Survey Readiness Isn’t an Annual Event: It’s a Daily Habit

By Sheila Grumbach

Survey readiness fails for one reason: staff scramble because they were never operating at “ready” in the first place. Build the habit of being ready for the patient every single day, and the survey stops being an event.

The mantra is simple: be ready for the patient, every patient, every day. That means knowing the National Patient Safety Goals, reviewing and updating policy on a real cadence, running environment of care rounds, and keeping regulatory embedded on an interdisciplinary team. Do that consistently, and a surveyor’s walkthrough stops being a scramble. It becomes a Tuesday.

Two things are tanking scores right now, and neither is exotic. High-level disinfection: know every scope and probe in every setting, in the OR and in clinic, and know exactly how each one is reprocessed and stored. And surgical attire: masks worn correctly, scrubs not worn outside the building, hair and beards covered. These are basics surveyors catch immediately, and they are also the fastest wins available to a struggling program.

For a new director walking into an unready facility, start with a gap analysis, not a project plan. Pull the SAFER matrix from the last survey and see what is still open. Check when policy was last revised against the newest AORN guidelines and Joint Commission requirements. That comparison tells you exactly where to spend the first ninety days.

Give sterile processing a real seat at the table, even where the reporting line is only dotted. It is the foundation of surgical site infection prevention, and usually the first place a mock survey finds trouble. In one case, a mock surveyor exposed gaps in a facility’s outlying clinics because sterile processing had no real influence there. Bringing that team in to guide the clinics, and staffing an experienced interim leader, closed the gap just before the real survey arrived.

Accountability cannot live with the manager alone. Build downtime checklists so staff inspect specific areas, fire and life safety, infection prevention, equipment, rather than waiting in the break room. Make it a game, not a chore: one program ran a phone-based Joint Commission scavenger hunt, staff photographing compliant hallways and properly stored equipment, with a prize for the most finds. Readiness improved, and so did basic facility knowledge, right down to where the malignant hyperthermia cart lives.

Watch two things ahead. AI tools have to stay inside whatever IT and compliance have already vetted, especially anything touching patient data; HIPAA does not bend for convenience. And the Joint Commission’s new Accreditation 360 model now interviews frontline staff directly, not just leadership, so staff need to speak to recent incidents, corrective actions, and the reasoning behind policy, not just where to find it on the intranet.

If you are a new director staring down an unready program, you are not alone, and you do not have to fix it solo. Delegate to formal and informal leaders, loop in anesthesia and surgeon partners early, and schedule regular one-on-ones with regulatory and infection prevention. They are a resource, not a grader. Start where the gaps are already documented, keep learning, and give yourself grace. Readiness is built incrementally, never all at once.