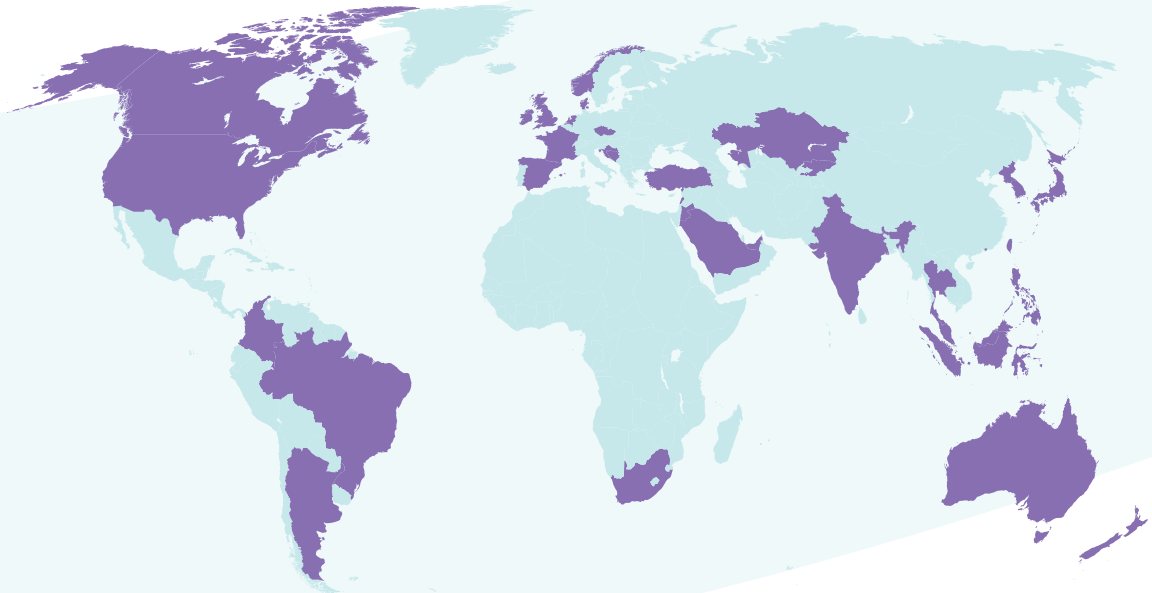
ISQua®
Accredited

Guidelines and Principles for the Development of Health and Social Care Standards

4th Edition Version 1.2, September 2015



Inspiring and driving improvement in the quality and safety of healthcare worldwide.

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1.0 Introduction

Part A of this document is a guide for organisations and surveyors using ISQua's Principles for the Development of Health and Social Care Standards, 4th Edition. It outlines the steps to be taken when undergoing an ISQua standards' survey, the roles and responsibilities, guidance on the use of the self-assessment tool, the rating system and the principles.

The International Society for Quality in Health Care (ISQua) is a not-for-profit, independent, health care quality organisation with members and contacts in over 100 countries. ISQua works to provide services to guide health professionals, providers, researchers, agencies, policy makers and consumers to achieve excellence in healthcare delivery to all people and to continuously improve the quality and safety of care. ISQua works closely, and is in 'Official Relations', with the World Health Organisation.

ISQua's mission is: "To inspire and drive improvement in the quality and safety of healthcare worldwide through education and knowledge sharing, external evaluation, supporting health systems and connecting people through global networks".

ISQua conducts its business through the provision of a number of programmes, some of which are listed below:

- An Annual International Conference;
- Membership (Individual and Institutional);
- Education through a Fellowship Programme;
- The International Journal for Quality in Health Care; and
- The International Accreditation Programme (IAP).

1.1 The International Accreditation Programme

ISQua launched the IAP in 1999 and it remains the only healthcare specific body that 'accredits the accreditors'. It achieves this through three unique programmes:

- Accreditation of Health and Social Care Standards;
- Accreditation of External Evaluation Organisations; and
- Accreditation of Surveyor Training Programmes.

ISQua's IAP has been designed as a straightforward process to support the improvement of performance and practice of health and social care standards and external evaluation bodies. The survey process is similar to the stages used by accreditation and other external evaluation bodies in several countries and is a proven and robust method of organisational development and independent evaluation. It includes:

- self-assessment;
- peer review evaluation;
- written report with recommendations;
- award; and
- continuous assessment.

The process is voluntary and is entered by application.

Evaluation services are provided on a voluntary basis by international surveyors.

1.1.1 Code of Conduct

ISQua personnel, including surveyors will:

- act ethically;
- be responsive to the needs and interests of clients;
- avoid conflicts of interest;
- act professionally;
- respect confidentiality;
- be competent to undertake the work and assignments they are given; and
- ensure complaints about any of ISQua's personnel or services are investigated promptly and fairly and resolved wherever possible.

1.1.2 Aim of the ISQua Principles

The ISQua International Principles have been developed for the assessment and accreditation of the health and social care standards of external evaluation organisations, including accreditation, certification, inspection and standards setting organisations.

This edition has been streamlined with new criteria building on; risk management, resolving ethical dilemmas and the requirement for the standards' development process to be published. The order of the principles has changed from that of the 3rd Edition to the following: Standards Development; Standards Measurement; Organisational Role, Planning and Performance; Safety and Risk; Patient/ Service User Focus; and Quality Performance. A comparative table between the 3rd and 4th Editions is found on page 32.

1.2 Roles and responsibilities

1.2.1 Governance of the IAP

ISQua is governed by a Board of Directors elected by and from its members. The Board Accreditation Committee (BAC) governs the IAP on behalf of the Board. The BAC is advised by the Accreditation Council, a committee of the Board, who oversee standards development and external evaluation assessment methodologies. The Board has delegated responsibility to the BAC to approve accreditation awards. The BAC makes the final award decision.

1.2.2 Validation panel

The Accreditation Council delegates its accreditation recommendation to a two person Validation Panel (VP) consisting of a Council member and a surveyor with no conflict of interest to the survey or organisation. The VP is responsible for:

- reviewing the report to ensure it is clear and the comments will provide the organisation with the direction needed to continually improve in meeting the principles;
- ensuring that the comments reflect that the appropriate rating has been applied;
- ensuring the report findings support any recommendations and/or opportunities for improvement;
- ensuring that the report supports the survey team's accreditation decision recommendation; and
- completing the validation panel report and submitting to ISQua.

The Validation Panel's recommendation goes to the ISQua Board Accreditation Committee, which makes the final decision regarding accreditation.

1.2.3 ISQua accreditation staff

ISQua staff work with each participating organisation and:

- train and allocate surveyors and validation panel members;
- issue the critical path details for surveys;
- carry out technical reviews;
- carry out reviews of the reports; and
- prepare reports for validation panels.

1.2.4 Participating organisations

All participating organisations should agree to abide by the terms and conditions of the IAP and adhere to the timescales as set in the critical path (see 2.0). As part of the application process they nominate a contact for all correspondence with ISQua and keep ISQua updated with any changes to these details.

1.3 Surveyors

ISQua surveyors are internationally based in over 18 countries representing managers and auditors from senior positions within the health and social care external evaluation industry. All ISQua surveyors have been recruited and trained in line with ISQua standards.

1.3.1 Survey team

The team consists of two surveyors, chosen by ISQua one of whom is appointed as the team leader. The role of the survey team is to validate the organisation's self-assessment through detailed feedback on how compliance to each criterion is achieved.

The organisation is requested to formally accept the survey team but if there is an objection to a selected surveyor, or a conflict of interest, the ISQua Accreditation Manager should be informed of reasons for the objection within 5 working days of receiving the information. ISQua will review the reasons for the objection and make the final decision to remove or retain the surveyor on the team.

1.3.2 Team leader

The team leader is responsible for co-ordinating the survey between the team members; for completing the report; and ensuring that there is a consensus of agreement on the ratings. The team leader communicates the report, rating matrix and recommendation regarding accreditation to ISQua.

1.3.3 Team member

The team member is responsible for preparing for survey including:

- ensuring endorsement from their organisation for participating in the survey;
- reading pre-survey materials;
- leading on the principles allocated;
- participating with the team lead;
- completing their section of the report; and
- answering any queries that the team leader or ISQua may have.

Section 2
Overview of the Process

2.0 Entry into the Programme

To be eligible for ISQua Accreditation, an organisation, or part of the organisation, must be a recognised external evaluation body within the health or social care sector. Their aim should be to improve the quality of care for the public by providing external evaluation services based on quality standards and related services that support performance improvement. The organisation may address specific clinical or specialist areas or services.

An application for accreditation of a set of standards may only be made by the organisation that owns the standards or by a third party, with written endorsement from the establishment that own the standards. Where this is the case, there must be a licence or written permission to use the standards.

To fully comply with the ISQua Principles 1 and 2, the standards should have been tested and evaluated to enable feedback.

All organisations must complete an application form prior to entry into the programme. Once this has been received and payment made to ISQua for access to the standards and tools, ISQua allocates a date for the survey. Upon acceptance of this date, a critical path is sent to the organisation, the critical path includes dates for the following:

- submission of completed self-assessment for technical review;
- submission of final self-assessment and supporting evidence for survey;
- survey;
- review the surveyors' report for factual errors;
- informal notification of assessment by Validation Panel;
- accreditation awarded – next available ISQua Board Accreditation Committee meeting.

For organisations undergoing re-accreditation the next survey will be scheduled at least three months prior to the current expiry date to enable all steps of the process to be completed.

2.1 Multiple standard sets

Generally each set of standards must be accredited on an individual basis, but, if the organisation has a multiple set of standards it wishes to submit for assessment at the same time, and they are all based on the same model, but with service specific differences, a crosswalk or comparison of differences should be provided to ISQua. ISQua will determine if a separate assessment is needed for each set, or if all sets can be assessed by assessing a core set and how the other sets differ.

Section 3
Working with the Principles

3.0 Assessing your own performance

The first task is to complete an initial self-assessment of the standards to be surveyed, using the self-assessment tool and the guidance provided in this document. Further guidance on what is required in order to meet each criterion is documented in the principles' guidance. Note should be taken of the difference between expected evidence, e.g. where the word should is used, to where the word could is used, as these are considered further examples. For Principles 1 and 2, suggested evidence is also included against each criterion. Please note that this is suggested evidence and the organisation may wish to present other evidence that meets the criterion. For Principles 3-6 the required evidence is examples from the standards being surveyed.

It is recommended that a small team is tasked with working through the self-assessment process. This helps with getting all the evidence together, checking details and identifying any areas for particular attention. If the team has any problems with interpreting the Principles or deciding what, or how much evidence should be provided, ISQua accreditation staff are available to assist with advice. They can also assist with interpretation or clarification on the principles and the survey process.

At the end of this exercise, you should have a gap analysis and identified actions where further work is required.

3.1 Completing the self-assessment tool

The self-assessment tool (SAT), including the text, is copyrighted and the property of ISQua. It is designed for self-assessment and external surveyor reporting. The SAT must be completed in English, in Arial 9 font, should be focused and not excessive. Automatic numbering or bullet point systems or any form of additional formatting of the document should be avoided as these can sometimes result in difficulties with different versions of software. This also applies to information that has been copied and imported from any other documents. Extra formatted headings, borders or other formatting, graphics and colour elements should be avoided.

Self-assess against each criterion. Clearly indicate your evidence of compliance and where this can be found, for example, minutes of meetings, evaluation results etc. For Principles 3-6 include examples from the standards' manual, criterion number and text. Then, if necessary, detail the actions you need to take to achieve better compliance to the criterion.

The overall rating is calculated by adding the ratings and then dividing by the number of criteria and then rounded up or down. For example, Principle 2 has 4 criteria, if they are rated as a 3, 4 and two 2's the total combined score is 11, this is divided by 4 (number of criteria) = 2.75, which is rounded up to 3 to give the overall score. An overarching statement regarding the level of compliance is added when the overall rating score has been calculated.

After the teams have completed the self-assessment, and the evidence has been collated, management should review, revise and approve both the self-assessment and the evidence used as validation.

3.2 Rating scale

When applying a rating, use the following rationale and guidance to determine the level of compliance. If necessary, add details of the improvements that would be required to achieve a higher rating. In order to achieve a rating of 4, something extra must be demonstrated as expressed in the rationale and guidance, for example, clients' expectations exceeded evidenced by evaluation results. This should be evident from the information provided in the self-assessment and subsequently the surveyor comments.

Rating	Rationale	Guidance
4	**Excellent achievement** ***Evidence exceeds the criteria*** Full achievement / exceeded the criterion and all elements with no gaps and all aspects of ratings 1-3 met No recommendation (but can have an Opportunity for Improvement)	a) Evidence of improvement based on at least one full quality improvement cycle. b) Evidence of innovative working. c) Seamless coordinated services, clients' expectations exceeded. d) Widespread use and achievement of best practice. e) Outstanding risk management/safety. f) Exemplary achievement.
3	**Good achievement** *Evidence meets the intent of the criteria* Majority of the criterion elements addressed (more than 60%) Recommendation or Opportunity for Improvement if required	a) Processes, implementation, documentation and awareness all evident by clients and staff. b) Processes, systems and staff appropriate. c) Clients' needs understood and met. d) Evidence of continuous quality improvement, good use of evaluation and best practice. e) Risk minimised. f) Complaints and appeals processes in place and acted upon.
2	**Fair achievement** *Partially in place and evidence of working towards implementation* Some of the criterion elements addressed (between 31 - 59%) **Recommendation required** **Criterion risk rated**	a) Evidence of appropriate processes or systems and client and staff awareness, but lack of supporting documentation, OR appropriate documentation but lack of consistent implementation and awareness. b) Some evidence of continuous quality improvement. c) Newly developed processes/documentation but not fully integrated. d) Risk mostly minimised.
1	**Poor achievement** *Nothing properly in place and no evidence of working towards implementation* Few or none of the criterion elements addressed (under 30 %) **Recommendation required** **Criterion risk rated**	a) Limited processes or systems in place. b) Little or no documentation. c) Lack of awareness by staff and clients. d) Inconsistent practice, lack of coordination. e) Risk not minimised.

There may be exceptions to the rating rationale and these may include:

- raising the rating, if the intent of the criterion has been met in an innovative way
- raising the rating, if an unmet element, while still applicable, carries less weight than usual in the organisation in question
- lowering the rating, if some elements are met technically, but still leaves an unusual amount of unresolved risk

The reason for the exceptions to the rating must be clear in the self-assessment. Section 4.0 gives further information on what ratings are required to achieve accreditation.

3.3 Core criteria

A number of criteria have been identified as core to the Principles, they include:

- central organisational processes;
- core processes safeguarding competencies;
- processes with immediate impact on patient safety and clinical effectiveness;
- formally approved, evidence based standards with a clear purpose; and
- transparency in rating.

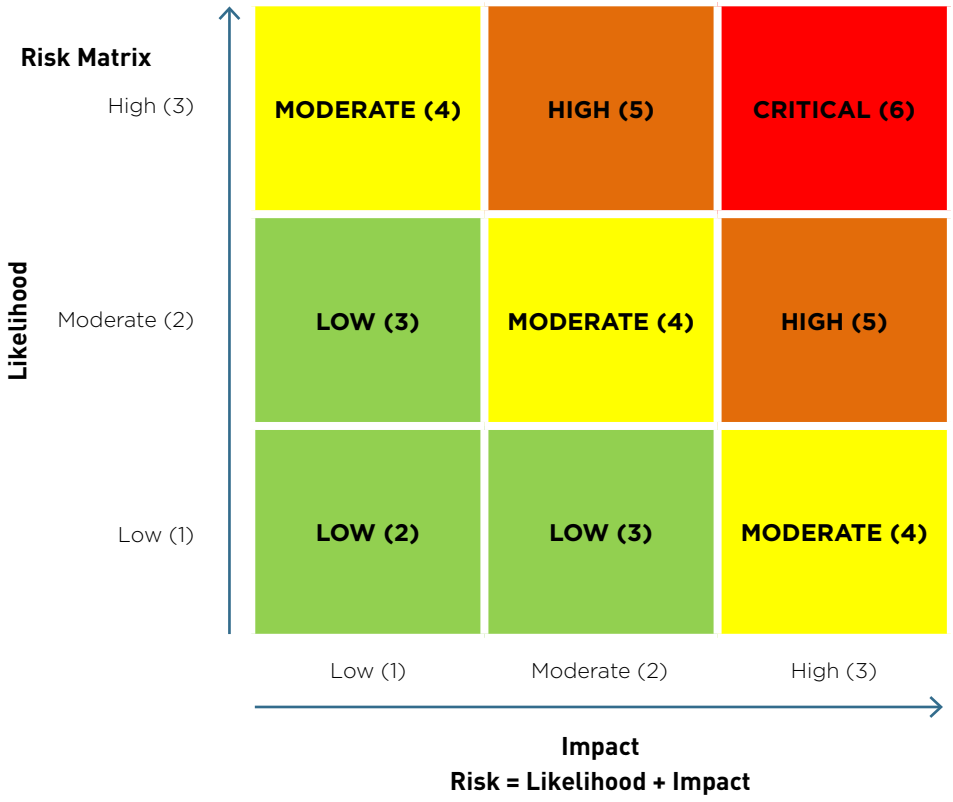
These criteria must achieve a rating 3 or higher for the principle to reach compliance. However, a core criterion rating of 2 may be acceptable, if the risk associated with the criterion is low or moderate as calculated on the risk matrix below and the necessary action can be achieved within 3-6 months post award.

3.4 Risk assessment

When a rating of 1 or 2 is given to any criterion during self-assessment, or by the survey team, a risk assessment needs to be carried out.

With a rating of 1 or 2, there is a potential risk for the organisation as some or many of the specific criterion elements are not in place. A risk assessment involves describing what the risk is in relation to the missing elements of the criterion and then quantifying this risk by assigning a numerical score using the following risk matrix. The risk matrix allows one to determine how likely it is that the identified risk will actually happen or materialise (the likelihood) and the impact on the organisation if the risk does materialise or happen (the impact).

The numerical risk assessment score (the overall score) is calculated by adding the score for the likelihood of the risk occurring with the score for the impact of the risk if it did occur. Or more simply, Risk = Likelihood + Impact



In completing the risk assessment, the risk associated with the criterion should be explicitly stated and a recommendation outlining how the risk will be addressed must be provided.

3.5 Not applicable criteria

From time-to-time certain criteria may not be applicable in all sets of standards. Any criterion, which is considered Not Applicable, should be discussed with ISQua Accreditation staff in advance and agreed by them prior to the technical review. Any elements of any criterion that are not applicable should be noted in the self-assessment, for example if volunteers are not routinely used (Principle 3.6). Once this is agreed, clearly state in the self-assessment why the criterion, or parts thereof, are not applicable, for example, due to national, legal, environmental or cultural aspects and the date agreed by ISQua. If the survey team find evidence that the criterion should be applicable, this will be noted in the report and a rating given.

3.6 Technical review

A technical review of the draft self-assessment is carried out by ISQua and the date of this is included in the critical path. The aim of the technical review is to ensure that the self-assessment has been completed in accordance with ISQua requirements and that all criteria and principles are rated. A report is sent to the organisation commenting on any areas which may need addressing, no comment is made on compliance. The organisation then has time to make any necessary changes to the self-assessment prior to submission to the survey team. This process ensures that the self-assessment is suitable for assessment and helps streamline the survey. The technical review report is sent to the survey team as part of the survey information.

3.7 Submitting the final self-assessment and required documentation

The completed self-assessment, a copy of the standards and supporting evidence must be submitted in English to ISQua.

Section 4
Post Survey - Award and Maintenance of Accreditation

4.0 Achievement of Accreditation

The accreditation process is developmental and helps organisations to assess their current standards and identify where improvements are needed. It is also an objective, measurable approach that is applicable internationally and facilitates consistency.

For a set of standards to achieve ISQua accreditation, an overall compliance rate of 70% of the maximum score (57 criteria x rating of 4 = 228) must be achieved. Each individual principle must also achieve a 70% compliance rate against the maximum score of the principle and the following rules must be met:

- all core criteria must achieve a rating of 3 or more, a rating of 2 may be accepted, if the risk associated with the criterion is rated low or moderate;
- there should be no more than two criteria within each principle rated as 2, if the risk associated with the criterion is rated low or moderate; and
- the 70% compliance rate can still be achieved even if there are a minimal number of criteria rated 1, the risk associated with each can only be low or moderate.

If one principle does not meet the above rules, but the surveyors' recommendations can be achieved within 3-6 months, accreditation can be recommended, with the completion of an Action Plan within 3-6 months of award outlining how and when the specific report recommendations will be addressed, or have been addressed.

If two principles do not meet the above rules, depending on the scenario, a recommendation on the individual report can be made to:

- defer an award for 3 months, subject to a written report from the organisation; or
- defer an award for 6 months, subject to a resurvey by two surveyors, one to have been from the original survey team.

The final accreditation decision is made by the Board Accreditation Committee (BAC).

4.1 Decision process

The survey team submit a draft report, ratings matrix and award recommendation to ISQua by the survey end date. To ensure fairness, consistency and quality assurance of the process, the following steps occur:

- ISQua staff carry out a review of the draft report to check for technical accuracy;
- the survey team submit their final report and award recommendation to ISQua;
- the organisation undertakes a factual review of the report to ensure that the surveyors have not misinterpreted evidence or missed information. Any comments raised from the factual accuracy review are discussed with the survey team lead and the report finalised as appropriate;
- the final report is sent to the Validation Panel with the survey team award recommendation; and
- the final report, including any changes suggested by the Validation Panel and agreed by the survey team, and the Validation Panel Report Form are sent to the Board Accreditation Committee (BAC) who make the final award decision.

ISQua's DCEO ensures there are no conflicts of interest at any stage of the approval process.

4.2 The award

If the report meets the accreditation requirements, the standards will be awarded accreditation status for four years with effect from the date of the ISQua BAC meeting where the result is formally approved. The award is also dependent on the completion of the post-survey evaluation and confirmation from the ISQua Finance Department that all accreditation related fees have been paid.

Following approval, ISQua will send a final report, issue a Certificate of Accreditation and provide the ISQua Accreditation logo and the policy, which sets out the requirements for its use. When the standards are awarded accreditation, ISQua will publish details of the award on its website.

4.3 Post-survey evaluation

ISQua is committed to improving its services and each organisation and survey team are asked to complete an on-line questionnaire on their experience of the survey. The summation of the evaluation results is published in an annual report, which is distributed to stakeholders.

4.4 Maintaining the award

Continuing accreditation status will be subject to the completion of a Progress Report within 12 months of award outlining how and when the report recommendations will be addressed, or have already been addressed. A second Progress Report showing these changes is required 30 months post award. Each report will cover progress and report on any remaining actions from the survey. Development and changes to the criteria may not be required until the next revision of the standards is due.

In order to maintain ISQua accreditation, an organisation must report any significant changes, such as new or updated versions of the standards. If there are any concerns about lack of progress, maintenance of standards or if the standards have been changed significantly, the Board Accreditation Committee will be informed and may request an independent review. An ISQua accreditation award can be removed by the BAC, depending on the result of this review.

If ISQua receives a complaint that any organisation is not maintaining their accredited standards, a written report will be requested and the ISQua complaint process, led by ISQua's CEO, commenced. The Board Accreditation Committee (BAC) will be informed. If the BAC decides there are substantive issues of concern, it may put the organisation on a more frequent reporting regime, or require it to have an extra survey at its cost to establish if standards are still being met. Depending on the severity and outcome of the complaint, an ISQua accreditation award can be removed by the BAC.

4.5 Appeal

It is expected that the process of sending the organisation the draft report for comment and correction and ISQua's internal editing and quality assurance processes to ensure accuracy and consistency, will mean there is no demand by organisations for an appeal. However, if there is dissatisfaction with the accreditation decision, the organisation has the right to appeal within 28 days of receiving the final decision, clearly outlining the grounds on which they disagree with the decision. The appeal will be independent of any other process.

Grounds for appeal are that:

- relevant and significant evidence was not properly considered, or was incorrectly interpreted;
- inappropriate weighting was given to the evidence; or
- the original decision making process was inconsistent with the published criteria for accreditation.

The appeal will be considered within one month of the request being received in writing by the ISQua Chief Executive Officer. The appeals panel will consist of three members:

- A member of the Board who will chair the appeals panel;
- Two independent experts, not involved in the survey. The CEO and Chair of the appeals panel shall decide on a fourth member of the panel, if required.
- The appeals panel's decision is reviewed and communicated to the Board.

If the appeal results in a recommended change in accreditation status, the decision must be endorsed by the ISQua Board Accreditation Committee (BAC). The BAC advises the outcome of the appeal.

Part B – The Principles

Foreword

ISQua is committed to ensuring that all standards and principles that support the International Accreditation Programme are revised at least every 4 years, to ensure they reflect considered best practice, recommendations from research and support external evaluation organisations in developing their standards.

The Accreditation Council, on behalf of the ISQua Board, is responsible for overseeing the review and development of all IAP standards, principles and assessment methodologies. The Council member responsible for this project was Brian Johnston, Australia.

This, the 4th edition of ISQua's Principles for the Development of Health and Social Care Standards, is the result of an extensive review that commenced in November 2011. This edition is available from September 2013 for surveys scheduled from May 2014 onwards. Those organisations with survey dates from March - May 2014 may elect to be surveyed against either the 3rd or 4th edition of the Principles.

In line with our own principles for developing standards, this review process began with a wide engagement of all our stakeholders, including client organisations, surveyors and other ISQua experts.

A literature review of best practice in developing and implementing healthcare specific accreditation standards was of little use, due to the dearth of relevant research. However, a number of our ISQua Experts provided important information to inform this process, including David Greenfield, Marjorie Pawsey and Charles Shaw.

Further work was carried out in reviewing ISO9001 and to a lesser extent ISO31000. 2011–2012 Baldridge Criteria for Performance Excellence was also used for reference. Intelligence was also gathered during the revision of the ISQua Standards for Healthcare Evaluation Organisations and was reviewed by the development team.

Using the RUMBA principles these standards were pilot tested by the Danish Institute for Quality and Accreditation in Health Care (IKAS); The Council for Health Service Accreditation of Southern Africa (COHSASA); Department for Communities and Social Inclusion (DCSI (previously DFC)), Adelaide, Australia; Paul Van Ostenberg, Senior Executive Director, International Accreditation and Standards, Joint Commission International (JCI), USA; Elma Heidemann, International Consultant, Quality and Accreditation, Canada; and Charles Shaw, UK. RUMBA principles ensure the criteria are Relevant, Understandable, Measurable, Beneficial and Achievable.

ISQua would like to thank all parties involved for their time, commitment and continued support.

Triona Fortune
Deputy Chief Executive Officer
July 2013

1.0 Introduction

The ISQua survey and international accreditation process is a mechanism for external evaluation and standards setting organisations to assure themselves that their standards meet international best practice requirements and to demonstrate this to their clients, funders and other stakeholders. Organisations can guide the development of their standards through the implementation of the ISQua Principles for the Development of Health and Social Care Standards.

These Principles have been developed as statements of outcomes that are necessary for the development of standards with the aim of patient safety, continuous quality improvement and patient/service user focussed care. They are supported by criteria that are the measurable components of the Principles. The criteria indicate the key structures, processes and outcomes necessary for the achievement of the Principles. This 4th edition of the ISQua Standards incorporates these same features.

2.0 Framework for Principles

The ISQua Principles are designed to provide guidance regarding the development, measurement, structure and content of standards as follows:

Standards Development	Standards are planned, developed and evaluated through a defined and rigorous process under Standards Development.
Standards Measurement	Standards enable consistent and transparent rating and measurement of achievement.
Organisational Role, Planning and Performance	Standards assess the capacity and efficiency of health and social care organisations.
Safety and Risk	Standards include measures to manage risk and to protect the safety of patients/service users, staff and visitors.
Patient/Service User Focus	The standards focus on patients/service users and reflect the continuum of care.
Quality Performance	Standards require service providers to regularly monitor, evaluate and improve the quality of services.

A comparative table of the extent to which criteria in the 3rd edition Principles have been incorporated into the 4th edition is included in this document.

2.1 Suggested Evidence

Since the 3rd edition, guidance on completing the self-assessment and suggested evidence is added underneath the guidance on each criterion. The suggested evidence is relevant to Principles 1 and 2 as the evidence for the remaining Principles is found in the standards. This was previously found in the guide and at the beginning of the self-assessment tool. Please note that this is not a definitive list and organisations may have further evidence which can be presented.

Principle 1

Standards Development

Standards are planned, developed and evaluated through a defined and rigorous process under Standards Development.

No	Criterion	Guidance
1.1	The need for new or revised standards is established taking into account: a) environmental scanning of trends relevant to the specific standards area b) feedback from current and potential users, professional, purchaser, provider and patient/service user groups, governments and other stakeholders c) using evaluation data collated from previous editions d) the knowledge and advice of experts	The cost/benefit of developing standards may be considered both to the organisation developing them and also to the users. Environmental scanning could take into account literature searches from national and international sources. **Suggested Evidence** To complete the self-assessment tool describe how the need and priority for developing or revising the standards were established. Include a description of how the views of each of the groups involved were obtained, e.g. consultation. This is supported by further evidence of: ■ Minutes of meetings ■ Feedback information ■ Evaluation data
1.2	Any relationships with the standards of other organisations, professional and regulatory requirements are identified and considered.	Links or overlap with other standards may be identified to aid implementation of the standards and avoid duplication where possible. **Suggested Evidence** To complete the self-assessment tool describe any relationships with the standards of other organisations and describe how these help minimise duplication. This is supported by: ■ reference to 3-4 criteria that demonstrate the incorporation of professional or regulatory requirements
1.3	There is a planned process for the development or revision of standards.	The process is in accordance with a plan that includes objectives, resources and timeframes. **Suggested Evidence** To complete the self-assessment tool describe the process. This is supported by: ■ The standards development plan ■ The process and timetable for developing or revising the standards

No	Criterion	Guidance
1.4 CORE	Standards are based on: a) current available research, evidence and experience; b) internationally recognised guidelines c) recommendations from WHO and other national/international professional organisations d) input from technical experts e) legal requirements, or f) other authoritative source	Standards based on those of other organisations/ countries may be adapted to local culture, economic situation, environment, accountabilities, and health service requirements. **Suggested Evidence** To complete the self-assessment tool describe any research or evidence of good practice on which the standards have been based. Describe how technical experts contributed to the standards development process. This is supported by: ■ reference to a number of criteria that demonstrate the incorporation of WHO or professional organisation recommendations and legal requirements
1.5	Government, professional, purchaser, provider and service user interests are provided with adequate opportunity for input into the standards development and revision process through direct or indirect representation and formal consultation.	Opportunities for other interested parties to participate may include publication of draft standards for comment, such as posting on the internet. **Suggested Evidence** To complete the self-assessment tool describe what groups were represented in the standards development process, how they were involved, the methodology, eg mailshot, web-based, workshops etc., and what consultation processes took place with which groups. This is supported by: ■ Details of consultation ■ Feedback ■ Minutes of meetings the process
1.6	The scope of the standards are clear in terms of: a) the type of health or social care organisation to which they apply b) whether they are designed for use by the whole organisation or a specific service c) the range of services covered	**Suggested Evidence** To complete the self-assessment tool reference or provide appropriate extracts from the standards introduction or manual that explain the scope and purpose of the standards.
1.7 CORE	The purpose of the standards is clear in terms of: a) setting a level of acceptable performance b) facilitating quality improvement c) for accreditation or certification d) for licensing or e) for insurance or public funding eligibility	**Suggested Evidence** To complete the self-assessment tool reference or provide appropriate extracts from the standards introduction or manual that explain the scope and purpose of the standards.

No	Criterion	Guidance
1.8	There is a clear framework for the standards that makes them easy for organisations and surveyors to use.	The framework may include: i. standards being grouped logically, e.g. by function or system ii. indexed iii. standards being labelled and pages identified so that their content can be easily located iv. the numbering system for the standards and their criteria or elements enabling them to be easily identified v. a clear description of the standards framework in the documentation provided to users **Suggested Evidence** To complete the self-assessment tool describe how the standards framework, layout and wording are appropriate for users. This is supported by: ■ Feedback from testing ■ Feedback from users
1.9	The wording of the standards is clear and unambiguous.	Clear wording may be achieved by: i) sentences having clear subjects and objects so it is clear what is required or who is responsible; ii) avoiding words that may have more than one meaning or interpretation e.g. adequate, good, well or sufficient iii) a formal review process to identify and clarify wording that is ambiguous or not clear iv) material being available to assist users in the interpretation of the standards v) avoiding acronyms **Suggested Evidence** To complete the self-assessment tool describe how the standards were tried and tested before approval, and how the results were used to ensure the wording is appropriate for users. This is supported by: ■ Feedback from testing ■ Feedback from users

No	Criterion	Guidance
1.10	Standards are tested and evaluated by providers and surveyors prior to approval to ensure that each standard is relevant, understandable, measurable, beneficial and achievable. Outcomes from the tests are used to determine any modifications to the standards and the process of application and assessment.	Test participants should be provided with clear instruction on the aims and objective of the test. **Suggested Evidence** To complete the self-assessment tool describe how the standards were tested before approval, and how the results of testing were used to ensure the standards framework, layout and wording were appropriate for users. This is supported by: ■ Instructions for participants ■ The plan for test including timescale, numbers and type of participants ■ Examples of feedback ■ Results of outcomes from the test
1.11 CORE	New and revised standards are approved by the standards setting body or appropriate authority before implementation.	The governing body or equivalent should define and document overall authority and responsibility for approving standards used by the organisation. **Suggested Evidence** To complete the self-assessment tool describe the process. This is supported by: ■ Evidence to show that the standards were approved before implementation
1.12	There is a process to determine the requirements under which the standards could be used by an independent assessment organisation, other than the body that developed the standards.	Requirements may include: i. the process being documented; ii. expectations being defined and agreed, e.g. that the standards are used as intended and that the independent organisation provides feedback on the standards and the results of using them **Suggested Evidence** To complete the self-assessment tool describe the process. This is supported by: ■ Evidence of any defined process and agreement for allowing another organisation to use the standards ■ If the standards can only be used by the applicant organisation, rate this criterion as Not Applicable (NA)

No	Criterion	Guidance
1.13	Information and education are provided to users and surveyors of the new and revised standards to enable interpretation and implementation.	The changes may be outlined in a statement, an index or cross-reference to the changes made. Client education may be part of the process of introducing the standards in the organisation. **Suggested Evidence** To complete the self-assessment tool describe the standards introduction process and timetable, demonstrating how they meet the elements of this criterion. This is supported by: ■ Examples of education activities ■ Examples of how users and surveyors are made aware of the changes made
1.14	There is a plan for the implementation of new and revised standards which includes: parameters, timeframes and any transitional arrangements.	Requirements could include revisions of standards being publicised and distributed to users and surveyors in sufficient time for them to develop an understanding of the standards before the date of implementation. **Suggested Evidence** To complete the self-assessment tool describe the parameters, timeframes and transitional arrangements and how users and surveyors are made aware of them. This is supported by: ■ The plan for implementation.
1.15	Feedback, (including satisfaction of users, surveyors and stakeholder groups), on the standards is obtained, documented and monitored. The data are analysed and evaluated to assist with improving the standards.	Processes should include: i. feedback on the standards being sought from the organisation surveyed and the surveyors after survey ii. periodic surveys of stakeholders being used to obtain their feedback on the standards iii. analysing feedback data on a planned, systematic basis iv. using the data in the standards revision process in a way that can be demonstrated **Suggested Evidence** To complete the self-assessment tool describe how user views are monitored. This is supported by: ■ Feedback tools ■ Results of feedback ■ Summary of relevant analysis and evaluation of data ■ Examples of how the data have been used in the development of the standards
1.16	The standards development process, for new or revised standards, is published and made available.	The process may be made available, for example, by being posted on the external evaluation organisation's website. **Suggested Evidence** To complete the self-assessment tool describe the process. This is supported by: ■ Example of how the process is made available

Principle 2

Standards Measurement

Standards enable consistent and transparent rating and measurement of achievement.

No	Criterion	Guidance
2.1 CORE	There is a transparent system for measuring or rating an organisation's performance on each standard, criterion or element.	The rating scale should enable users to rate and measure consistently. Testing of the rating scale should have ensured reliability and may have occurred when previous standards were developed and tested by the organisation if the same rating scale is used throughout. On-going validity is determined through evaluation. **Suggested Evidence** To complete the self-assessment tool describe the measurement or rating system for the standards and the criteria or elements. ■ Evidence of feedback and evaluation
2.2	Guidelines or other information are provided to: a) assist surveyors to rate standards consistently, and b) users to assess their own performance against the standards	Guidance should be provided if criteria or standards are weighted and how ratings are to be applied where there are identified risks or safety issues. **Suggested Evidence** To complete the self-assessment tool describe the guidelines available. This is supported by: ■ Guidelines, measurement tool or other information provided to assist consistent rating
2.3 CORE	There is a defined methodology for measuring overall achievement of a set of standards in a consistent way.	Examples of how the methodology may define achievement include: i. achievement on all compulsory standards, or ii. all standards being achieved at a defined level, or iii. no standards being rated at below a defined level The methodology may be used by organisations to assess their overall achievement of the standards as part of a self-assessment process. Overall performance on the standards may be used for the purposes of certification or accreditation, but these may not be the only criteria used and additional criteria may be used to decide on accreditation. The methodology may be included in the guidelines (see 2.2). **Suggested Evidence** To complete the self-assessment tool describe the system for measuring the overall achievement of the standards, e.g. numeric rating system, scoring, or voting. This is supported by: ■ Evidence of how it is made available to organisations and surveyors

No	Criterion	Guidance
2.4	The satisfaction of organisations and surveyors with the measurement and rating system is evaluated and results used to make improvements.	Processes should include: i. feedback on the rating system obtained from surveyed organisations and the surveyors, e.g. its usefulness and ease of use ii. analysis of feedback data on a planned and defined basis iii. using the data to improve the rating system in a way that can be demonstrated iv. It is recommended that after each survey feedback is gathered. **Suggested Evidence** To complete the self-assessment tool describe how satisfaction with the measurement system is measured and evaluated. Describe the results have been, or will be, used to make improvements to the system This is supported by: ■ feedback forms ■ examples of results

Principle 3

Organisational Role, Planning and Performance

Standards assess the capacity and efficiency of health and social care organisations.

No	Criterion	Guidance
3.1	The standards require organisations to define: a) mission b) values c) ethics or code of behaviour, and d) their strategic objectives within a plan	A strategic plan sets the long term objectives of an organisation to address major changes or improvements. Ethics or code of behaviour refers to how an organisation ensures that all its decisions and actions conform to moral and professional principles of conduct. The term mission refers to the overall function of an organisation. Values are generally guiding principles and behaviours about how the organisation and staff are expected to operate.
3.2	The standards require an organisational plan which identifies desired or expected services and measures progress in achieving them.	The plan is based on the organisation's strategic direction and takes account of efficient use of resources, environmental and financial factors. The plan may take include links to other plans within the organisation, for example, human resources, risk, communication, financial plans etc.
3.3 CORE	The standards define the responsibilities, with any required delegation, within an organisation for: a) governance b) clinical governance, c) organisational management, encompassing service activities d) financial stewardship, and e) quality performance	Responsibilities should be defined for management, clinicians, other staff and, where applicable, volunteers. Governance responsibilities may relate to determining the organisation's direction, setting objectives and developing policy to guide the organisation in achieving its mission, and monitoring the achievement of those objectives and the implementation of policy. Clinical governance is composed of at least the following elements: ■ Education and Training ■ Clinical audit ■ Clinical effectiveness ■ Research and development ■ Openness ■ Risk management ■ Information Management Organisational management responsibilities may relate to implementing policy, setting targets or goals for the future through planning and budgeting for the organisation's range of services, establishing processes for achieving those targets, allocating resources to accomplish those plans and ensuring that plans are achieved by organising, staffing, controlling and problem-solving.

No	Criterion	Guidance
3.4	The standards must be consistent with the legal and health policy requirements of the environment in which they apply.	Common legal and regulatory requirements that may be referenced relate to: i. employment ii. health and safety iii. building iv. environmental protection, reportable diseases v. waste management vi. food and hygiene vii. health professional registration, health information viii. medicines and technical standards Health policy may relate to new public health initiatives based on latest research or evidence that have been issued as guidelines but not incorporated into law.
3.5	The standards require that organisations use a planning process, taking into account professional practice recommendations, to determine the level of staffing and skill mix required to meet the needs of the services provided.	Professional bodies may have requirements or standards for the numbers of qualified staff required to ensure a safe service.
3.6 CORE	The standards require that staff, independent practitioners and volunteers, have relevant and current: a) orientation and training b) education c) knowledge d) skills and e) experience	
3.7 CORE	The standards require that those permitted by law and by the organisation to practice, including independent practitioners, are credentialed and have their scope of practice defined.	There should be arrangements for systematically checking each individual member of staff for the validity of the necessary credentials and whether the scope of practice is up to date.
3.8 CORE	The standards require that organisations have an arrangement to ensure that the performance and competency of the staff, independent practitioners and where applicable volunteers, are in keeping with the job position. The performance and competency is evaluated on a regular basis.	Requirements could include review of scope of practice, competency assessments and performance evaluations being documented and shared with the staff member (or practitioner or volunteer) involved.
3.9	The standards require that organisations have arrangements for relevant on-going education (study, courses and training sessions) that are necessary to acquire and maintain the required level of performance and competency.	

No	Criterion	Guidance
3.10 CORE	The standards require staff to follow current accepted evidenced based standards, protocols and guidelines.	
3.11	The standards require organisations to involve patients/service users, their families, staff and where possible the wider community in planning for the provision of services.	Where the organisation has no influence in the range of services they provide (e.g. when it's politically determined) this should be noted in the evidence.
3.12	The standards require that the planning of functions, activities and the development of departments and services makes provision for coordination with each other and with relevant external services.	

Principle 4

Safety and Risk

Standards include measures to manage risk and to protect the safety of patients/service users, staff and visitors.

No	Criterion	Guidance
4.1	The standards require the organisation to manage risk through a risk management framework which must include both reactive and proactive measures.	Proactive risk management is essential to quality and safety and should be applicable to all organisations. A risk management framework includes elements such as: i. context ii. scope, objectives and criteria for assessing risk iii. risk management responsibilities and functions iv. staff training v. a list of identified risks – strategic, operational, financial and hazards vi. summary of risk plans for major risks vii. processes for communicating with stakeholders
4.2	The standards require that the risk management framework is supported by a plan, policies, procedures, a risk register and processes.	The risk management plan includes reporting, reviewing and monitoring of risks. The procedure should detail how risks are identified, reported, managed and acted upon, together with the process used to record them. A risk register should be kept of all identified risks. The risk register is a live document which is updated on a regular basis. The identified risks may be rated in accordance with their severity and/or potential impact to the organisation. Monitoring requirements could include the organisation: i. undertaking routine surveillance of actual performance compared with required performance ii. investigating the current situation and specific issues at specified intervals iii. using results from the monitoring and review processes to make improvements
4.3 CORE	The standards require organisations to undertake risk assessments to safeguard patients/service users from unintended consequences of care/treatment.	Risk assessments could be required to include: i. medication management, ii. falls ii. infection control iv. nutrition v. equipment risks, e.g. fire/injury risks from use of lasers vi. risks resulting from long term conditions

No	Criterion	Guidance
4.4	The standards require organisations to have processes for reporting, investigating and taking action in response to safety incidents, adverse events and near misses affecting patients/service users, staff or visitors and for using findings to improve services.	The processes should include: i. training for staff in the reporting and investigation methods ii. means for documenting and reporting incidents/events iii. root cause analysis iv. processes for informing patients/service users of adverse events they are effected by
4.5	The standards require the organisation to protect the health and safety of staff.	The health and safety programme for staff needs to be appropriate to the risks in the particular care sector and may include: i. protective clothing and equipment for staff ii. workplace assessments iii. workload monitoring and stress management iv. staff vaccination v. prevention from manual handling injuries vi. prevention from needlestick injuries vii. protection from occupational hazards, for example radiation, chemical and substances, viii. health promotion, and ix. managing violence and aggression The standards should reflect government and legal requirements or reference if these are addressed by separate agencies.
4.6	The standards require organisations to: a) train staff on the safe operation of equipment, including medical devices, and b) ensure only trained and competent people handle specialised equipment	
4.7 CORE	Standards require organisations to ensure that: a) relevant safety laws and regulations are met b) the buildings, space, equipment and supplies necessary for the stated services are provided, and c) facilities and equipment are inspected, tested, maintained and updated or replaced in a planned and systematic way	Where there are separate systems for assessing patient safety these should be referenced in the standards. It is important for organisations to ensure they are able to carry out treatment and care in an environment which has sufficient space; the correct equipment and has systems in place to ensure supplies are available and won't compromise patient safety. Local legal requirements for health and safety may also give further guidance.

No	Criterion	Guidance
4.8 CORE	The standards provide guidance to assist organisations in managing issues relating to patient/service user safety relevant to their care sector, including any appropriate safety priority areas from the WHO Global Patient Safety initiatives or equivalent patient safety goals	Further information may be found on the WHO website on the nine patient safety solutions. 1. Look-Alike, Sound-Alike Medication Names 2. Patient Identification 3. Communication During Patient Hand-Overs 4. Performance of Correct Procedure at Correct Body Site 5. Control of Concentrated Electrolyte Solutions 6. Assuring Medication Accuracy at Transitions in Care 7. Avoiding Catheter and Tubing Mis-Connections 8. Single Use Injection Devices 9. Improved Hand Hygiene to Prevent Health Care Associated-Infection
4.9 CORE	The standards require organisations to have a planned and systematic programme for the prevention and control of infections which includes at least hand-washing and cleaning requirements.	Other requirements may include, as appropriate to the care or services provided: i. structures and resources ii. use of isolation and precaution techniques iii. use of antibiotics (according to a local formulary) iv. sterilisation and decontamination activities v. monitoring of infection rates vi. collection, analysis and use of infection event data vii. reporting of results of the programme viii. on-going staff education
4.10 CORE	The standards require patient/service user records to be current, complete, accurate and secure to assist the safety and continuity of care and treatment.	In the case of both electronic and hard copy records, requirements may include, as relevant to the service provided: i. legible, dated, timely and signed entries ii. alert notations iii. progress notes, observations, consultation reports, diagnostic results iv. all significant events such as alteration to patients/ service users' condition and responses to treatment and care v. any near misses, incidents or adverse events vi. use of only recognised abbreviations There should be procedures for ensuring records are: vii. stored viii. kept confidential and secure ix. retained and or destroyed in accordance with law and legislation

Principle 5

Patient/Service User Focus

The standards focus on patients/service users and reflect the continuum of care.

No	Criterion	Guidance
5.1	Standards identify the rights of patients/ service users and how they will be informed of those rights. Rights include at least : a) privacy b) dignity and respect c) confidentiality of information d) personal safety and security e) how consent will be granted f) the right to refuse treatment	Patient/service user rights may be included in a Patients Charter or equivalent. Related standards should require: i. documentation of patient/service user rights and responsibilities, and ii. implementation of staff training on them
5.2	Standards require systems to receive, investigate and resolve patient complaints in a timely way.	
5.3	Standards require processes to receive and resolve ethical dilemmas in a timely way.	Ethical dilemmas may include decisions not to treat, to withdraw or discontinue treatment and where treatment is given against the wishes of the individual.
5.4	The standards require staff to involve patients/service users in their own care and services by: a) respecting their preferences and choices b) informing them about their options for care and treatment, and c) obtaining their informed consent	Choices may include whether or not to be treated, the type of treatment, who they want involved in their care or service and end of life wishes. Preferences may relate to: i. how individuals are addressed ii. their personal effects iii. their clothing and self-care routines iv. food, drink and meals v. activities, interests, privacy, visitors Written consent is obtained and documented in the record of care for such activities as: vi. participation in research or experimental procedures vii. all operative and invasive procedures, anaesthesia and moderate/deep sedation viii. where there is a significant risk of adverse effects, and ix. photographs and promotional activities, for which the consent should be for a specific time or purpose
5.5	Standards require that the cultural context and spiritual preferences of patients/service users are recognised.	This standard may require processes to: i. provide access to spiritual care or advice that meets patients/service users' needs ii. train staff on the cultural beliefs, needs and activities of different patient groups iii. where culturally appropriate to provide separate facilities and services for women and men

No	Criterion	Guidance
5.6	Standards identify how patients/service users gain access to care or services, including: a) information on the range of services provided by the organisation based on the needs of the community b) access for individuals with disabilities and special needs, and c) coordinated admission or entry processes	
5.7 CORE	Standards require that the assessments of patients/service users: a) involve relevant disciplines b) are performed by qualified individuals, and c) are completed and documented as required by organisational policy	
5.8 CORE	Standards require that individual treatment or care plans are prepared and documented: a) based on the assessment of patient/ service user needs; including the results of diagnostic tests where relevant b) involve the patient/service user and their families when appropriate, and c) include the goals or desired results of the treatment or care	
5.9	Standards require that: a) treatment or care plans, applicable guidelines and/or pathways are followed b) the progress of patients/service users in achieving the goals or desired results of treatment, care or service is monitored c) patients/service users' needs are reassessed when indicated, and d) the treatment or care plan is revised according to reassessment results	Treatment or care plans, use of guidelines, monitoring and reassessment all reduce variation in care. The standards may also set expectations as to who participates in care planning, the documentation of care plans in the patient record, the frequency of monitoring and reassessment and care plan modification.
5.10	Standards require that discharge, or referral to an outside organisation or practitioner, transfer of care to another organisation for continuing care, is planned.	Requirements should include: i. planning initiated at first contact with the organisation and continuing throughout the contact / admission ii. planning includes patients/service users and their families iii. planning involves making links with referral agencies, other levels of health service and other organisations iv. if death is the expected outcome of the service, planning including the preparation of patients/service users and their families for death, the management of pain and symptoms, linkage with support groups, counselling, and addressing spiritual and cultural needs

Principle 6

Quality Performance

Standards require service providers to regularly monitor, evaluate and improve the quality of services.

No	Criterion	Guidance
6.1	The standards require organisations to publish information on the services provided.	The information provided should be easily accessible and updated regularly to ensure it is current and accurate. Where possible information should include data on performance.
6.2	The standards require quality improvement plans to: a) be formalised b) be comprehensive for all parts of the organisation c) promote continuous quality improvement d) allocate responsibilities e) be subject to evaluation	
6.3 CORE	The standards require quality performance processes and outcomes to be measured.	These should include as a minimum: i. governance ii. clinical governance iii. organisational management, encompassing service activities iv. utilisation and efficiency of services, and v. quality performance This could include: vi. performance indicators vii. patient/service user satisfaction and viii. other performance measures key to the type of health or social care delivered Requirements could include: ix. the use of the above methods to measure functions such as human resources, infection control, risk management and patient/service user care and services x. encouragement of the use of indicators expressed as ratios with defined numerators and denominators xi. use of other performance measures such as surveys, audits and feedback xii. the referencing of clinical performance indicators to evidence based medicine xiii. encouragement for health or social care organisations to develop, implement or enrol in a quality indicators programme
6.4	The standards require the information collected in measuring performance to be used to evaluate and guide quality improvement.	Data collected should be relevant to, and supported by, those involved in the provision of a particular service. The criterion is intended to support the analysis of data and the information generated being readily accessible on a timely basis to those responsible for and/or involved in the delivery of that service to enable improvements to be made.

No	Criterion	Guidance
6.5	The standards require that policies, procedures or processes and plans for all key functions in the organisation are: a) documented b) authorised c) kept current by being reviewed against agreed timescales, and d) implemented	Authorisation may be demonstrated by the signature of a person with authority to approve policies and plans, or the recorded decision of a governing body.

Comparative Table
4th Edition to 3rd Edition

The table below shows the current criterion number and its comparative in the 3rd Edition. Where the criterion is new to the 4th Edition the reference to the 3rd is noted as New.

Standard/Criterion/Topic 4th edition	4th Edition reference	3rd Edition reference
STANDARDS DEVELOPMENT	**1**	**5**
Establishing need for new standards	1.1	5.1
Relationships with other standards	1.2	5.2
Standards development plan	1.3	5.3
Standards based on research, guidelines, legal requirements, technical input	1.4	5.4
Involvement of interested parties in development process	1.5	5.5
Clear scope of standards	1.6	5.6
Clear purpose of standards	1.7	5.6
Clear standards framework	1.8	5.7
Clear wording of standards	1.9	5.8
Testing/piloting of standards	1.10	5.9
Approval of standards by standards setting body	1.11	5.10
Use of standards by an independent assessment organisation	1.12	5.11
Information and education are provided to users and surveyors	1.13	5.12
Timeframes, transitional arrangements for implementation	1.14	5.13
Satisfaction with standards monitored, data evaluated	1.15	5.14
Standards development process published and made available.	1.16	New
STANDARDS MEASUREMENT	**2**	**6**
Transparent rating system for standards, criteria	2.1	6.1
Guidelines for users for consistent rating	2.2	6.2
Defined methodology for measuring overall achievement	2.3	6.3
Satisfaction of users with rating system evaluated	2.4	6.4
ORGANISATIONAL ROLE, PLANNING AND PERFORMANCE	**3**	**1**
Defined mission, values, ethics, strategic objectives	3.1	1.1
Organisational plan, measurement of identified desired results	3.2	3.7, 3.10
Defined responsibilities for quality improvement, governance, management	3.3	1.2, 1.3
Integration of law, health policy.	3.4	1.9
Staff planning, staffing levels, skill mix	3.5	3.1
Orientation, training, skills and experience	3.6	3.2
Credentialing, defined scope of practice	3.7	3.3
Performance/competency evaluation	3.8	3.4
On-going education	3.9	3.4
Following standards, evidence based guidelines	3.10	3.5
Involvement of patients/service users and staff in planning	3.11	3.6

Standard/Criterion/Topic 4th edition	4th Edition reference	3rd Edition reference
Coordinated planning of activities and development	3.12	3.9
SAFETY & RISK	**4**	**4**
Risk management framework	4.1	4.1, 4.2
Risk management plan, policies, procedures, risk register and processes.	4.2	New
Clinical risk assessment	4.3	4.7
Incident, adverse event, near miss reporting/investigation system	4.4	4.3
Staff health and safety protection	4.5	4.4
Staff training on equipment	4.6	4.5
Safety law, building and equipment safety	4.7	4.6
Patient safety issues/priority safety areas	4.8	4.9
Prevention and control of infections	4.9	4.8
Patient/service user records	4.10	4.10
PATIENT/SERVICE USER FOCUS	**5**	**2**
Patient/service user rights	5.1	2.1
Complaint system	5.2	2.2
Processes to receive and resolve ethical dilemmas	5.3	New
Patient/service user involvement in own care/services	5.3	2.3
Cultural and spiritual sensitivity	5.5	2.4
Access to care or services	5.6	2.5
Patient/service user assessment	5.7	2.6
Patient/service user treatment or care plans	5.8	2.7
Following, monitoring progress, revising care/service plans	5.9	2.8
Discharge, referral, transfer of care.	5.10	2.9
QUALITY PERFORMANCE	**1**	**5**
Information to public on services, quality	6.1	1.4
Quality improvement system	6.2	1.6
Key indicators/measures	6.3	1.7
Data evaluation, analysis, use for improvement	6.4	1.8
Document control, key policies, procedures plans	6.5	1.5

Change in Scale

The following table summarises the change in the numbers of standards and criteria between the two editions based on an acceptance of the revised model.

	4th edition	3rd edition
Principles	6	6
Criteria	57	56

Glossary

Glossary	
Access / Accessible	Ability of patients/service users or potential patients/service users to obtain required or available services when needed within an appropriate time.
Accreditation	Act of granting credit or recognition by an external evaluation organisation of the achievement of accreditation standards, demonstrated through an independent external peer assessment of that organisation's level of performance in relation to the standards. See also ISQua accreditation
Accountability / Accountabilities	Responsibility and requirement to answer for tasks or activities. This responsibility may not be delegated and should be transparent to all stakeholders.
Appropriate	The degree to which something is suitable for a specific purpose. This may be that a service is consistent with a patient/service user's expressed requirements.
Assessment / Reassessment	Process by which the characteristics and needs of patients/service users, groups or situations are evaluated or determined so that they can be addressed. The assessment forms the basis of a plan for services or action.
Audit	A systematic independent examination and review to determine whether actual activities and results comply with planned arrangements.
Capacity	Abilities, resources, assets, and strengths of groups or individuals to deal with situations and meet their needs.
Certification	Formal recognition of compliance with set standards validated by external evaluation.
Client	Individuals or organisations being served by the organisation.
Code of Behaviour	Documented set of agreed principles and guidelines that is a guide for behaviours and informs all parties of responsibilities and expectations under the code.
Community	Individuals, families, groups and organisations that interact with one another, cooperate in common activities, solve mutual concerns, usually in a geographic locality or environment.
Competence / Competent / Competency	An individual's knowledge and skills are appropriate to the service provided and assurance that the knowledge and skill levels are regularly evaluated.
Complaint	Expression of a problem, an issue, or dissatisfaction with services that may be verbal or in writing.
Confidential / Confidentiality	Guaranteed limits on the use and distribution of information collected from individuals or organisations.
Consent	Voluntary agreement or approval given by an individual.
Coordinate / Coordination	The process of working together effectively with collaboration among providers, organisations, teams and services in and outside the organisation to avoid duplication, gaps, or breaks.
Credential / Credentialed	Proof an individual's knowledge, skills, and competence and their compliance with specific requirements.
Criteria	Specific steps to be taken, or activities to be done, to reach a decision or a standard.
Culture / Cultural needs	A shared system of values, beliefs and behaviours. The design and delivery of services consistent with the cultural values of those who use them.
Data	Unorganised facts from which information can be generated.
Education	Systematic instruction and learning activities to develop or bring about change in knowledge, attitudes, values or skills.
Effectiveness	The degree to which services, interventions or actions are provided in accordance with current best practice in order to meet goals and achieve optimal results.

Glossary	
Efficient / Efficiency	The degree to which resources are brought together to achieve desired results most cost effectively, with minimal waste, re-work and effort.
Ethics/Ethical	Acknowledged set of principles which guide professional and moral conduct.
Evaluation	Assessment of the degree of success in meeting the goals and expected results (outcomes) of the organisation, services, programs or clients.
External Evaluation Organisation	A recognised body that evaluates through independent peer assessment the performance of organisations in relation to quality standards for organisational functions.
Goals	Broad statements that describe the outcomes an organisation is seeking and provide direction for day-to-day decisions and activities.
Governance	The function of determining the organisation's direction, setting objectives and developing policy to guide the organisation in achieving its mission, and monitoring the achievement of those objectives and the implementation of policy.
Governing Body	Individuals, group or agency with ultimate authority and accountability for the overall strategic directions and modes of operation of the organisation. Also known as the council, board, board of commissioners, etc.
Guidelines	Principles guiding or directing action.
Health Professionals	Medical, nursing or allied health professional staff that provide clinical treatment and care to patients/service users, having membership of the appropriate professional body and, where required, having completed and maintained registration or certification from a statutory authority.
Human resources	The personnel requirements of the organisation.
Incidents	Events that are unusual, unexpected, may have an element of risk, or that may have a negative effect on patients/service users, clients, groups, staff, or the organisation.
Indicator	Performance measurement tool that is used as a guide to monitor, evaluate, and improve the quality of services. Indicators relate to structure, process, and outcomes and are rate based, i.e. have a numerator and denominator so that they can be compared and benchmarked.
Information	Data that is organized, interpreted and used. Information may be in written form or other media such as: audio, video or photograph form.
Information Management	Control of information including data that is organized, interpreted and used.
ISQua Accreditation	A public recognition by ISQua of the achievement of the ISQua international standards or principles by a healthcare external evaluation or standards setting body, demonstrated through an independent external peer assessment of that body's organisational performance, standards or training/education programs in relation to the standards. There are three accreditation programmes – organisation accreditation, standards accreditation, surveyor/assessor training program accreditation.
Licensing	Grant a licence to permit the use of something or to allow an activity to take place.
Linkages/links/linked	Connections, contacts, work partners and working relationships established with others.
Management	Setting targets or goals for the future through planning and budgeting, establishing processes for achieving those targets and allocating resources to accomplish those plans. Ensuring that plans are achieved by organizing, staffing, controlling and problem-solving.
Mission	A broad written statement in which the organisation states what it does and why it exists. The mission sets apart one organisation from another.

Glossary	
Need	Physical, mental, emotional, social or spiritual requirement for well-being. Needs may or may not be perceived or expressed by those in need. They must be distinguished from demands, which are expressed desires, not necessarily needs.
Objective	A target that must be reached to achieve goals. It is the translation of the goals into specific, concrete terms against which results can be measured.
Organisation	Comprises all sites/locations under the governance of, and accountable to, the governing body/owner(s).
Operational	The processes, actions and resources to achieve the goals and objectives of the organisation.
Orientation	The process by which staff become familiar with all aspects of the work environment and their responsibilities.
Performance evaluation	The continuous process by which a manager and a staff member review the staff member's performance, set performance goals, and evaluate progress towards these goals.
Provider	Organisation or group which provides health care which can be primary care, community, acute, specialist, social.
Policies	Documented statements that formalise the approach to tasks and concepts that are consistent with organisational objectives.
Policy	A proposed or adopted course or principle of action.
Procedure	Written sets of instructions conveying the approved and recommended steps for a particular act or series of acts. or Invasive or non-invasive treatment or care of a patient/service user in a clinical or social care setting.
Process	Series of interrelated activities and communications which accomplish services.
Qualified	Having the credentials for, being professionally and legally prepared and authorised to perform specific acts.
Quality	The degree of excellence, extent to which an organisation meets clients' needs and exceeds their expectations.
Quality improvement	On-going response to quality assessment data about a service in ways that improve the processes by which services are provided to clients.
Quality improvement plan	The current action plan for meeting service quality requirements.
Records	Documents stating results achieved or providing evidence of activities performed and are the product of key processes, for example, staff records, individual patient/service user records, records of investigations and tests.
Reliability	Extent to which results are consistent through repeated measures by different measurers, or at different times by the same measurer, when what is measured has not changed in the interval between measurements.
Research	Contribution to an existing body of knowledge through investigation, aimed at the discovery and interpretation of facts.
Results (Outcomes)	The consequences of a service or intervention.
Rights	Something that can be claimed as justly, fairly, legally, or morally one's own. A formal description of the services that clients can expect and demand from an organisation.
Risk	Chance or possibility of danger, loss or injury. This can relate to the health and well-being of staff and the public, property, reputation, environment, organisational functioning, financial stability, market share and other things of value.

Glossary	
Risk management	A systematic process of identifying, assessing and taking action to prevent or manage clinical, administrative, property and occupational health and safety risks in the organisation.
Risk management framework	A set of components that provide the foundations and organisational arrangements for designing, implementing, monitoring, reviewing and continually improving risk management throughout the organisation. The framework should be embedded within the organisation's overall strategic and operational policies and practices.
Safety	The degree to which the potential risk and unintended results are avoided or minimised.
Scope	The range and type of services offered and any conditions or limits to service coverage.
Services	Products of the organisation delivered to patients/service users, clients, or units of the organisation that deliver products.
Staff	Employees of the organisation.
Stakeholder	Individuals, organisations or groups that have an interest or share in services.
Standard	A desired and achievable level of performance against which actual performance is measured.
Strategic plan	A formalised plan that establishes the organisation's overall goals, and that seeks to position the organisation in terms of its environment.
Survey	External peer review which measures the performance of the organisation against an agreed set of standards.
Surveyor	External peer reviewer, assessor of organisational performance against agreed standards.
Validity	The relationship of the data obtained to the purpose for which it accomplishes, or measures what it seeks to measure
Values	Principles, beliefs or statements of philosophy that guide behaviour and that may involve social or ethical issues.

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Review Committee

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Change Log

Change No.	Change Type	Location	Description of Change	Date
P0001	Addition	Page 2 Item 1.0	Membership (Individual and Institutional) added to bullet list	July 2014
P0002	Fix	Page 8 Item 3.4	Risk = Likelihood + Impact	July 2014
P0003	Addition	Page 14 Subheading	Standards are planned, developed and evaluated through a defined and rigorous process under Standards Development.	July 2014
P0004	Fix	Page 19 Subheading	Standards enable consistent and transparent rating and measurement of achievement.	July 2014
P0005	Fix	Page 25 Item 4.4	Not a Core Criteria	July 2014
P0006	Fix	Page 25 Item 4.6	Not a Core Criteria	July 2014
P0007	Addition	Page 7 Item 3.2	Good Achievement Recommendations or Opportunity for Improvement if required	July 2014
P0008	Fix	Page 8 Item 3.3 & 3.4	Requirements for Core Criteria clarified	July 2014
P0009	Fix	Page 3 Item 1.2.2	Requirements for Validation Panel clarified	September 2015
P0010	Fix	Page 5 Item 2.0	Requirement for entry into the programme expanded on and clarified	September 2015
P0011	Addition	Page 6 Item 3.1	An overarching statement regarding the level of compliance is added when the overall rating score has been calculated.	September 2015
P0012	Fix	Page 8 Item 3.4	Requirements for Risk Assessment expanded on and clarified	September 2015
P0013	Removal	Page 9 Item 3.8 & 3.8.1	Removed – repetition of information	September 2015
P0014	Fix	Page 10 Item 4.0	Requirements to achieve accreditation expanded on and clarified	September 2015
P0015	Fix	Page 11 Item 4.4	Requirements to maintain the award expanded on and clarified	September 2015
P0016	Fix	Page 14 Item 2.0	The framework for Principles has been expanded on and clarified	September 2015

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