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2025 Joint Commission Survey Data Analysis: Opportunities for Improvement Identified from Surveyor Observations in Hospitals

As part of its ongoing efforts to improve healthcare as well as its own processes, Joint Commission regularly collects and analyzes standards compliance data from its accreditation surveys and certification reviews. These data help Joint Commission tailor education and resources appropriately for healthcare organizations (HCOs) and understand HCOs' strengths and opportunities for improvement. In addition, beginning January 1, 2026, Joint Commission surveyors will start capturing HCOs' patient safety and quality improvement strengths as part of the new Survey Analysis For Evaluating STrengths (SAFEST) initiative. Such strengths will be shared at the end of the accreditation survey in a SAFEST report, with the ultimate goal of disseminating performance strength examples to other HCOs to encourage learning, improvement, and collaboration.

Previously, Joint Commission would publish in *Perspectives* "the top 10 challenging standards" for each accreditation program based on elements of performance (EPs) that had the highest number of Requirements for Improvement (RFIs). This article takes a different approach, focusing more on actual surveyor observations, trends and themes, and helpful details and examples rather than percentages of noncompliance.

To identify the top opportunities for improvement across clinical and physical environment topic areas, survey scoring data were analyzed using a new ranking methodology that accounts for both the frequency and importance of survey findings. Using the Joint Commission's *Survey Analysis for Evaluating Risk®* (*SAFER®*) Matrix, a weighting formula was developed to assign values based on the risk and scope of each survey finding. Findings placed in the low-risk, limited scope category of the *SAFER* Matrix were given minimal weight, whereas findings scored in the high-risk categories or widespread scope categories were assigned a more significant weight. Standards were then ranked based on the sum of weighted findings. The hospital standards identified in this article were nationally ranked as the top five opportunities for improvement within the clinical and physical environment topic areas.

Clinical Areas	Physical Environment Areas
1. Conducting activities to reduce health care–associated infections	1. Maintaining interior spaces that are safe and suitable to the care, treatment, and services provided
2. Safely and accurately administering medications	2. Ensuring critical pressure relationships
3. Implementing nursing policies	3. Providing a clean, odor-free environment
4. Ensuring availability of resuscitation equipment and supplies	4. Properly handling and storing hazardous chemicals
5. Conducting a preanesthesia assessment	5. Properly maintaining and ensuring safety of furnishings and equipment

Following are the top three themes observed during survey that are associated with each improvement area.

Clinical Improvement Opportunities

Conducting activities to reduce health care—associated infections

1. Expired or improperly maintained supplies and equipment. Numerous observations highlighted expired medical supplies, including Ambu bags, Foley catheter kits, and surgical gloves. Surveyors also reported repeated findings of instruments with peeling, cracked, or improperly wrapped tape, as well as equipment with visible residue, stains, or bioburden, indicating lapses in maintenance and readiness.

2. Noncompliance with infection prevention protocols and manufacturer's instructions. Many surveyors noted that staff did not always follow hand hygiene protocols before and after patient contact or glove changes. Also, staff were not adhering to manufacturer's instructions for cleaning, disinfection, or sterilization processes, such as improperly using disinfectant wipes, incorrectly cleaning medical devices, and not using appropriate personal protective equipment (PPE).

3. Improper use or lack of PPE. Staff were not wearing required PPE, such as gloves, gowns, masks, or beard covers, during patient care or procedures. There were also cases in which PPE was used incorrectly, such as wearing contaminated PPE outside designated areas or not following the organization's policies for PPE use in restricted or high-risk environments.

Safely and accurately administering medications

1. Not administering medications as ordered. Medications were not being administered according to the most recent physician orders. Examples include administering pain medications outside the prescribed pain scale parameters, titrating infusions at incorrect rates or intervals, and giving medications for indications not specified in the order.

2. No documentation or clarification. There was no documentation to justify deviations from orders or no evidence that providers were contacted for clarification. This includes situations in which medications were given without a corresponding order or changes were made to medication administration without proper documentation or provider notification.

3. Incorrect medication preparation or verification. Several observations involved errors in medication preparation or verification, such as administering the wrong formulation (for example, crushing enteric-coated tablets), using expired medications, or not visually inspecting medications for integrity before administration.

Implementing nursing policies

1. Not following nursing policies and physician orders. There were many instances in which nursing staff did not follow established protocols or physician orders. Examples include missing or delayed documentation of required assessments (for example, Richmond Agitation-Sedation Scale, Clinical Institute Withdrawal Assessment for Alcohol, vital signs, neurological checks), not performing or documenting medication administration as ordered, and not completing required patient assessments within specified time frames.

2. Incomplete or missing documentation. A recurring issue observed among surveyors was incomplete documentation in patient records. This includes no evidence of assessments (for example, skin, wound, pain, or nutritional assessments), incomplete medication administration records, and no documentation of interventions or reassessments after medication or treatment changes.

3. Not implementing or following organization policies. Policies were either not established or, when present, not consistently implemented. Staff were not adhering to policies for administering medications, monitoring patients, and following safety protocols (such as Universal Protocol, moderate sedation, and infection prevention measures).

Ensuring availability of resuscitation equipment and supplies

1. Expired or missing emergency equipment and supplies. Surveyors often observed expired items, including automated external defibrillator (AED) pads, laryngoscope blades, suction canisters, and oxygen cylinders. They also noted missing or incomplete equipment, such as AED pads for specific age groups, adult or pediatric defibrillator pads, and oxygen tanks.

2. Not complying with equipment check policies. Required daily, weekly, or monthly checks of emergency carts, defibrillators, and related equipment were not being done or documented. This includes missing log entries, incomplete documentation, and discrepancies between physical checks and recorded logs. Also, staff did not follow manufacturer's instructions for use or internal policies on equipment readiness.

3. Improper security and integrity of emergency carts. In multiple instances, crash carts or emergency equipment were unlocked or improperly secured or had mismatched lock numbers compared to documentation.

Conducting a preanesthesia assessment

1. Lack of required preanesthesia or presedation assessments. Preanesthesia or presedation assessments, including airway evaluations and American Society of Anesthesiologists classifications, were not being performed or documented prior to procedures involving moderate or deep sedation. This was noted across various departments, including Emergency, Surgery, and Interventional Radiology.

2. Incomplete or missing documentation of assessment elements. Even when assessments were attempted, key elements were missing from documentation. Common omissions include the Mallampati score, auscultation of heart and lungs, physical examination details, and time of assessment. These gaps were often contrary to the organization's policies or medical staff rules and regulations.

3. Not adhering to organization policies and procedures. Surveyors noted that staff did not follow the organization's policies on preanesthesia or presedation evaluations. Specific policies, guidelines, or bylaws that require comprehensive assessments and documentation were not adhered to in practice.

Physical Environment Improvement Opportunities

Maintaining interior spaces that are safe and suitable to the care, treatment, and services provided

1. Physical environment deficiencies. Surveyors frequently observed issues such as stained or damaged ceiling tiles, peeling or chipped paint, wall damage, and unclean surfaces in patient care and support areas.

2. Safety hazards and accessibility concerns. Surveyors often noted hazards such as unsecured medical supplies (for example, needles, sharps), improperly installed or inaccessible emergency pull cords, exposed wiring, and tripping hazards from loose or missing floor plates.

3. Cleanliness and infection control issues. Surveyors frequently observed unclean conditions, such as dirty floors, dust, expired food, and improper use of sinks for both handwashing and cleaning instruments.

Ensuring critical pressure relationships

1. Incorrect pressure relationships in critical areas. Operating rooms, sterile storage, and decontamination areas frequently had incorrect pressure relationships, such as negative pressure where positive is required or vice versa. These issues were often confirmed by facilities or clinical staff and sometimes corrected during or after the survey.

2. Temperature and humidity noncompliance. Temperature and humidity levels in operating rooms and sterile areas were outside required ranges (for example, temperatures below 68°F or humidity above 60%), with a lack of corrective action or documentation explaining the deviations. This includes both real-time monitoring and retrospective log reviews.

3. Air exchange and ventilation deficiencies. Surveyors frequently noted deficiencies in air exchange rates, with some rooms not meeting the minimum required air changes per hour. In some cases, documentation was missing or outdated, and corrective actions were not always evident.

Providing a clean, odor-free environment

1. Dust, dirt, and debris accumulation. Surveyors saw dust, dirt, and debris on various surfaces, including heating, ventilating, and air conditioning (HVAC) vents; equipment; floors; and storage areas. Examples include dusty HVAC vents in patient rooms and kitchens, dusty medical equipment, and dirty floors in both clinical and nonclinical areas.

2. Unclean or soiled equipment and furniture. Surveyors reported unclean or soiled patient care equipment, furniture, and fixtures. This includes soiled sinks used for handwashing, dirty refrigerators, stained or ripped furniture, and adhesive residue on surfaces.

3. Maintenance and facility issues. Surveyors noted facility-related concerns such as missing or stained ceiling tiles, damaged walls, rusted or stained fixtures, and lack of required safety equipment (for example, eyewash stations for chemical storage).

Properly handling and storing hazardous chemicals

1. Eyewash station accessibility and compliance. Eyewash stations were not accessible, with stations blocked by equipment or carts, too far from hazardous chemical use areas, or behind locked doors. Eyewash stations also did not comply with American National Standards Institute (ANSI) requirements for activation time, water temperature, and unobstructed access.

2. Maintenance and condition of eyewash stations. Eyewash stations were poorly maintained, with missing or improperly placed dust caps, debris or residue on spray heads, and expired eyewash solutions. Stations were not regularly inspected and/or inspection was not regularly documented. Some stations were inoperable or not checked at the required frequency.

3. Personal protective equipment (PPE) and chemical handling practices. Staff either did not use or improperly used PPE when handling hazardous chemicals. Chemical containers were unlabeled or unsecured, and staff were not trained in or aware of emergency procedures. There were also instances in which hazardous chemicals are used or stored without appropriate risk mitigation measures, such as eyewash stations or PPE.

Properly maintaining and ensuring safety of furnishings and equipment

1. Damaged or degraded furnishings and equipment. Surveyors observed torn upholstery on chairs, mattresses, and exam tables, as well as peeling paint, exposed foam, and frayed or cracked surfaces. These conditions were frequently cited as barriers to effective cleaning and disinfection, posing potential infection control risks.

2. Cleanliness and maintenance concerns. Surveyors saw dirt, dust, stains, tape residue, and ice or frost buildup on equipment, appliances, and surfaces. Also noted were soiled refrigerators, freezers, kitchen appliances, and patient care equipment.

3. Equipment not meeting safety or calibration standards. Surveyors noted that equipment or appliances were not properly maintained, had overdue or missing calibration (for example, thermometers), or were missing safety checks. This includes expired calibration stickers, untested electrical appliances, and missing or broken safety features, which are not in accordance with manufacturer's instructions or the organization's policy.

Look for similar articles on opportunities for improvement based on survey data for Joint Commission's other accreditation programs in future issues of *Perspectives*. P

Updated: *Survey Process Guides* for Hospitals and Critical Access Hospitals

On December 1, 2025, Joint Commission posted updated *Survey Process Guides* (*SPGs*) for **hospitals** and **critical access hospitals** on its website. The *SPGs*, which contain a step-by-step outline of each part of the survey process, are effective January 1, 2026. Updates from the last published version of the *SPGs* are easily identified by underlined and strikethrough text and include the following:

- New survey process for Joint Commission requirements not related to Centers for Medicare & Medicaid Services (CMS) Conditions of Participation (CoPs)
- Updated Performance Improvement Evaluation Tool
- New Emergency Management Discussion Tool
- Updated Primary Care Medical Home Certification Evaluation Guide
- New Medical Staff–Related Standards Compliance Evaluation Guides

The *SPGs* were revised earlier this year to replace the *Survey Activity Guides* for hospitals and critical access hospitals as part of the launch of Accreditation 360: The New Standard. The *SPGs* closely follow the CMS interpretive guidelines and survey procedures, providing a direct correlation between the survey process and the associated elements of performance and CoPs.

Access the revised *SPGs* in the Accreditation 360 section of Joint Commission's website. A complete summary of changes is on page 2 of the *SPGs*. P

Joint Commission Celebrates 75 Years of Elevating Healthcare

In 1951 four major healthcare associations came together to continue the work started in 1910 by Ernest Codman, MD, and the American College of Surgeons (ACS) a few years later to establish a system of hospital standardization. Those associations—ACS along with the American College of Physicians (ACP), the American Hospital Association (AHA), and the American Medical Association (AMA)—founded a new entity, the Joint Commission on Accreditation of Hospitals (JCAH). JCAH picked up the mantle of hospital standardization and initially focused on several core objectives, including the following:

- Establishing standardized criteria for hospital operations
- Tracking patient outcomes
- Creating baseline quality standards for hospitals
- Improving medical record documentation
- Ensuring performance accountability

JCAH would evolve over the years (and change its name to the Joint Commission on Accreditation of Healthcare Organizations [JCAHO], The Joint Commission, and now Joint Commission) to reflect the ever-evolving healthcare landscape, but the enterprise's mission has remained the same: **to enable and affirm the highest standards of healthcare quality and patient safety for all.**

In 2026 Joint Commission celebrates its 75th anniversary as the leader in healthcare accreditation, trusted across diverse care settings worldwide for patient safety and quality. Here are just a few Joint Commission highlights from the past several decades:

- 1953: JCAH publishes the first Standards for Hospital Accreditation
- 1965: Hospitals accredited by JCAH are "deemed" as compliant with the Centers for Medicare & Medicaid Services Conditions of Participation
- 1970s: JCAH expands beyond hospitals, launching accreditation programs for psychiatric facilities, long-term care organizations, and ambulatory care
- 1987: JCAH becomes Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to reflect its expanded scope of healthcare settings
- 1994: Joint Commission International is formed, accrediting its first hospital in Sao Paolo, Brazil
- 2002: Joint Commission establishes its first annual National Patient Safety Goals for improving the safety of patient care

- 2010s: Joint Commission expands its disease-specific certification program offerings, partnering with such organizations as the American Heart Association and American Stroke Association
- 2025: Joint Commission launches Accreditation 360: The New Standard to simplify processes and ease burden on healthcare organizations

Today, Joint Commission is proud to accredit and/or certify more than 22,000 healthcare organizations. Join us this year as we celebrate and reflect on how Joint Commission has helped to advance patient safety and quality of care around the world.

The American College of Surgeons (whose Chicago headquarters is pictured here) joined with the American Hospital Association, American Medical Association, and American College of Physicians to establish the Joint Commission on Accreditation of Hospitals in 1951.

Journal on Quality and Patient Safety

INNOVATION • IMPLEMENTATION • IMPACT

Following is the December 2025 Table of Contents for *The Joint Commission Journal on Quality and Patient Safety (JQPS)*. Joint Commission works closely with *JQPS* (published by Elsevier) to make it a key component in helping healthcare organizations improve patient safety and quality of care.

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