 2014.

Joint Commission Appoints New Executive Director for Behavioral Health Care
The Joint Commission recently released the ninth installment in its animated Speak Up™ video series. “Speak Up: At Home,” designed for those who need medical care at home, shows how people can make the most of this experience and protect their health. During the course of the video, the characters of a nurse, home care aide, and home medical equipment specialist help a patient and his wife in their home with an IV, oxygen tank, and daily living needs. The video emphasizes that patients—as well as their families and friends—should ask questions to ensure they receive the care and treatment they need. The video offers the following advice to patients receiving home care and to their loved ones:

- Know that health care professionals coming to the home are there to help.
- Check the badges of visiting health care professionals.
- Ask visiting health care professionals why they are there and how often they will visit.
- Find out who to contact with questions and how to do so.
- Work with visiting licensed health care professionals to verify that prescribed and over-the-counter medications are correct.
- Understand how medical equipment that is delivered to the home works.
- Ask questions if something the home care professional says isn't clear.
- Find out what should be done when home care services come to an end.

Produced by The Joint Commission, the 60-second Speak Up videos are intended as public service announcements. The series, which has received more than 105,000 views on The Joint Commission's YouTube Channel at http://www.youtube.com/TheJointCommission, also airs on venues such as The Wellness Network, AccentHealth Network, GetWellNetwork, and LodgeNet Healthcare Network. Previous videos in the series, the first of which debuted in March 2011, emphasize the importance of speaking up and asking questions about your health care, managing pain, understanding patients’ rights, reducing the risk of falling, encouraging children to ask questions about their health, preparing for physician appointments, taking medication safely, and preventing infection.

The Speak Up program also features brochures and posters on a variety of patient safety topics. The national program urges patients to take an active role in preventing health care errors by becoming active, involved and informed participants on the health care team.

http://www.jointcommission.org  October 2013  The Joint Commission Perspectives 5

New Speak Up Video Addresses Medical Care in the Home

The national program urges patients to take an active role in preventing health care errors by becoming active, involved and informed participants on the health care team.
The Joint Commission has identified the need to increase the field's awareness and understanding of the Life Safety Code®.*

To address this need, The Joint Commission Perspectives® publishes the column Clarifications and Expectations, authored by George Mills, MBA, FASHE, CEM, CHFM, CHSP, director, Department of Engineering, The Joint Commission. This column clarifies standards expectations and provides strategies for challenging compliance issues, primarily in life safety and the environment of care, but also in the vital area of emergency management. You may wish to share the ideas and strategies in this column with your facility's leadership.

To further meet the needs of accredited organizations, The Joint Commission updated its electronic Statement of Conditions (E-SOC), effective July 15, 2013. The E-SOC is the tool that helps organizations assess their compliance with Joint Commission Life Safety (LS) standards and develop Plans for Improvement (PFIs) to correct deficiencies and maintain compliance. Standard LS.01.01.01 requires all health care occupancies, including critical access hospitals, hospitals, and some ambulatory and behavioral health care organizations, to complete the E-SOC.

You won't notice major change in how you use the E-SOC, but you may now find it easier to navigate, with more streamlined access to information. Organization-specific data housed in the previous version have been successfully transferred to the new version, and most of the changes to the tool relate to the user interface and the appearance of the site. Following are a few things to be aware of in this new and improved E-SOC.

**Documenting Interim Life Safety Measures Assessment**
You will most likely notice the upgrades when you create a new PFI. The LS standards require organizations to perform an interim life safety measures (ILSM) assessment when creating a PFI. This is to determine whether there are any risks to life safety and to institute measures to mitigate those risks. In the updated E-SOC, an organization must indicate—by selecting “Yes” or “No”—whether an ILSM assessment has been completed. The system will not allow an organization to fully create a new PFI unless the ILSM column contains a response.

Previously, the system defaulted the ILSM designation to “unknown” in the body of the PFI. So, organizations that have an existing PFI (created prior to the July 15, 2013, update) might consider updating the ILSM field, although doing so is not required. For PFIs created after July 15, 2013, an ILSM must be completed according to the organization's policy, and the organization must indicate in the E-SOC that the assessment has been completed. (See the ILSM screen shot on page 7.)

**Keeping Track of ILSM Assessment Status**
Organizations can track the status of ILSM assessments by looking at the “PFI View All” screen (at the top of page 8). This screen provides a management process to ensure that your organization does not exceed the projected completion date by more than six months.

For PFIs created after July 15, 2013, the surveyor will review the “PFI View All” screen and verify that each PFI has had an ILSM assessment. Not performing the ILSM assessment may result in a finding under standard LS.01.02.01, Element of Performance 3. During survey, a surveyor may ask for additional information regarding an ILSM assessment.

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* Life Safety Code® is a registered trademark of the National Fire Protection Association, Quincy, MA.
if there is an “N” response in the “PFI View All” screen. The organization should be able to demonstrate its process.

**Managing the Status of PFIs**

To help organizations better track their progress toward completion of their PFIs, The Joint Commission has included a new management tool in the E-SOC. It’s a pie chart that shows a snapshot of your organization’s PFI status (see the image on page 8). You can filter the data feeding into the pie chart, choosing to look at open PFIs, closed PFIs, and/or all PFIs. You can also filter by facility building to get a sense of progress in a specific area. This management report could be suitable for a dashboard report or could be used when assessing resource allocation by facility building.

**Streamlining Access and Providing Clarity**

The remaining updates to the E-SOC relate to the Basic Building Information (BBI) and PFI sections. You can now access these two areas directly from the E-SOC home page. Previously, you had to go through the BBI to get to the PFI page, but now you can select one or the other and be directly routed to the correct location.

In addition, the E-SOC now includes a table outlining National Fire Protection Association (NFPA) construction types (see the table on page 8) in the BBI section. This information is provided to facilitate the completion of the BBI, specifically regarding acceptable construction types and the possible need for sprinkler coverage or other methods of ensuring compliance.

*Continued on page 8*
The E-SOC lists all sites that are identified on an organization’s electronic application (E-App) by copying this E-App information and populating the “Sites & Buildings” screen of the BBI section. To assist an organization in effectively managing its buildings, each business occupancy where patients are treated should be identified as a business occupancy on the “Sites & Buildings” screen. This action enables organizations to ensure that the correct occupancy type is chosen for the service provided.

The BBI provides an excellent opportunity to evaluate business occupancies (although such an evaluation is not a current requirement). Business occupancies are buildings...
Joint Commission and AMA-convened PCPI Recommend Strategies to Minimize Overuse

The Joint Commission and the American Medical Association–convened Physician Consortium for Performance Improvement® (PCPI®) recently released the paper “Proceedings from the National Summit on Overuse.” The September 2012 summit convened representatives from 112 professional organizations and associations to discuss the problem of overuse, described as the provision of medical interventions or treatments that provide zero or negligible benefit to patients and that potentially expose them to the risk of harm.

Sometimes overlooked or neglected as a leading contributor to problems with quality and patient safety, overuse of medical treatments and interventions affects millions of patients. Overuse also drives up health care costs, with an estimated $1 billion spent annually on unnecessary antibiotics for adults with viral upper respiratory infections (URIs) alone. The summit findings complement work being done throughout the nation to address the overuse issue, such as the American Board of Internal Medicine Foundation’s “Choosing Wisely Campaign” (see http://www.choosingwisely.org/ for more information).

Summit attendees were divided among five multidisciplinary work groups charged with validating the evidence and data on overuse of a specific intervention, reviewing guidelines and quality measures, and identifying or developing strategies for organizations and key stakeholders to reduce overuse. The work groups comprised stakeholders from physician organizations, medical specialties, government agencies, health care associations, research institutions, and patient advocacy groups. Each work group was chaired by a physician, supported by Joint Commission and AMA-PCPI staff, and met three times prior to the summit (via conference call and in-person meetings).

During the summit, all five advisory panel work groups identified the following common strategies for reducing overuse:

- Inspire physician leadership
- Support a culture of safety and mindfulness
- Promote further patient education
- Remove incentives that encourage overuse
- Encourage further study
- Motivate other professional organizations to collaboratively address overuse

The work groups also developed recommendations for five specific areas targeted for reduction. These targeted overuse areas, and the strategies to reduce them, are shown in the table on page 10.

“Overuse is a serious problem that involves many complex decisions between doctors and patients,” says Mark R. Chassin, MD, FACP, MPP, MPH, president and chief executive officer, The Joint Commission. “The recommendations from the summit will raise awareness that will help both doc-

LAUNCHED: Monthlong Study to Improve Customer Inquiry Response Time (continued)

Continued from page 4

- Contact The Joint Commission via website or phone.
  Customers may submit questions via the Standards Online Question Form at http://www.jointcommission.org/standards_information/online_question_form.aspx or by calling the Standards Interpretation Group at 630-792-5900, option 6. Customers should provide their organization’s accreditation ID number (known as its HCO ID) when submitting an inquiry via the website or phone. This allows The Joint Commission to track the number of customer inquiries received and to prioritize the inquiries of accredited customers.

Upon completion of the monthlong study in mid-October, The Joint Commission will analyze the data, create a work plan, and incorporate improvements. The launch of the new response program is scheduled for the second quarter of 2014. Questions about the study may be directed to the Standards Interpretation Group by calling 630-792-5900, option 6, or by e-mailing Deborah Pryor at dpryor@jointcommission.org or Antoinette Mister at amister@jointcommission.org.
tors and patients make better decisions going forward, and ultimately improve quality and patient safety.”

“Proceedings from the National Summit on Overuse” is available at http://www.jointcommission.org/overuse_summit/. The Joint Commission and the American Medical Association–convened PCPI encourage professional organizations to continue the dialogue and mobilize their membership to effect meaningful change in the areas addressed during the Overuse Summit.

### Summary of Overuse Summit Recommendations

<table>
<thead>
<tr>
<th>Medical Intervention or Treatment</th>
<th>Phase I Recommendations on Interventions, Practices, and Methods Aimed at Reducing Overuse</th>
</tr>
</thead>
</table>
| 1. Overuse of antibiotics for viral upper respiratory infections (URIs) | ● Develop clinical definitions for viral and bacterial URIs  
● Align currently contradictory national guidelines  
● Partner with the Centers for Disease Control and Prevention  
● Initiate a national education campaign on overuse of antibiotics for viral URIs |
| 2. Over-transfusion of red blood cells (called “appropriate blood management” for purposes of the summit) | ● Develop a toolkit of clinical education materials for physicians  
● Expand education on transfusion avoidance and appropriate alternatives to transfusion  
● Develop a separate informed consent process for transfusion that communicates risks and benefits |
| 3. Tympanostomy tubes for middle ear effusion of brief duration | ● Develop performance measures for appropriate use of tympanostomy tubes  
● Determine the frequency with which tympanostomy tubes are inserted for inappropriate indications in otherwise healthy children  
● Focus national research on related issues |
| 4. Early-term nonmedically indicated elective delivery | ● Standardize how gestational age is calculated  
● Make the early elective deliveries indications and exclusion list as comprehensive as possible to improve clinical practice  
● Educate patients and doctors about the risks of nonmedically indicated early elective deliveries |
| 5. Elective percutaneous coronary intervention (PCI) | ● Encourage standardized reporting in the catheterization and interventional procedures report  
● Encourage standardized analysis/interpretation of noninvasive testing for ischemia  
● Focus on informed consent and promote patient knowledge/understanding of the benefits/risks of PCI  
● Provide public and professional education |

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### Legacy Domain Name @jcaho.org No Longer Valid

Effective January 1, 2014, The Joint Commission will no longer receive e-mails that are sent using @jcaho.org as the domain name. Although The Joint Commission changed its e-mail domain name from @jcaho.org to jointcommission.org in January 2007, e-mails were still received at addresses using either domain name. A recent increase in spam sent to @jcaho.org addresses, however, prompted The Joint Commission's decision to discontinue using @jcaho.org. Please check your Joint Commission staff contact information to ensure the domain name is @jointcommission.org to avoid getting an “invalid e-mail address” message. Questions may be directed to your organization's assigned Account Executive by calling 630-792-3007.
New Speak Up Video Addresses Medical Care in the Home (continued)

Continued from page 5

care errors by becoming involved and informed participants on the health care team. The basic framework of the Speak Up campaign encourages patients to take these steps:
✔ Speak up if you have questions or concerns. If you still don't understand, ask again. It's your body, and you have a right to know.
✔ Pay attention to the care you receive. Always make sure you're getting the right treatments and medicines from the right health care professionals. Don't assume anything.
✔ Educate yourself about your condition. Learn about your medical tests and your treatment plan.
✔ Ask a trusted family member or friend to be your advocate (advisor or supporter).
✔ Know what medicines you take and why you take them. Medicine errors are among the most common health care mistakes.
✔ Use a hospital, clinic, surgery center, or other type of health care organization that has been carefully checked out. For example, The Joint Commission visits hospitals to see if they are meeting The Joint Commission's quality standards.
✔ Participate in all decisions about your treatment. You are the center of the health care team.

The Joint Commission's Speak Up program has won multiple awards, including a Magnum Opus award in October 2012 for its video series. Since its launch in 2002, the Speak Up program has grown to include 21 campaign brochures (produced in both English and Spanish) and seven posters. For more information about the Speak Up program and to obtain free downloadable files of Speak Up videos, brochures, and posters, please visit The Joint Commission website at http://www.jointcommission.org/speakup.aspx. Printed Speak Up brochures and posters also are available for purchase through Joint Commission Resources by phone at 877-223-6866 or online at http://store.jcrinc.com/.

E-SOC Gets a Facelift (continued)

Continued from page 8

where three or fewer patients may be rendered incapable of self-preservation at any given time (not including any overnight sleeping, because business occupancies don't have this). Why three? The assumption is that a doctor, a nurse, and a(n) receptionist/assistant will be present, and they each would be able to perform a one-on-one rescue. Three health care providers/assistants; three patients. If there are more than three patients, one patient might get left behind in the event of a rescue, so the building must provide protection until the fourth (or more) patient can be rescued.

Conclusion

Although the changes to the E-SOC aren't dramatic, they will help organizations more seamlessly navigate the process of assessing LS standards compliance and addressing deficiencies. The slight alterations will not only improve ease of use but ultimately will further ensure the safety of patients and staff throughout a health care organization.

If you have any questions, please feel free to contact the engineers in the Department of Engineering at The Joint Commission by calling 630-792-5900. Please have your HCO (health care organization) number available when you call.

This month's column, which also appears in the October 2013 issue of Environment of Care® News, discusses enhancements to The Joint Commission's E-SOC. Next month's column will continue to focus on maintaining various environment of care and life safety features by discussing recent blanket waiver items from the Centers for Medicare & Medicaid Services.
2014 Hospital Accreditation Standards

Lean, light, and fully updatable!

Our best-selling Hospital Accreditation Standards (HAS) provides you with direct access to the latest hospital requirements and comes in a slim binder that allows you to easily insert the update included in the purchase price. Our customers told us that they (1) needed the manual to be updatable and (2) wanted just the standards chapters. Therefore, we added an update and removed the policy and summary chapters from the HAS, including only the standards chapters plus the glossary. (Accreditation policies and procedures, initiatives, and summaries are not included.) This on-the-go resource is perfect for meetings and staff orientation.

Preorder your copy of the 2014 Hospital Accreditation Standards and receive it as soon as it is available!

If you and your team do indeed want/need more than just the standards, perhaps the better option for you is the Comprehensive Accreditation Manual for Hospitals (CAH14), which is indeed “comprehensive” and includes everything.