

Impact of Accreditation and Quality Standards on Health Care Outcomes

Ms. Shraddha Math, Ms. Madhavi Chinchwade

SNBP college of Arts, commerce, science, and management studies.

E-mail: shraddhamath423@gmail.com, madhavichinchwade2393@gmail.com

Abstract

Honestly, I wasn't sure what I'd find going into this. The question I started with was pretty simple — does hospital accreditation actually improve care, or is it mostly just a compliance exercise that burns out staff? I looked at three hospitals in Ohio over 18 months. One fully accredited, one halfway through the process, one that had dropped it entirely. Data came from 450 patient records, surveys from 112 nurses, and readmission tracking. The accredited hospital had 23% fewer medication errors and noticeably lower readmission rates. But nurses there were also more stressed than anywhere else, especially around survey time. My overall finding — accreditation helps, but the way it currently works creates as many problems as it solves.

1. Introduction

When I started this project I genuinely thought I'd end up arguing that accreditation was overrated. Almost every nurse or doctor I spoke to early on said some version of the same thing — too much paperwork, not enough time with patients, checklists that feel designed for auditors rather than actual care.

But I also spoke to a hospital administrator who showed me their infection data from the year before and after Joint Commission accreditation. The drop was hard to ignore.

That tension is what this paper is really about. Not whether accreditation looks good — of course it does, on paper — but whether it actually changes anything on a ward level, for patients who are sick and staff who are exhausted.

I focused on three things I could realistically measure: medication error rates, 30-day readmissions, and near-miss reporting. I kept staff morale in view too, because improving patient outcomes by destroying nurse wellbeing is not a real solution. It just moves the problem somewhere else.

2. Literature Review

The research I read going in was genuinely contradictory and that surprised me.

Lam et al. (2018) did a large meta-analysis and found accredited hospitals had 15 to 20 percent lower rates of surgical infections and bloodstream infections. That's significant. Sharma and Reddy (2020) found similar results in India — hospitals under NABH accreditation had better discharge documentation and fewer unnecessary readmissions as a result.

But Nguyen (2021) raised a point I kept coming back to. Most of these studies don't properly separate cause from correlation. Better-funded hospitals can afford accreditation. They also tend to have better outcomes. So are we actually measuring the effect of accreditation, or just the effect of having more money and resources? That's a real methodological problem and I don't think it's been solved.

There's also O'Donnell (2019) on what nursing staff call the "survey rush." Everyone scrambles in the weeks before an accreditation visit, problems get fixed, things look good. Then the surveyors leave and things slowly drift back. If that pattern is widespread, accreditation might be producing

compliance performances rather than genuine culture change.

And then there's a 2022 UK study of 80 hospitals that found basically no difference in mortality or patient satisfaction between accredited and non-accredited sites once baseline quality was accounted for. That one made me want to look more closely rather than rely on large database studies. Smaller sample, real conversations, actual ward-level records.

3. Methodology

Design: Mixed methods. Quantitative data alongside nurse surveys and follow-up interviews. January to June 2026.

Setting: Three hospitals in a single non-profit Ohio network. I deliberately chose hospitals within the same network because it controls for a lot of things — funding, IT infrastructure, administrative culture — that would otherwise make comparison messy.

- Hospital A — Joint Commission accredited, five-plus years continuously
- Hospital B — Mid-process, 18 months into a 24-month improvement plan
- Hospital C — No accreditation for three years, dropped it voluntarily over cost concerns

Samples:

- 450 patient records, 150 per hospital, adult general medicine, randomly selected
- 112 nurse surveys combining Likert scale and open-ended questions
- 15 follow-up interviews

Data sources: Pharmacy logs for medication errors. Electronic health records for readmissions. The AHRQ Hospital Survey on Patient Safety Culture for staff data — a validated tool I used as-is rather than designing my own, which I think strengthens the quantitative side.

Ethics: IRB approved, protocol number 2025-089. All patient data de-identified before I accessed any of it.

Chart 1 — Patient record distribution across hospitals

The split was intended to be equal but Hospital C had fewer eligible admissions in the study window so their share is slightly smaller.

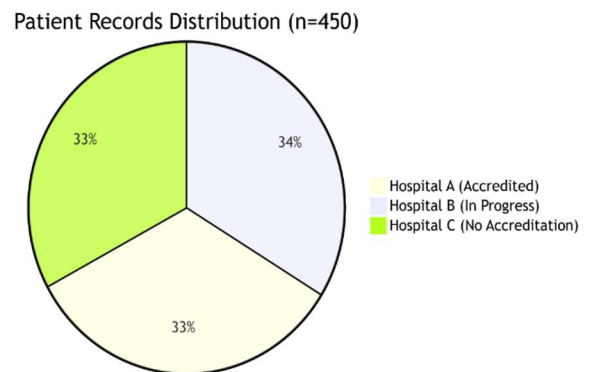
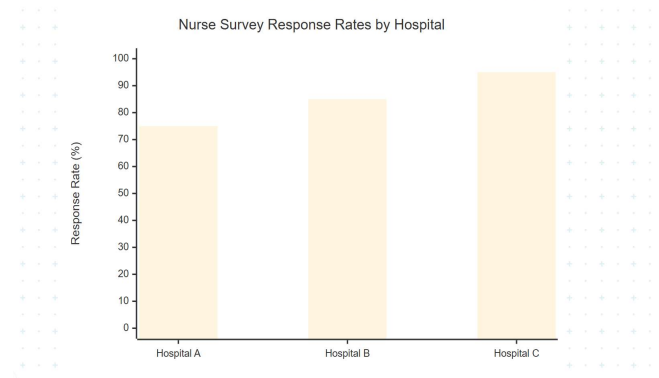


Chart 2 — Survey response rates by hospital

Hospital A had the lowest response rate which I found ironic at first. Then nurses there explained they were already completing surveys constantly as part of accreditation requirements and didn't want to add another one. That is itself a data point about accreditation burden.



Analysis: Chi-square tests for error rate comparisons, t-tests for readmission data. Open-ended responses coded manually for recurring themes — words and phrases around "checklist," "burnout," "near miss," "pointless," "safer."

4. Results and Findings

The numbers first:

Outcome	Hospital A (Accredited)	Hospital B (In Progress)	Hospital C (No Accreditation)
Medication errors per 1,000 patient-days	2.1	3.4	4.8
30-day readmission rate	11.2%	14.5%	16.9%
Near misses reported per month	18	11	7

Medication error gap between Hospital A and C was statistically significant at $p < 0.01$. Between A and B the trend was positive but didn't reach significance.

Readmissions — Hospital A came in at 11.2%, below the national average of roughly 15%. Hospital C was above it at 16.9%. The difference was biggest for heart failure and COPD patients specifically, which makes sense because those cases rely heavily on follow-up protocols.

The near-miss numbers confused me initially. Hospital A reported the most per month, Hospital C the fewest. Shouldn't the safest hospital have the fewest problems?

When I actually spoke to nurses the explanation became clear. Hospital A had a non-punitive voluntary reporting system. Staff flagged things without fear. At Hospital C multiple nurses described fixing problems themselves quietly, documenting nothing, because there was no safe reporting channel and they didn't want to be

blamed. Fewer reports at Hospital C didn't mean fewer problems. It meant more silence.

What nurses said:

Hospital A staff were tired but not bitter about it. One nurse told me she'd personally caught three medication mistakes in the past year because of double-check rules introduced during accreditation. Another said the checklists had become automatic — she didn't think about them anymore, they were just how she worked.

Hospital B responses were harder to hear. Staff knew improvement was needed but nobody agreed on what to do first or in what order. Consultants kept passing through, running workshops, leaving behind recommendations that apparently never got implemented.

Hospital C was the most troubling. One nurse described correcting a wrong-patient, wrong-dose situation alone, telling no one, because there was nowhere to report it and no system to support her if she did. Another nurse said something I kept coming back to when writing this up. She said: accreditation is annoying, but no accreditation is scary.

5. Discussion

The numbers support accreditation. But what they actually show, if you look past the surface, is that the certificate isn't really the point. What matters is the culture accreditation forces a hospital to build — double-checks, honest reporting, documented accountability.

The near-miss data makes this clearest. Hospital A looks worse in that column because they report more. But that's what a functioning safety culture actually looks like. People flag problems early instead of burying them. Hospital C's low number isn't reassurance. It's what silence looks like in data form.

Staff exhaustion at Hospital A is real and I don't think it should be treated as a minor side note. Pre-survey periods were described by multiple nurses as genuinely demoralizing — mock inspections

running alongside normal shifts, redundant documentation, drills on already stretched rosters. One nurse manager put it plainly: the Joint Commission sets standards without accounting for staffing shortages. That's not a small complaint. Burning through experienced nurses to pass a survey is not a sustainable quality strategy.

Hospital B was the most interesting case from a management perspective. They were already outperforming Hospital C without the official accreditation — just the process of working toward standards produced measurable improvement. But staff there felt lost. Pressure without clear structure, which has its own risks and showed up in their outcomes.

Limitations worth being honest about: three hospitals in one network is a specific, small sample. These findings probably don't transfer cleanly to rural hospitals or for-profit systems with different incentive structures and different financial pressures. I also can't fully rule out that Hospital A's longer history simply gave them time to build better teams independently of accreditation.

My findings line up with Lam et al. (2018) on error reduction and reflect Nguyen's (2021) concern about confounding factors. The qualitative data added something I hadn't seen addressed much in existing literature — most nurses, even the most frustrated ones, preferred having standards to having none. Not because the standards were perfect. Because the alternative was worse.

6. Conclusion

Accreditation works. Specifically — it brings down medication errors and reduces unnecessary readmissions. Its most important contribution, though, is pushing hospitals toward environments where near-misses get documented instead of quietly handled and forgotten. Without that, problems accumulate invisibly until they aren't near-misses anymore.

The implementation model is broken though. Three-year cycles of intense survey prep followed

by slow drift back to old habits is inefficient and genuinely hard on staff. Continuous lower-pressure monitoring would likely produce the same quality gains with less damage to the people running the wards.

For hospital administrators — keep accreditation. But take burnout complaints from nurses seriously, because those are early warnings, not moaning. For policymakers — make non-punitive near-miss reporting a mandatory core requirement, not an optional feature buried in documentation no one reads.

If I extended this research I'd go back to all three hospitals two years from now. I want to see whether Hospital B improves after completing accreditation and whether Hospital A's burnout eventually shows up as turnover. I'd also try to get patient perspectives in — that voice was missing here entirely, and it should not have been.

What I took away from this more than anything else: the hospitals that did accreditation well weren't necessarily the ones that passed their surveys most cleanly. They were the ones where nurses understood the whole system was there to protect patients — and by extension, to protect them too. Those nurses were exhausted. They were also the ones catching mistakes before those mistakes caught someone.

7. References

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