The Joint Commission Explained

How hospital accreditation works, why it matters, and how Linq helps teams stay ready

Executive Summary

Bottom line. The Joint Commission is an outside organization that checks whether a hospital follows important safety and quality standards. If the hospital meets those standards, it can earn accreditation. Accreditation is official recognition that the hospital passed this outside review. [1] [2]

Why it matters. Hospitals must do more than complete tasks. They also need to show what was done, fix problems, and prove that the fixes worked. Missing records or unfinished follow-up can create risk during a survey.

How Linq helps. Linq keeps required tasks, failed checks, follow-up work, photos, notes, and approvals connected. The hospital creates its proof during everyday work instead of searching for it right before a survey.

Important distinction. Software can organize compliance work, but it cannot replace hospital policies, trained staff, or professional judgment. Linq cannot guarantee accreditation. The Joint Commission makes that decision.

At A Glance

- **The Joint Commission** An independent organization that reviews hospitals for safety and quality.
- **Accreditation** Official recognition that a hospital meets the standards covered by the review.
- **Noncompliance** A problem found when the hospital does not meet a requirement.
- **Linq** Software that helps teams assign work, track problems, document fixes, and find proof.

What The Joint Commission Is

The Joint Commission is an independent health care accrediting organization. Since 1951, it has reviewed hospitals and other health care organizations using standards for safe, high-quality care. It is the largest health care accreditor in the United States. [1]

Accreditation is like an outside checkup of the hospital's systems. It is not the same as a state license. The Joint Commission is also separate from CMS, the federal agency that runs Medicare and Medicaid. Some hospitals use a Joint Commission survey to show CMS that they meet Medicare participation rules. This is called deemed status. Hospitals may also use a state survey or another CMS-approved accreditor. [1]

What Accreditation Evaluates

Surveyors check whether the hospital's written policies match what people actually do. They look at areas such as:

- Patient rights, patient care, medication safety, infection prevention, and the prevention of medical errors.
- Hospital leadership, staff training, quality data, and improvement work.
- Building safety, fire protection, emergency planning, utilities, and equipment maintenance.
- Policies, patient records, work records, staff interviews, direct observation, and performance data.

The 2026 Direction

The 2026 framework puts more focus on being ready every day. On January 1, 2026, the National Performance Goals chapter replaced the former National Patient Safety Goals chapter for hospitals. It covers 14 priority topics that hospitals can measure and act on. A new Survey Process Guide also replaced the former Survey Activity Guide for hospitals and critical access hospitals. [2] [4]

What that means. Hospitals need a repeatable system that connects each rule to the person responsible, the work they must do, the proof they must save, and the steps for fixing problems.

Accreditation And Certification

Accreditation reviews the hospital as a whole. Certification usually reviews one program, service, or specialty. A certification decision normally does not change the hospital's accreditation status. However, a serious safety threat found during certification may lead to a wider accreditation survey. [3]

How Hospitals Use Accreditation

Hospitals use accreditation in two ways. It is an outside review, and it is also a guide for managing safety and quality every day. The work continues before, during, and after a survey.

Stage	What the hospital does	What the process tests
Before the survey	Connect standards to policies, staff roles, training, inspections, maintenance, and required proof.	Has the hospital turned the rules into clear daily work?
During the survey	Share records, answer questions, show real work, and take part in tracers across departments.	Do staff actions match hospital policy? Do handoffs reveal safety gaps?
After the survey	Review findings, fix problems, submit proof of correction, and complete any follow-up survey.	Did the hospital fix the issue and prove the fix?
Between surveys	Track due work, failed checks, open fixes, repeated problems, and improvement results.	Does the hospital stay compliant instead of preparing only at survey time?

The Survey Process

1. **Review the standards** The hospital identifies the rules that apply and connects them to its policies and daily work.
2. **Complete the on-site survey** Most surveys are unannounced and happen 30 to 36 months after the last full survey. Surveyors read records, watch care and work processes, and interview patients and staff. [1] [2]
3. **Take part in tracers** A tracer is when a surveyor follows a real patient or process through the hospital. This can reveal problems between departments, such as a failed inspection that never led to a repair. [2]
4. **Fix the findings** A problem is reported as a Requirement for Improvement, or RFI. The SAFER Matrix ranks the finding by how likely it is to cause harm and how widespread it is. Proof of correction is generally due within 60 days. [2] [3]
5. **Stay ready** Accreditation generally lasts about three years, but the hospital must keep meeting the standards throughout that time. [2]

Advantages For The Hospital

Clear safety rules. The standards give every department a common starting point for patient care, maintenance, documentation, problem reporting, and improvement.

An outside opinion. The survey gives the hospital an independent review of its systems and everyday practices. The Gold Seal of Approval can show patients, employees, the board, insurance companies, and partners that the hospital earned accreditation. [1]

A path to CMS deemed status. A hospital may use Joint Commission accreditation as a CMS-recognized way to show that it meets certain Medicare and Medicaid participation rules. This is one option, not the only option. [1]

Help with state or contract rules. Many states and business partners recognize Joint Commission accreditation. It may support licensing, certification, Medicaid participation, or contracts. The exact effect depends on state law and each agreement. [1]

Clear responsibility. Accreditation pushes hospitals to decide who owns each task, keep good records, fix problems, and check that the fix worked. This can make work more consistent across departments and locations.

A better view of risk. Leaders can separate work that is finished from work that is overdue, failed, waiting for correction, or failing repeatedly. That tells them more than one overall completion score.

Ongoing improvement. Survey findings, internal reviews, tracer results, and performance data can show where the hospital needs to improve. The point is to make care safer over time, not simply pass one survey.

What Accreditation Does Not Guarantee

Accreditation means the hospital met the standards covered by the review and completed required corrections. It does not promise a perfect result for every patient. It also does not mean the hospital will meet every rule every day or that software will prevent every problem.

Why The Operational Benefits Matter

The everyday benefits are practical: clearer responsibility, fewer missed tasks, faster fixes, less repeated checking, easier access to records, and a better view of problems that keep happening.

What Happens When A Hospital Is Not Compliant

First, understand the level of risk. One finding does not automatically mean that a hospital loses accreditation. The result depends on how serious the problem is, how much of the hospital it affects, the chance of harm, how the hospital responds, and whether the fix lasts.

1 **The hospital receives findings** The final survey report lists each area where the hospital did not meet a requirement. The SAFER Matrix ranks each finding by the chance of harm and how widespread the problem is. [2]

2 **The hospital submits proof of correction** The hospital must fix each finding and submit Evidence of Standards Compliance. This is proof that the problem was corrected. The Joint Commission generally requires it within 60 days after the survey. [2] [3]

3 **A follow-up survey may happen** Some decisions require another survey within six months. Surveyors use it to check whether the hospital is still following the corrected process. [3]

4 **Serious problems can threaten accreditation** Immediate safety threats, false information, licensing problems, unfinished follow-up, or major noncompliance may lead to Preliminary Denial of Accreditation. After review and appeal rights are used, this may become Denial of Accreditation. [3]

5 **CMS or state consequences may follow** The Joint Commission reports adverse decisions for deemed organizations to CMS. If the hospital uses accreditation for deemed status, that path to Medicare certification may be at risk. An adverse Joint Commission decision does not by itself mean that Medicare payments stop immediately. Separately, CMS may end a hospital's provider agreement if the hospital no longer meets its participation rules. State and contract effects depend on the law and the agreement. [1] [5] [6]

Business And Operational Effects

- **Safety risk.** The problem may increase the chance of harm to patients, employees, or visitors.
- **More work and cost.** Leaders may need to create correction plans, collect proof, retrain staff, hire consultants, or prepare for another survey.
- **Disruption.** A high-risk finding may require fast changes to staffing, equipment, buildings, work processes, or services.
- **Loss of trust.** A serious decision may affect the confidence of patients, employees, medical staff, the board, insurance companies, partners, and the community.
- **Financial or legal risk.** The hospital may face payment risk, contract problems, claims, government action, or unexpected expenses. The result depends on the facts and the rules that apply.

Why Staying Ready Is Hard

The main challenge. Hospitals usually know what work must be done. The hard part is making sure thousands of tasks happen on time, every failure gets fixed, and the full record is easy to find.

- The standards may be in manuals, maintenance tasks in one system, photos in email, and correction plans in spreadsheets.
- Frontline teams may not know which tasks have the highest survey or safety importance.
- A preventive maintenance task or inspection may be marked as failed without creating an owned follow-up task.
- A good system-wide average can hide an open problem at one hospital, department, location, or type of equipment.
- Leaders may see completion rates but not weak proof, repeated failures, old open corrections, or whether a fix worked.
- Teams may spend survey week searching for records instead of showing a reliable process.

How Linq Supports Continuous Readiness

Linq connects compliance work from the first assignment to the final proof that a problem was fixed. The basic flow is Assign, Monitor, Correct, and Prove.

Step	How Linq supports the hospital	Operational result
Assign	Schedule repeat maintenance, inspections, rounds, and checks. Show each person the work due for their team, department, or location.	People can see what they own and when it is due.
Monitor	Use one dashboard to see work that is due, finished, overdue, failed, or waiting for correction across the hospital.	Leaders can move from a summary to the exact location, equipment item, task, or record.
Correct	When a configured maintenance task or inspection fails, Linq can create a linked child task with an owner, status, and history.	A failed check becomes assigned follow-up instead of a red mark or forgotten email.
Prove	Keep the original task, result, readings, notes, photos, correction, final result, and approval in one connected history.	The hospital can find the whole story without rebuilding it from several systems.

Where Linq Can Be Used In Hospitals

Hospitals can set up Linq around work they already do. Examples include:

Hospital area	Example workflows	Connected record
Environment of Care	Safety rounds and inspections of rooms, work areas, and other hospital spaces.	The inspection, problem, owner, fix, proof, and closure.
Life Safety and Fire Protection	Repeat inspections, tests, safety problems, and follow-up work.	The equipment or location history connected to the rule and final fix.
Utility Systems	Emergency generators, heating and cooling, water, electricity, and other critical systems.	The maintenance or test result, problem, repair, retest, and approval.
Biomedical and HTM	Preventive maintenance, calibration, condition checks, and follow-up after failed work.	The equipment, technician, readings, documents, and repair history.
Emergency Equipment	Crash carts, defibrillators, temporary pacemakers, and emergency supplies.	The scheduled check, result, problem, follow-up, and final resolution.
Temperature Controlled Equipment	Refrigerators, freezers, incubators, heat blocks, and fluid or linen warmers.	The reading, safe range, problem, escalation, and proof of correction.
Support Services	Dishwashers, three-compartment sinks, water softeners, filters, kitchens, and similar areas.	Standard questions, required answers, result, problem, and completed action.

The Complete Compliance Record

Depending on how the hospital sets up Linq, one record can include:

- The original requirement, due date, assigned person, equipment, and location.
- The completion date, status, answers, readings, notes, photos, and documents.
- The failed item and the rule that started follow-up work.
- The linked corrective-action task, responsible person, due date, and number of days open.
- The repair or other fix, final result, reviewer approval, and closure history.

A Simple Linq Example

1 Schedule the work. An emergency generator inspection is due and assigned to a technician.

2 Record the result. The inspection fails because the starting batteries do not meet the hospital's approved limits.

3 Create follow-up. Linq creates a child corrective-action task. This is a new task linked to the failed inspection so the problem has an owner.

4 Fix the problem. The batteries are replaced, the generator is tested again, and notes and proof are added to the child task.

5 Verify the fix. An approved reviewer checks the repair and closes the task. The original failure and the fix stay connected.

What a surveyor can see. The hospital can quickly show the first inspection, the failed result, the repair task, who completed it, the saved proof, and the final approval.

Benefits By Role

Role	What improves
Technicians and field teams	One daily list of assigned work, clearer questions, less reliance on paper or memory, and easier documentation while doing the job.
Facilities and HTM leaders	A view of overdue maintenance, failed inspections, open fixes, repeated equipment problems, and work by team or location.
Compliance and quality teams	Consistent workflows, easier practice surveys, connected proof, faster record searches, and a clear view of open risks.
Hospital executives	A hospital-wide view with the ability to open the original record instead of relying only on summary percentages.
Survey support teams	A clear history of what was required, what happened, what failed, what action followed, and how the problem was resolved.

Additional Operational Advantages

- Use the same inspection questions and proof requirements at different locations while keeping a local owner for the work.
- Use readiness views or scoring, if configured, to help leaders focus on higher-risk gaps and still open the original records.
- Find repeated failures by equipment item, location, department, or type of work. This can support improvement and equipment replacement decisions.
- Spend less time matching spreadsheets, searching for attachments, and connecting separate work orders.
- Keep a consistent history so people can see who did the work, who reviewed it, and when it was closed.

A Practical Starting Point

Start small. Choose a few important workflows, test the full process from assignment to proof, and expand after it works.

1 **Choose a pilot** Pick one to three types of repeat work that have clear pass or fail rules and matter for safety or a survey.

2 **Connect the rule to the work** For each workflow, record the policy, responsible role, equipment or location, schedule, required proof, escalation path, and review step.

3 **Set up the workflow** Build the schedule, mobile questions, required fields, safe ranges, problem rules, notifications, and linked corrective tasks.

4 **Test a pass and a failure** Complete one task that passes and one that fails. Follow the failure through repair and approval. Make sure the proof is readable and the failed task always gets a next step.

5 **Practice a tracer** Start on the leadership dashboard, open the original task, and find the full history. Make sure every summary number connects to a real record.

6 **Review before expanding** Check user access, data quality, record history, data retention, system connections, downtime plans, and change controls before adding departments or hospitals.

Executive Readiness Questions

- Can frontline staff quickly see today's required compliance work?
- Can leaders find overdue work, failed tasks, high-risk problems, and old corrective actions without collecting spreadsheets?
- Does every failed maintenance task or inspection that needs follow-up create a linked task with an owner?
- Can a reviewer start with a dashboard number and open the original task and complete correction history?
- Can the hospital show who did the work, when it happened, what proof was saved, and who approved closure?
- Can teams find repeated failures and check whether the correction continued to work?
- Can the team find a sample record quickly during a practice tracer without rebuilding the story by hand?

The Most Important Test

Pick any important compliance task today. Can the hospital quickly show what was required, what happened, what failed, who fixed it, and how the fix was approved? If yes, the hospital is building readiness into daily work.

Conclusion

The Joint Commission sets standards and provides an outside review. The hospital is responsible for its policies, trained people, professional judgment, leadership, and results. Linq helps organize the daily work. It can show what is due, turn failed checks into follow-up tasks, show leaders what is still open, and keep the proof connected to the final fix.

The goal. Know what is due. Know what was finished. Know what failed. Fix the problem. Save the proof. Be ready every day.

Important Notice

Linq is not affiliated with or endorsed by The Joint Commission. Linq can support compliance management, maintenance, inspections, corrective actions, and documentation. Using Linq does not prove or guarantee compliance with Joint Commission, CMS, state, NFPA, manufacturer, accreditation, or other requirements.

Hospitals should follow the current Joint Commission manual, CMS rules and guidance, federal and state law, safety codes, local authorities, hospital policy, and advice from qualified clinical, compliance, legal, and engineering professionals. The Joint Commission alone decides accreditation status.

Sources

[1] Joint Commission What Is Accreditation. Definition, accreditation overview, standards, CMS deemed status, state recognition, and the three-year cycle.

[2] Joint Commission Accreditation Process. Survey timing, Survey Process Guide, tracer methodology, SAFER Matrix, corrective submissions, and intracycle monitoring.

[3] Joint Commission Accreditation And Certification Decisions. Accreditation, follow-up survey, preliminary denial, denial, and corrective evidence requirements.

[4] Joint Commission Standards. Standards framework and the National Performance Goals effective January 1, 2026.

[5] Electronic Code Of Federal Regulations 42 CFR Part 482. Conditions of Participation for hospitals and the basis for Medicare and Medicaid survey activity.

[6] Electronic Code Of Federal Regulations 42 CFR 489 53. CMS authority to terminate a provider agreement when participation requirements are not met.

Source review current as of September 11, 2026.