HONG KONG ASSOCIATION OF GERONTOLOGY

Report On

Pilot Project on Accreditation System for Residential Care Services for the Elders in Hong Kong

30 September 2004

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Abbreviations

C&A homes	Care-and-attention homes
CQI	Continuous quality improvement
DH	Department of Health
EBPS	Enhanced Bought Place Scheme
HKAG	Hong Kong Association of Gerontology
HWFB	Health, Welfare and Food Bureau
LORCHE	Licensing Office of Residential Care Homes for the Elderly (Social Welfare Department)
NGOs	Non-governmental organizations
The Project	Pilot Project on Accreditation System for the Residential Care Homes for the Elderly in Hong Kong (subsequently re-named "Pilot Project on Accreditation System for the Residential Care Services for the Elders in Hong Kong")
RCHEs	Residential care homes for the elderly
SC	Steering Committee of the Pilot Project on Accreditation System for the Residential Care Services for the Elders in Hong Kong
SPS	Service Performance Section (Social Welfare Department)
SQSs	Service Quality Standards
SWD	Social Welfare Department
WG	Working Group of the Pilot Project on Accreditation System for the Residential Care Services for the Elders in Hong Kong

Chapter 1 Introduction

Background

Ageing population and rising demand of residential services

1.1 Hong Kong is experiencing rapid population ageing. According to the Census and Statistics Department (2004), the proportion of persons aged 65 or over is projected to rise from 11.7% in 2003 to 27% in 2033. The demographic trend implies the rising demand for both community and residential services for older people in the future.

1.2 According to overseas experience, the demand for institutional care for people over age 65 is 5.5%. A study by Deloitte and Touche pointed out that in 1997, 4% of older people over age 60 in Hong Kong stayed in various types of residential care. With continuing growth in the number of older people, the demand for residential care places will increase in the coming 20 years.

Mixed growth in residential care home

1.3 Community and residential services for older people in Hong Kong started in the late 1970s. With the increase in the number of older people in the 1980s, the range of residential services as well as the number of residential places correspondingly increased. However, the demand for residential places had far outstripped the supply of government-funded places. In response to market demand, there was a mushrooming of private aged homes in the 1990s. By the end of 2003, the number of private sector places, including places under Enhanced Bought Place Scheme (EBPS), had reached 45,926, accounting for 66% of the total residential places for the elderly in Hong Kong. This far exceeded the number of subvented places of 20,638 (i.e. 29.6% of the total) and self-financing places of 3,051 (i.e. 4.4% of the total) (SWD 2003).

1.4 There is a wide range of subvented residential services including homes for the aged, care-and-attention homes, nursing homes and medical infirmaries, each with different sets of admission criteria to cater for the varying needs of older people. In the past, government-subvented residential services were categorized by service types based on different levels of care. Residents had to apply and transfer to another institution when their physical conditions and functional abilities deteriorated. This practice has resulted in unnecessary transfer and the discontinuity of care for older people. Since 1994 the Government has promulgated the concept of "Ageing in Place",

which proposes to establish residential care homes for the elderly (RCHEs) that could cater for the varying needs of older people without the need for transfer. In the year 2000, the Government piloted an exercise of continuum of care in three subvented RCHEs.

1.5 In 1994, the Working Group on Care for the Elderly recommended a mixed economy of provision that could provide a wider choice of service types for older people in need of residential care. The Deloitte & Touche's Report (1997) further recommended the Government to "move away from the current inputs control model of purchasing from the subvented sector, to the bought place model that is in place for purchasing from the private sector". The Report also proposed to increase the incentives of private sectors by minimizing competition from low quality providers. One of the measures was to enhance and enforce the standards of care so that the low quality providers would either have to upgrade themselves or leave the market. Similar experiences in the USA and the UK proved that this measure was effective.

Concerns on quality issues

1.6 As the private sector has played an indispensable role in providing residential services for older people, the service quality of private RCHEs is always a matter of public concern. Since 1983, a number of unfortunate incidents involving profit-making homes aroused public concern on the regulation of residential homes in Hong Kong. In order to regulate all RCHEs, the Residential Care Homes (Elderly Persons) Ordinance was enacted in October 1994. The Ordinance, which came into full operation on 1 June 1996, specifies requirements regarding the registration of health workers, duties of operators and home managers, staffing, space, location, design and safety precautions of RCHEs. The Licensing Office of Residential Care Homes for the Elderly (LORCHE) of SWD is responsible for administering the licensing system. However, the licensing requirements are just the basic standards for RCHEs, as there is no measurement on the quality and outcome of care of residents in the homes. It is increasingly felt that an appropriate quality assurance system is needed in Hong Kong.

Development of quality measures in government-subvented RCHEs

1.7 On the basis of recommendations put forward by a consultancy team on the social welfare subvention system in 1995 – 1998, SWD established the Service Performance Monitoring System in 1998 to monitor the quality and output of all subvented services provided by non-governmental organizations (NGOs) and the direct services by SWD. Subvented service units have to go through self-assessment, submit

self-assessment/statistical reports to SWD and receive review visits/on-site assessment from SWD. A set of generic Service Quality Standards (SQSs) was developed to provide a yardstick for the aforesaid services to comply, whereas a modified version of SQSs was applied to subsidized places under the EBPS in private RCHEs. SQSs specify the basic features of quality service management in the social welfare sector. Nevertheless, given the very nature of being generic for all kinds of subvented and government-provided social welfare services, SQSs are not intended to be clinically specific for residential services for older people. RCHEs not receiving government subsidy do not need to follow the SQS requirements.

Importance of sector-wide acceptable standards

1.8 In view of the rising demand for residential services for older people, there is a need to establish high-quality residential service. The above-mentioned development highlights the importance of a set of sector-wide agreeable standards specifically developed for residential care services for older people. Quality residential service thrives on a mixed economy of providers, competition amongst providers and quality standards.

1.9 Overseas experiences have demonstrated that accreditation can help to set standards and stimulate improvements. The accreditation system has the additional advantage of providing a basis for benchmarking among the service providers as well as facilitating the consumers to make informed decisions.

Commissioning of the Pilot Project on Accreditation System for Residential Care Services for Elders in Hong Kong

1.10 At the initiation of the Hong Kong Association of Gerontology (HKAG) and with the recommendation of SWD, the Lotteries Fund Advisory Committee has approved funding for HKAG from 1 July 2002 till 30 June 2004 to undertake the Pilot Project on Accreditation System for Residential Care Homes for the Elderly in Hong Kong (subsequently re-named "Pilot Project on Accreditation System for Residential Care Services for the Elders in Hong Kong"). The Project has the following objectives:

(a) to set up a system of voluntary accreditation of residential care services for elders in Hong Kong;

(b) to promote the quality of care through promulgation of the quality process and outcome monitoring in residential care services for elders;

(c) to define the cost of the accreditation mechanism and the future charging mechanism of the voluntary accreditation; and

(d) to serve as a service quality reference benchmark for the community in the procurement of non-subsidized RCHE service from the private or non-profit-making sectors.

1.11 The Project was guided by a Steering Committee set up under SWD, with representatives from all key stakeholders, including SWD, Health, Welfare and Food Bureau, Department of Health, Hospital Authority, Hong Kong Council of Social Service, Hong Kong Association of the Private Homes for the Elderly, Hong Kong Private Nursing Home Owners Association, and HKAG. The Steering Committee provided steer to the Pilot Project to ensure that it operated in line with the policy of residential care services for elders in Hong Kong, monitored the progress, provided the necessary support to the implementation of the Project, and deliberated on the recommendations of the Project. List of members of the Steering Committee and the terms of reference are in Appendix 1.

1.12 The Project was managed and monitored by a Working Group set up by HKAG. The Working Group comprised of experienced practitioners and academics in elderly care, including geriatricians, welfare organization administrators, RCHE managers, therapists, nursing/health educators and academics/researchers in gerontology. It is responsible for project development, construction of the instrument, development of accreditation standards, monitoring of accreditation process and consultation with the sector. Membership list is in Appendix 2. A total of 3 full-time staff were appointed for the Project, including one project director, one project officer and one project assistant. The two professional staff members are from the fields of social work and nursing with rich experience in care of older people. Staff list is in Appendix 3. A Task Group with members from SWD and HKAG was also formed to deliberate on policy implementation and operational matters. List of members of the Task Group is in Appendix 4.

Project Overview

1.13 The Project went through three stages of development: exploratory, development and testing, and formulation of the accreditation system.

Phase 1 (July 2002-December 2002) --- The search for appropriate tools and systems

1.14 The exploratory stage involved information-collection and literature review of local and overseas quality assurance concepts and systems, overseas study visits to gain in-depth understanding and comparison of accreditation systems in practice, and formulation of a tentative framework of a local assessment tool. Information related to accreditation was collected through library research, internet browsing, and liaison with overseas organizations. A literature review was done to explore the concepts of accreditation, quality management, the issues of continuous improvement, benchmarking and the use of indicators, the experience of overseas countries in launching accreditation and the instruments used. Locally, materials provided by SWD on licensing and SQSs were studied to explore the issues related to the operation of an accreditation system. Discussion was held with LORCHE and Service Performance Section on the operation of existing systems, and on possible interface with the future accreditation system. Study visits were made to four countries, namely: the USA, Canada, the UK and Australia, to examine in details their quality assurance efforts to health and long-term care. After carefully studying both local and overseas systems and experiences, the Working Group drafted a preliminary assessment instrument.

Phases 2 and 3 (January 2003 – December 2003) --- Development of appropriate local accreditation standards and assessment instrument

1.15 The development and testing of a locally appropriate set of assessment standards, instrument, and accreditation process lasted for a period of 12 months. A collaborative approach with RCHEs from both subvented and private sectors was taken in the whole process of the accreditation development. The process included two pilot accreditation exercises, assessors training and validation of the accreditation instrument. Details are in Chapters 5 and 6.

1.16 Based on experience and feedback of the pilot accreditation, a set of accreditation standards, assessment instruments, and accreditation process were finalized.

Validation Study

1.17 Parallel to the development of the accreditation standards and assessment instruments, an independent validation study was conducted. The objectives are to test and collect views on the validity and reliability of the assessment instrument and process.

Phase 4 (January 2004 – June 2004) --- Formulation of the accreditation system

1.18 A locally appropriate system was formulated after taking into consideration overseas experiences, feedback and results of the two pilot accreditation exercises, and close consultations with HWFB, SWD, local elderly services sectors, and experts in elderly care.

A sector-wide acceptable accreditation mechanism

1.19 The Project placed great emphasis on engaging the whole sector of RCHEs, both private and non-governmental, in the development of the accreditation system. The Project invited active participation of home operators and professional staff in the following areas: development of the assessment instruments, assessor training, and two pilot accreditation exercises. Open seminars for all practitioners were organized to introduce the concept of accreditation and continuous improvement, and to inform the sector of the progress of the Project. The enthusiastic response to the first and second pilot accreditation had indicated the receptiveness of RCHEs to the setting-up of an accreditation system for residential care services for elders in Hong Kong.

Chapter 2 International Trends in Quality Assurance

Introduction

2.1 In this chapter, the development of quality assurance systems in healthcare services in different economies and world trends on accreditation are examined with a discussion on implications of accreditation for Hong Kong.

Quality Development in Health Care

2.2 Quality assurance as well as comprehensive quality management approaches of Total Quality Management (TQM) and Continuous Quality Improvement (CQI) has become a standard practice in modern health care by the end of twentieth century. There is an increasing expectation in the community on right of access to information to assist users' choices on health care facilities and health care providers. Information is needed to help identify sources of care that meet certain "quality" expectations. These expectations may relate to structures, processes and outcomes of care. These factors have created a climate in which decision makers at all levels are seeking objective quality evaluation data on health care organizations. Licensure, accreditation, and certification are systems available to meet the need for quality and performance information. Internationally, licensure is usually a process by which a governmental authority grants permission to a health care organization to operate and to ensure the organization meets minimum standards to protect public health and safety while accreditation is a process by which a recognized body, usually a non-governmental organization, assesses and recognizes that a health care organization meets pre-determined and published standards.

2.3 A uniformed set of quality monitors or indicators will provide a valuable comparison of performance between the public and private health sectors. The progressive changes of health care services from an acute care setting to ambulatory care and a congregate setting for long term care have called for proper monitoring of the quality of the service. This will help to ensure that the desired reductions in the cost of care do not limit the access to care, reduce the quality of care, or increase the risk to the patient or staff. Quality management is, therefore, very important. It can improve the effectiveness of the organization and management of the services, bring efficiency to the care process, avoid rework, reduce the inappropriate use of scarce resources, improve staff's performance, and enhance patient and staff education. Allocation decisions based on objective quality data have increased acceptance and sustainability.

Quality Evaluation Programme in Overseas Countries

United States of America

2.4 In the USA, the Joint Commission on Accreditation of Healthcare Organizations (2003) is the major accreditation body in the healthcare field. It is an independent not-for-profit organization. Its origin could be traced back to 1910 when Dr. Ernest Codman started the "end result system" of hospitals in the US (Roberts et. al 1987) to standardize hospital services and to monitor the effectiveness of medical treatments. In 1917, the American College of Surgeons (ACS) set up the Hospital Standardization Program, which was the forerunner of the American accreditation system. As the programme gradually became too large and complex for one organization to administer, several medical associations joined force with the ACS in 1951 to create the Joint Commission on Accreditation of Hospitals (JCAH). The latter evolved to become the JCAHO of today and extended its scope from accreditation of hospitals to other healthcare services, e.g. long-term care in 1966. JCAHO started as a voluntary system. However since the 1960s, it has been providing "deemed status survey" to support hospitals and nursing homes in meeting the conditions necessary for participation in the Medicare scheme (Scrivens 1995).

2.5 There is also another accreditation scheme, which provides accreditation for continuing care communities --- the Continuing Care Accreditation Commission (CCAC) (2003). On the other hand, The Baldrige National Quality Program also provides a set of Health Care Criteria for Performance Excellence (2003) with a system perspective for understanding performance management and sharing of good practices. The Criteria also form the basis for the Malcolm Baldrige National Quality Award process.

Canada

2.6 In Canada, the Canadian Council on Health Services Accreditation (CCHSA) is the national accreditation body in Canada (CCHSA 2002a, 2003) and nearly enjoys a monopoly in accreditation.

2.7 The CCHSA is an independent, non-profit organization, whose role is to objectively review the care and quality of the services provided by healthcare organizations in Canada, and compare the findings against a set of national standards. At the early stage of the development of accreditation system, Canada followed closely the footsteps of the USA. In recognition of the different needs of the Canadian National

Health System, a separate Canadian program for hospital accreditation was established in 1953 by a group of medical associations (Scrivens 1995). The accreditation program was designed to be voluntary and free from government intervention. However, with official recognition from the federal government, it gradually became the sole authority to accredit hospitals in Canada. Like JCAHO, the Canadian accreditation body gradually expanded its scope to include other healthcare services, e.g. long-term care in 1978.

Europe

2.8 In Europe, the ExPeRT (External Peer Review Techniques) Project (Shaw & Heaton 2000) funded by the European Union had identified four approaches of external peer review used in healthcare services in different EU member states.

2.9 Visitatie (Peer Review) --- Originated from the Netherlands, peer review of clinical departments was usually carried out in the form of on-site standards-based surveys conducted by uni-disciplinary teams of clinicians. Standards derived from practical guidelines and personal experiences are used to assess the quality of professional performance of peers with an aim to improving the quality of patient care.

2.10 Accreditation --- Resembling the model of JCAHO, this approach is to conduct systematic assessment of hospitals against explicit standards. It is practised in the UK, Spain, Netherlands, Finland, France, and Italy.

2.11 European and National Quality Awards --- The European Quality Award was stimulated by the development of Baldrige Awards in the USA. Health care providers who apply for European Quality Award are assessed against performance standards in specific areas such as clinical results, patient satisfaction, administration and staff management. Several countries, particularly those in Scandinavia, have developed their own national award with reference to the European framework.

2.12 ISO 9000 --- A series of standards for service industries (ISO 9000) developed by the International Organization for Standardization (ISO) were used in some European countries, e.g. Germany and Switzerland, to assess quality systems in specific aspects of health services. However, as the ISO standards are more related to administrative procedures rather than to clinical results, they have been used mostly in more mechanical departments such as laboratories, radiology and transport, but some have also been used in the assessment of whole hospitals and clinics.

2.13 In the UK, the National Care Standards Commission (NCSC) is an independent public body under the Care Standards Act 2000. It has taken over the roles of 150 local authorities and 80 health authorities, and applied a consistent national framework (National Minimum Standards) to regulate social care and private and voluntary health care services, including residential care homes throughout England. Although it is a regulatory body by nature, it also places heavy emphasis on continuous quality improvement.

Australia

2.14 The Australian Council on Healthcare Standards in Australia carries out hospital accreditation. For the residential care homes, the Australian Commonwealth Government established the Aged Care Standards and Accreditation Agency (ACSA) to provide accreditation under the Aged Care Act 1997. ACSA is an independent company wholly owned by the Commonwealth Government. Under the Accreditation Grant Principles 1999, aged care homes have to be accredited with ACSA in order to receive Commonwealth funding.

Taiwan

2.15 On the basis of JCAHO, the Department of Health formulated a set of working procedures for hospital accreditation in 2002 (Taiwan College of Healthcare Executives 2002). In the same year, the Long Term Care Professional Association (2002) commissioned by the Social Service Bureau of the City of Taipei had drafted an instrument and scoring scheme for the accreditation of elder care facilities in Taipei.

Singapore

2.16 The web site of Licensing & Accreditation Branch of the Department of Health of Singapore government has only mentioned the accreditation of clinical laboratories. It has required nursing homes to apply for a license from the Department. An Inspection Checklist for Nursing Homes has also been provided for the care homes' compliance.

Summary of Overseas Development

2.17 Quality of healthcare service is a worldwide concern and different economies have set up a variety of systems for quality evaluation. Among these different attempts, accreditation stands out as one of the most prominent approaches, which is widely

practised in North America, Australia and some parts of Europe. It has been observed that concerns about quality of aged care services have prompted some economies to extend the concept of accreditation to residential care homes, e.g. Australia and Taiwan.

International Trends in Accreditation

2.18 On the basis of the information gathered, ten international trends in accreditation can be identified.

(a) Licensing co-exists with accreditation.

(b) Accreditation is largely operated by non-statutory independent bodies.

(c) Accreditation promotes continuous quality improvement.

(d) Accreditation is a kind of peer review, which provides education and consultation in the process, and quality control of assessors through training is emphasized.

(e) Accreditation provides tailor-made standards for residential homes.

(f) Accreditation is a process and outcome-focused system, and makes use of performance indicators as tools for service quality evaluation.

(g) Over the years, comprehensive methodology has been developed on accreditation.

(h) The development of accreditation database in the accreditation process is conducive to service development, quality enhancement, public accountability and consumer choice.

(i) Accreditation bodies put heavy emphasis on research & development.

(j) Accreditation as a means of quality assurance has worldwide recognition and application.

Licensing co-exists with accreditation

2.19 In other economies, the accreditation system usually co-exists with licensing system. Australia, for example, has a licensing system operating in line with an accreditation system, each serving different functions.

2.20 Accreditation has many similarities with licensing of healthcare services. They both make use of predetermined sets of standards and processes to assess the performance of the organizations and involve authority to give some form of recognition to the organizations which meet the standards. However, they are yet different in many ways.

2.21 According to Rooney & Ostenberg (1999) of the Quality Assurance Project (QAP), accreditation and licensing are different in three major aspects:

(a) Accreditation standards are usually set at optimal and achievable level to encourage continuous improvement efforts within healthcare organizations, while licensing regulations are generally established to ensure that an organization meets minimum standards in public health and safety.

(b) Accreditation decision is made following a periodic on-site evaluation by a team of peer reviewers, while licensing is granted following an on-site inspection, usually by government inspectors, to decide if minimum standards have been met.

(c) Accreditation is often a voluntary process in which organizations have the freedom to choose whether to participate, while securing a licence is a prerequisite for the residential care homes to start and continue their operation.

2.22 Nevertheless, the concern on the quality of care and aspiration to share good practices to promote quality improvement have prompted most governments to go beyond licensing to setting up an accreditation system. This has helped to promote continuous quality improvement in residential care services for older people.

Accreditation by non-statutory independent bodies

2.23 Accreditation is usually carried out by non-statutory independent bodies, as they possess the advantage of independence and flexibility. The status of the accreditation body as being non-statutory and independent also allows the process to be carried out in less regulatory atmosphere. Different from compliance with the licensing requirements, the organizations pursuing accreditation do not run the risk of ceasing operation if they fail to attain the accreditation standards. However, in some economies, accreditation is a necessary condition for the residential care homes to receive government funding, e.g. Australia.

2.24 Scrivens (1995) suggested that accreditation being an independent, objective, highly credible and unbiased process is crucial to the acceptability of the accreditation system. The involvement of relevant professional bodies is deemed essential. However, Scrivens (ibid) cautioned that, due to the rapid expansion of professional bodies within the healthcare field, a board incorporating the representatives of all groups would be too large to be manageable. CCHSA solves this problem by utilizing a stakeholder approach. It involves various interest groups in a broad consultation process in standards development (CCHSA, 2002a, 2002b). Other boards have included the representation of consumers, e.g. JCAHO of the USA, and CCHSA of Canada, etc. (Scrivens 1995).

Accreditation promotes continuous quality improvement

2.25 Rooney & Ostenberg (1999) suggests that one of the major strengths of accreditation is its support for continuous improvement efforts through consultation, education and sharing of good practices rather than reliance on a punitive inspection methodology. Scrivens (1995) also quoted the approach of JCAHO in emphasizing the review of quality of care by the healthcare organizations themselves, while shifting the role of surveyors to look at how healthcare organizations monitor themselves and make necessary improvements. She also suggested that, as the healthcare organizations found out new ways to improve their service quality, they could go beyond the existing standards and scale new heights. Therefore, the standards could undergo continuous upgrading rather than fixed at a point and remain unchanged.

2.26 National Care Standards Commission (NCSC) in the UK, a regulatory body safeguarding National Minimum Standards, adopts the "continuous quality improvement" framework. The emphasis is on raising the quality of care rather than just ensuring adequate standards are provided and maintained. The providers are

expected to set up systems for ensuring continuous improvement of services. It is also observed that there is "a preference for consultancy, discretion and accommodation" in the new approach adopted by NCSC. The inspectors are suggested to "listen to the providers as they explain how they have achieved or not achieved outcomes". The inspectors should facilitate the service providers in making an improvement plan to accomplish the unmet outcomes and only exercise enforcement when there is a real risk to the service users or a history of non-compliance (NCSC 2002).

2.27 Continuous improvement is also regarded by ACSA as a central part of a comprehensive accreditation system to manage and improve the quality of services provided in the residential sector. The aged care homes are asked to demonstrate their commitment to identify needs and opportunities for improvement in a systematic and planned way. It is assumed that care homes should go beyond compliance with the standards and there is no ceiling to the level of quality. "Even when standards have been met – the quality of service can always be improved" (ACSA 2001a). The concept of "continuous improvement" is merged with the emphasis on "self assessment" (ACSA 2001b) and "data and measurement" (ACSA 2002) to form an integral strategy in promoting quality improvement.

2.28 The pursuit of continuous service improvement in accreditation carries two implications. Firstly, the system can start with compliance of basic requirements and gradually raising the bar when the care homes can achieve a better level of performance. This will give room for those homes which lag behind to catch up through quality improvement efforts. Secondly, there are built-in incentives for those homes with higher level of performance to upgrade their services continuously.

<u>Accreditation as peer review to encourage stakeholder consultation and continued education</u>

2.29 Accreditation is a form of peer review, usually carried out by trained and approved assessors/surveyors from the same field. According to the experience of some care homes in Canada, the surveyors from CCHSA are able to provide not only assessment and validation of evidences during the course of the survey, but also education and consultation to the care homes. The surveyors having similar background are familiar with the home operation. They are more able to understand the difficulties encountered and make suggestion for improvement. Their advice, very often practical and to the point, is therefore beneficial to the organization. Some accreditation bodies like JCAHO also provide consultation and educational programmes to the sector (JCAHO 2003).

2.30 The surveyors, in turn, gain valuable professional experiences through participation. Some surveyors found ample networking opportunities and good chances to learn and broaden their skills through serving as a surveyor. They are also exposed to a variety of good practices. With in-depth understanding of service provision gained through contacts with staff and service users of other homes, they will bring home valuable insights to their own facilities. But it is essential to note that assessors/surveyors should be properly trained with the relevant code of professional ethics before being allowed to practise.

2.31 As the role of assessors or surveyors is so important in the accreditation process, the accreditation bodies usually put great emphasis on their quality control. They set entry qualification for the applicants to ensure the applicant's qualifications are met with relevant experience and expertise. Before formal appointment, applicants are required to go through pre-service training and in some cases, a period of preceptorship. For re-registration, it is always necessary for assessors or surveyors to be in ongoing practice and continuous education (CCHSA 2003).

Accreditation provides tailor-made standards for residential care homes

2.32 In view of its healthcare origin, accreditation is able to provide tailor-made standards for the residential care homes and other healthcare facilities. According to Rooney & Ostenberg (1999), ISO standards have several limitations when compared with accreditation in the healthcare field. For instance, ISO standards are phrased in terminology rooted in manufacturing industries (e.g. "product realization", "design and development", "production", "nonconforming product", etc.). Healthcare organizations adopting ISO standards need to exercise creative interpretation to translate them into more familiar terms and demonstrate their applicability to patient care or patient outcomes. The ISO standards also do not address what the specification should be in order to produce a service or product of high quality. By looking at both management and delivery of care and focusing on process and outcomes, the accreditation standards offer more specific guidelines than ISO standards in care settings.

Accreditation as a process and outcome-focused system

2.33 Donabedian (1980) proposed three major approaches to the evaluation of quality, namely, structure, process, and outcome. Rooney, & Ostenberg (1999) of the QAP distinguished the three approaches as follows:

(a) Structure Standards –the system's inputs, e.g. as human resources, the design of a building, living environment, the availability of equipments and supplies, etc.

(b) Process Standards –the activities or interventions carried out within the organization in the care of patients or in the management of the organization or its staff, including the clinical guidelines.

(c) Outcome Standards –the effect of the intervention on a specific health problem is examined and whether the expected purpose of the activity is achieved.

2.34 From overseas experiences, it is observed that the emphasis on structure standards was changed to process standards, and recently evolved to outcome standards. This development might be attributed to the actual experience that structure and process standards could not guarantee desired outcome. For instance, during the 1990s, JCAHO was criticized as focusing on structure and process measures rather than the measuring of appropriateness of care to the residents in their accreditation survey. There were many instances where residents suffering actual harm because of inadequate care went undetected by JCAHO surveyors (Hash, 1998). Subsequently, more emphasis was placed on utilizing the ORYX – the outcome-focused performance measurement initiative introduced by JCAHO (2003) to provide a more targeted and complete basis for evaluation and continuous improvement. In response to stakeholders' feedbacks and suggestions, CCHSA (2002) changed its structure based standards to the process-oriented Client-centred Accreditation Program (CCAP) in 1995, which was further upgraded to the present more outcome-focused AIM (Achieving Improved Measurement) Accreditation Program in 2000. By closely monitoring the outcome indicators, information can be obtained on whether the residents are cared for properly.

2.35 The outcome-focused accreditation system is also better than ISO certification in several aspects. According to Rooney & Ostenberg (1999) of QAP, ISO standards focus directly on "capability" rather than the "results", and stress more on the quality and conformity of the process than on the outcome. For example, ISO standards only outline the requirements of the management system that are capable of producing quality and demand that they are put into practice. There are, however, no clear specifications on what constitutes good outcomes or results in a particular field such as healthcare except the vague reference to customer satisfaction and statutory requirements. In contrast, outcome-focused accreditation provides remedy to these

problems by emphasizing results and ensuring good outcome by regular monitoring.

Use of performance indicators

2.36 Many accreditation bodies place emphasis on the development of performance indicators and use them as tools for service quality evaluation. In Europe, the monitoring of performance indicators provides a valuable supplementary source of information to standard-based evaluation, as the indicators focus on the key structures, processes and outcomes that represent an overview of the quality of a long term care institution.

2.37 In many economies, the performance indicators of residential care homes are compiled and published. For example, the Centre of Medicare and Medicaid Services and state agencies of the USA use the Minimum Data Set (MDS) Quality Indicators to provide benchmarking reports to long term care facilities. The indicators are released for public reference. By publishing their performance indicators, residential care homes are encouraged to seek continuous improvement to their services. Canadian Council on Health Services Accreditation (CCHSA) (2002) has published a list of indicators which are linked to accreditation as a reference for the healthcare organization in their quality monitoring and improvement activities.

A comprehensive and systematic methodology for accreditation

2.38 With years of experience, the accreditation methodology is constantly improved and refined to become more comprehensive and systematic and well suited to the long term care settings. It can be observed that a refined accreditation system comprises several steps, as described below.

2.39 As a first step, care homes are required to prepare a self-assessment. At this stage, the care homes are required to compare their performances against the accreditation standards, gather feedback from stakeholders and identify strengths and opportunities for continuous improvement. It also provides a set of basic data for the care home for assessors to validate during the on-site assessment process. CCHSA (2003), NCSC (2003) and ACSA (2003) have already implemented this approach, while JCAHO (2003) has put this into pilot test.

2.40 Another emerging trend is examination and use of pre-collected data submitted by the residential care homes to study trends, problems, and focus of the survey. JCAHO, for instance, has provided the surveyors with ORYX performance

data, sentinel events and complaint data to help identifying areas of special risk or non-compliance. CCHSA (2003) and NCSC (2002) have also adopted similar approach.

2.41 The accreditation bodies also include in their methodology a document review process similar to the practices in ISO certification. Interviews are held with stakeholders such as board members, care home management, frontline staff, residents and their families, and community partners such as family doctors, visiting nurses, etc. JCAHO (2002) also provides a public information interview to any one interested to provide information during the survey. Observations on delivery of care are emphasized in the survey.

2.42 To provide a forum for exchanging views, exit meetings at the end of assessment are usually held for the assessors/surveyors to report findings to the home operators. The home operators can make use of the chance to seek or provide clarification. Many accreditation bodies also establish appeal mechanism to settle possible disputes arising from the results of the accreditation.

2.43 By adopting a comprehensive and systematic methodology, accreditation is able to obtain a holistic view of the quality of services not matched by other approaches in quality assurance. Continued refinements of the methodology through years of practices in different economies provide a pool of valuable experience for the accreditation bodies to draw on in developing our system.

Accreditation database

2.44 Information obtained during the accreditation process can be compiled into a database for reference by the accreditation body, the residential care sector, the consumers and the general public. According to Rooney & Ostenberg (1999) of the QAP, the accreditation database highlights the number of organizations meeting the standards and pinpoints problematic areas or opportunities for improvement. Furthermore, the residential care homes can compare their performance with similar organizations, providing an incentive for continuous improvement. The database can also inform the public of the different quality of RCHEs in the market and facilitate informed choice.

Emphasis on research and development

2.45 The emphasis on research and development, particularly the development of performance indicators and the use of information for service improvement, is another essential function of accreditation bodies. For example, JCAHO's research work includes the use of performance indicators, i.e. the ORYX initiative and the collection of sentinel events figures (JCAHO 2003). The figures on sentinel events gathered from the accredited organizations are analyzed and uploaded on the web for the reference of the sector. Also, the Centre of Medicare and Medicaid Services and state agencies utilize Minimum Data Set Quality Indicators developed by the University of Wisconsin to provide benchmarking reports to long term care facilities. Such reports are released for public information on a web site called Nursing Home Compare. Moreover, CCHSA has published a list of indicators, which are linked to accreditation, as a reference for healthcare organizations in their quality monitoring and quality improvement activities. CCHSA also collaborates with other research organizations in the development of indicators and compiles a national report which summarizes aggregated accreditation survey data and highlights trends across the country for service improvement and for reference of the industry (CCHSA 2002). In Europe, by 2005, all healthcare organizations in Europe will be required to join a quality evaluation scheme and to collect data about their service quality for the compilation of reports on experiences of using quality indicators in Nordic countries (Ovretveit 2001).

2.46 Efforts in collecting relevant data and establishment of databases by accreditation bodies around the world also open up valuable channels for comparing and benchmarking findings with international partners; and greatly facilitate improvement in service quality.

Accreditation as an international movement

2.47 The International Society for Quality in Health Care Inc. (ISQua) has set up an international accreditation programme known as Agenda for Leadership in Programs for Healthcare Accreditation (ALPHA) (Heidemann, 2000). This is formed in response to the interest of the healthcare accreditation bodies around the world to gain access to external, independent peer assessments following international recognized standards and criteria.

2.48 ALPHA 2003 is a framework for accreditation bodies to develop and improve their standards. Accreditation bodies can request to have their accreditation standards evaluated in relation to the key principles, or apply for external assessment of its

performance by peers from other countries and seek for international accreditation status. ISQua believes that international accreditation will give credibility to an accreditation body. It will reassure its stakeholders that the organization possesses sound and consistent systems with worldwide recognition of its achievement.

Implications

2.49 Hong Kong should develop an accreditation system as a key part of the quality assurance system for residential care homes. Licensing and accreditation should co-exist to serve different functions.

2.50 Licensing is a statutory function of the government to ensure that residents in RCHEs receive services of acceptable standards that are of benefit to them physically, emotionally and socially. Accreditation is usually operated by a non-statutory independent body and participation is voluntary. Accreditation assesses the participants' performance by optimal and achievable standards through external peer review. The strength of this approach is that it provides opportunities of education and consultation to the home operators and encourages them to strive for continuous improvement to their services.

2.51 Accreditation is accepted in many economies as an important part of quality assurance system for residential care homes as it possesses distinctive strengths in three aspects. These include tailor-made standards for residential care homes, a process and outcome-focused approach which provides more indication on explicit results, and a comprehensive and systematic methodology, which provides a holistic view of services, not rivaled by other alternatives. Accreditation is now internationally accepted. There is a rich pool of international experience that can be tapped in developing an accreditation system for Hong Kong.

Chapter 3 Accreditation of Residential Homes in Overseas Countries

Introduction

3.1 This chapter explores the experience of four English-speaking countries, which have put in place systems of accreditation for residential homes. Strengths and weaknesses of the four systems are highlighted. These will give insights for Hong Kong in designing a local accreditation system.

3.2 The four accreditation bodies taken for comparison are the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) of the USA, the Canadian Council on Health Services Accreditation (CCHSA), the National Care Standards Commission (NCSC) of the UK, and The Aged Care Standards and Accreditation Agency (ACSA) of Australia.

Comparison of Different Systems

Nature of accreditation

3.3 A fundamental question about the nature of accreditation is whether it should be voluntary. Some of the accreditation schemes, such as the CCHSA, operate on a voluntary basis. The participating organizations join and pay for the scheme on their own initiatives.

3.4 One of the inherent weaknesses of a voluntary accreditation system is that the accreditation body needs to attract its customers. Therefore, many accreditation organizations make education an integral part of accreditation or provide it as a value-added function so that the participating healthcare organizations can get more value for money from the process.

3.5 Overseas experiences have shown that when accreditation is required by law and/or linked to government funding, the issues of public interest and accountability will come into focus. It inevitably changes the nature of accreditation. Scrivens (1995) suggested that when the government began to use accreditation to supplement its activities, the emphasis of accreditation would shift from the professional model of education and support to one of regulation, and standards would change from focusing on good practice to "minimal hurdles to be crossed" (i.e. minimum standards).

Table 3.1 Nature of accreditation

	JCAHO	CCHSA	NCSC	ACSA
Nature of accreditation	Voluntary + "Mandatory"*	Voluntary	Mandatory	Mandatory
Required by law?	Yes (substitute some state licensing requirements)	No	Yes (Care Standards Act)	Yes (Aged Care Act)
Linked up with government subsidy?	Yes (deeming status for Medicare)	No	N.A. (as a requirement of operation)	Yes

* Its accreditation could be considered to be "mandatory" because of its capacity in substituting some licensing requirements of the state and providing deeming status for Medicare. Yet it is different from other mandatory accreditation in the sense that the homes can still exercise consumer choice in taking alternatives other than JCAHO.

3.6 Both JCAHO and CCHSA adopted voluntary accreditation at the beginning. However, after JCAHO's accreditation is given "deeming status", i.e. it has been regarded as meeting the conditions necessary for participation in Medicare, and fulfilling licensing requirements in some states, it becomes part of the regulatory mechanism. Participation of the healthcare organizations in accreditation also becomes to some extent "mandatory" if they want to receive government funding support. To strengthen public accountability, JCAHO has to initiate a series of reforms to step up the quality control of its survey activities (JCAHO 2003). On the other hand, CCHSA still maintains its status as a voluntary accreditation body, although some provinces are considering accreditation as a condition of granting government subsidy.

3.7 According to the Care Standards Act 2000 in the UK, NCSC is a regulatory body providing mandatory registration, i.e. the social care and private and voluntary healthcare bodies (including residential homes for the elderly) have to register in order to operate. In Australia, the Aged Care Act 1997 and Accreditation Grant Principles 1999 specify that the aged care homes have to be accredited with the ACSA to receive Commonwealth Government Funding. Hence, its situation is quite similar to JCAHO's "deeming status" as condition of receiving Medicare subsidy.

3.8 There are, however, significant differences between the two. ACSA is at present the only accreditation body for the aged care homes and 90% of care homes depend on government subsidy to survive. It, therefore, enjoys a kind of monopoly. Furthermore, ACSA maintains a close link with the Commonwealth Department of Health and Ageing, and may recommend sanctions on homes that do not meet

Accreditation Standards or other legal obligation, thus playing the role of a regulatory body in this regard. On the other hand, there are other options for the care home operators to choose besides JCAHO's accreditation, e.g. State Surveys (Brown 1999a & 1999b). Therefore, JCAHO has to compete with other bodies and has to modify its approach continuously to cater for its customers' demand.

3.9 If accreditation is made "mandatory", the nature of accreditation bodies is likely to resemble a regulatory body, and they will take up some regulatory functions. This in turn will have impacts on the expectation of the public as well as the care home operators. The public will regard the accreditation body as a safeguard of public interests and expect them to guarantee minimal risk (e.g. JCAHO, NCSC and ACSA). There is concern about the potential conflict of interest if the accreditation bodies are paid directly by the organizations they accredited (e.g. JCAHO) (Schlosberg 1997). On the other hand, the care home operators will regard accreditation as a matter of life and death, and will try to apply political pressure to modify the standards/approaches of the accreditation bodies to suit their own needs (e.g. NCSC and ACSA).

3.10 For the two bodies established by law, i.e. NCSC and ACSA, they encountered similar problem of having to work under a very tight timetable imposed by law. NCSC was established in April 2001 and was expected to assume the full range of responsibilities and to assimilate 2,500 staff (including 1,400 inspectors) within one year. Serious delays were observed in locating offices, setting up information technology infrastructure and transferring home registrations. It caused heavy strain on staff manpower to guarantee inspection frequency and quality (NCSC 2003).

3.11 On the other hand, ACSA had to accredit all 3,000 homes in Australia in one exercise, creating heavy demand on number of assessors within a short period of time, and sometimes compromising the quality of the assessors. There was no time to fine-tune the system. The care home operators also found it difficult to adjust to the new system requirements within a short period of time.

3.12 The link of accreditation to granting of government subsidy is another issue of critical importance. The requirement solves the problem of accreditation bodies having to play to market forces and provides them with a stable income to launch their work (e.g. JCAHO and ACSA).

3.13 Voluntary accreditation provided by CCHSA in Canada was considered to be a valuable experience by nearly all stakeholders. Service providers place particular emphasis on the intangible benefits of accreditation: raising reputation, promoting

learning and continuous improvement, etc. Because of the voluntary nature of accreditation, CCHSA has to be very sensitive to the needs of the sector in order to maximize its attraction to the healthcare organizations, e.g. making use of the stakeholder approach to consult the sector on upgrading the accreditation standards and process, emphasizing the quality control of its work, etc. However, as CCHSA relies mostly on fee income paid by accredited healthcare organizations, most care home operators expressed concern about the high accreditation fees.

Philosophy and working approach

3.14 Most of the accreditation bodies adopt a non-punitive approach in working with the aged care home. For instance, CCHSA emphasizes accreditation as a supportive rather than punitive process to facilitate quality improvement (CCHSA 2003). According to JCAHO, the approach of its survey is not meant to be punitive, and the surveyors are expected to provide expert consultation and education to the healthcare organizations, besides assessing the compliance with the accreditation standards (JCAHO 2003).

3.15 Even NCSC, a regulatory body by law, emphasizes that it operates in an enabling rather than disabling manner, and makes use of a constructive "Firm but Fair" approach that aims at working with providers, not against them (Connor et al 2002, NCSC 2002) to achieve quality improvement. Hence it can be concluded that a non-punitive approach is essential if quality rather than mere compliance with minimum standards is the main emphasis of the accreditation system.

3.16 Continuous improvement is also a major theme pursued by all accreditation bodies. For instance, ACSA and NCSC have included the concept in their standards and educational and training packages. CCHSA highlights continuous evaluation and improvement through self-assessment, peer review and benchmarking as an element of its working approach (CCHSA 2003). JCAHO makes use of the ORYX performance measurement system to support continuous improvement in safety and quality of care in accredited organizations (JCAHO 2003).

Organizational structure

3.17 Because of their background, the boards of JCAHO and CCHSA mainly consist of representatives from professional associations. To keep in contact with the sector and the public, these two bodies invite client and consumer representatives. For CCHSA, two government observers also sit on the board (Scrivans 1995). Furthermore,

CCHSA has adopted a stakeholder approach in consultation and improvement of the accreditation system and process.

Table 3.2 Organizational structure

	JCAHO	CCHSA	NCSC	ACSA
Board composition	Professional association, client & consumer representatives	Professional association, client & consumer representatives and government observers	Appointed by government	Appointed by government
No. of board members	28	14	15	9
Staff strength	500 staff 500 surveyors	80 staff 350 surveyors	1,100 staff 1,400 inspectors	76 staff 71 staff assessors 327contract assessors
Workload	Accredited 17,000 health care organizations (including 2,400 long term care organizations)	Accredited 1,000 health care organizations (3,322 sites, services or programs including 1,015 long term care centres) (2002 figures)	Carried out registration of 39,000 service providers and 65,000 inspection (2003 estimate)	Accredited 2,949 aged care homes (2002 figures)

3.18 As both NCSC and ACSA are established by government initiatives through legislation, members of the boards are appointed by the governments.

Standards

3.19 The standards used in the four systems are quite similar. They can be grouped under six categories according to their nature:

(a) Organizational leadership and management
(b) Environment
(c) Human resource
(d) Residents' rights and lifestyle
(e) Health and personal care
(f) Information management

3.20 Among the four sets of standards, the AIM Standards of CCHSA stand out from other systems. Besides the grouping of standards that resemble other systems, four quality dimensions are added to facilitate the surveyors to assess the quality aspects of the healthcare facilities concerned.

Table 3.3 Accreditation standards

USA – JCAHO	Canada - CCHSA	UK – NCSC	Australia - ACSA
(1) Resident rights & organizational ethics (2) Continuum of care (3) Assessment of residents (4) Care & treatment of residents (5) Education of residents (6) Improving organizational performance (7) Leadership (8) Management of environment of care (9) Management of human resource (10) Management of information (11) Surveillance, prevention & control of infection	(1) Leadership & partnership (2) Environment (3) Human resources (4) Information management (5) Long term care Quality Dimension (1) Responsiveness (2) System competency (3) Client or community focus (4) Work life	(1) Choice of homes (2) Health & personal care (3) Daily life & social activities (4) Complaint & protection (5) Environment (6) Staffing (7) Management & administration	(1) Management systems, staffing & organizational development (2) Health & personal care (3) Resident lifestyle (4) Physical environment & safe system

Scoring system

3.21 JCAHO and CCHSA, the two systems with longer history, have developed elaborate scoring systems. For the two relatively new systems, i.e. NCSC and ACSA, simple categories on compliance / non-compliance are used.

Table 3.4 Scoring system

	JCAHO	CCHSA	NCSC	ACSA
Scoring system	Elaborated scoring System	Elaborated scoring system	Compliance or Non-compliance	Compliance or Non-compliance

Process

3.22 There are many common elements in the accreditation process of the four bodies. These include:

(a) The use of pre-site visit data by assessors or surveyors to identify issues for investigation and discussion.

(b) Self-assessment to prepare the care homes for accreditation and to provide background information for the assessors or surveyors.

(c) Document review.

(d) Site visits.

3.23 During the site visit, interviews are held with various stakeholders such as the care home management, staff and service users. Observation of care delivery is also made in all four systems. At the end of the site visit, some systems (e.g. JCAHO, CCHSA, ACSA) organize exit meetings or de-briefings to provide opportunities for the assessors and the care home management to discuss the assessors' observations and recommendations whereas others only forward the draft report to the care homes for comment.

3.24 All the four systems have set up decision-making mechanism to review the recommendations of the assessors / surveyors to grant or deny accreditation status to the care homes. All of them have established appeal mechanisms. The accreditation information is released to the public though it may be in different forms. In some systems, only the list of accredited organizations is published whereas more detailed information such as the performance reports of the care homes are also released in other systems.

3.25 The four systems also have their own special features as showed in Table 3.5. Some accreditation bodies (e.g. JCAHO, NCSC) use case tracking, care tracking or tracer methodology to trace a number of individuals served through the care process to assess the quality of care. Due to their regulatory functions, NCSC, ACSA and JCAHO make unannounced surveys or spot checks to the care homes. NCSC may carry out law enforcement action if necessary. Besides carrying out regular external audits, ACSA assessors also undertake ongoing supervision of the homes through support contacts and review audits. The CCHSA system has a very unique feature of integrating quality assessment, risk assessment and identification of higher priority recommendations into the accreditation process. JCAHO places significant emphasis on the public involvement and requires the homes to arrange a Public Information Interview to provide opportunities for the public and stakeholders to give their views.

Table 3.5 Accreditation process special features

	JCAHO	CCHSA	NCSC	ACSA
Special features	Tracer methodology	Built-in quality assessment	Case tracking	Spot check
	Public information interview	Risk assessment	Unannounced visit	Support contact
	Unannounced survey	Identification of higher priority recommendations	Law enforcement	Review audits

Accreditation cycle and accreditation status

3.26 Different cyclical periods are observed for different accreditation systems, but the norm seems to be the three-year cycle. A fixed cycle is easy to administer in terms of planning and budgeting. Care homes not attaining full compliance are given a reasonable time frame to remedy the situation. On the other hand, ACSA awards accreditation status of varying validity period, depending on the results of the accreditation assessment.

3.27 However, short accreditation cycles often attract criticisms as care home operators expressed concern that soon after they had received the results of the previous cycle, they had to start preparation for the next visit. It was considered expensive if the accreditation would have to be repeated every year.

3.28 On the other hand, an accreditation period longer than three years is considered too long to ensure effective monitoring, and there are concerns that the care homes may not be able to keep up the performance once the accreditation status has been granted (Scrivens, 1995). Therefore, some accreditation bodies provide focused surveys or visits (e.g. JCAHO, CCHSA) to assess the degree to which the care homes have improved its level of compliance relating to specific recommendations mentioned in the previous accreditation survey. Some conduct unannounced surveys or spot checks (e.g. JCAHO, ACSA) to verify whether there is any non-compliance with the accreditation standards.

3.29 Concerning the accreditation status, JCAHO has the most complicated system, with more than 8 categories before 2000. JCAHO has to provide an elaborate list of definitions on the web for public reference. To reduce the complexity, JCAHO has discontinued the practice of "accreditation with commendation" since 1 January 2000. Other accreditation bodies maintain more simple systems, usually consist of "accredited" and "non-accredited", with conditions attached for those "accredited" homes that cannot attain full compliance, e.g. requirements for improvement, focused visits, etc.

Table 3.6 Accreditation status and accreditation cycle

USA – JCAHO	Canada – CCHSA	UK – NCSC	Australia - ACSA
1. Accreditation with full standards compliance 2. Accreditation with requirements for improvement 3. Provisional accreditation 4. Conditional accreditation 5. Preliminary denial of accreditation 6. Accreditation denied 7. *Accreditation with commendation 8. Accreditation Watch	1. Accreditation 2. Accreditation with condition: report 3. Accreditation with condition: focused visit 4. Accreditation with condition: report & focused Visit 5. Non accreditation	1. Registered 2. Not registered	1. Accredited 2. Non-accredited Higher rating award - Merit - Commendable
3-year cycle	3-year cycle	Annual registration	3 or 2 or 1-year cycle depending on home performance

* This category has been discontinued as from 1 January 2000. However, organizations awarded this status in prior surveys can retain this designation until their next complete surveys.

3.30 The merits of a simple system are evident. For the accreditation body, it is easy to operate as there is no need for an elaborated scoring system. For the home operators, the consumers and the public, a simple system is easier to comprehend. The usual controversies related to complex grading systems are avoided, as the public will focus on whether the homes are "accredited". A simple system of "accredited" and "non-accredited", however, may not offer incentives for those care homes already having good performance to make further improvements. Indeed, they may have the feeling that it is unfair to classify them with other homes with less astounding performance in the same category. To address this concern, ACSA has introduced a higher rating award for those care homes which have exceptionally good performance.

Surveyors or assessors

3.31 The quality of the surveyors or assessors of the accreditation bodies is a matter of great concern. There are negative comments from the sector about the performance of the surveyors or assessors. These include the punitive attitude of surveyors, inconsistency and subjectivity in judgment, unprofessional attitudes and behaviors and insufficient knowledge about the service, etc.

Table 3.7 Qualification and training for surveyors or assessors

	JCAHO	CCHSA	NCSC	ACSA
Basic qualification	5 years of experience in facility	Senior health service professional	Existing Inspectors	No specific educational requirement but appropriate working experience is required
Training	Two-week classroom training session	4 days orientation programme	Conversion training program plus CD Rom and web-based training	5 days training
Preceptor-ship / internship	Yes	Yes		
Continual education requirement	Yes	Yes		Yes
Continual practice requirement		A minimum of two weeks of surveying each year		A minimum of two complete audits
Certification exam	Yes			Yes

3.32 In the assessment, the surveyors or assessors represent the accreditation system, and their performance has a crucial impact on the quality of assessment and eventually the success of the system. The accreditation bodies therefore employ a variety of measures to control the quality of the surveyors or assessors, e.g. training, preceptorship, code of practice for surveyors or assessors, feedback and appraisal system, continual education requirement, continual practice requirement, and even certification examination, etc.

3.33 It should be noted that ACSA has decided to maintain an arm's length from training and registration of the assessors. However, it has then lost direct control over the quality of training and the quality of the assessors.

Release of information to the public

3.34 From Table 3.8, it is clear that it is a worldwide trend to make the information of the accredited organizations available on the web. This can raise the transparency and the credibility of the accreditation process. The consumers can also utilize the information to make informed choices.

3.35 However a transparent system has its limitations. Some assessors may be very cautious about their comments when the report is widely read by the public. They may refrain from giving frank comment if that may be misunderstood. Furthermore,

jargons used in the reports may constitute a barrier to communication. Besides putting the information on the web, ACSA makes the information available in other channels, since not every member of the public has access to the internet.

Table 3.8 Information released to the public

	JCAHO	CCHSA	NCSC	ACSA
Release of information to the public	Quality check on the web include performance reports of the homes	List of accredited organizations	A plan to put inspection reports on the web in the future	All accreditation and review audit reports and decisions are put on the web

Customer service

3.36 Those accreditation bodies adopting voluntary accreditation (e.g. CCHSA and JCAHO) usually pay more attention to customer service and continuously improve their accreditation standards, process and other services to cater to the needs of the customers – the healthcare organizations. For instance, CCHSA implements the "one stop customer service model" with an accreditation specialist following the healthcare organization through the accreditation process (CCHSA 2001). JCAHO also operates a similar system where an account representative serves as the major contact person to coordinate the accreditation survey (JCAHO 2001). Both bodies also keep close watch of the development in the field, develop new programmes and standards, and attract new potential customers through the involvement of stakeholders.

Continuous improvement of the system

3.37 A sustainable system thrives on continuous improvement. Table 3.9 is a snapshot of the improvement initiatives put forward by different accreditation bodies. It highlights the importance of the continuous improvement of the accreditation systems in order to cater to the changing needs of society, the consumers and the accredited organizations.

Table 3.9 Improvement initiatives

	JCAHO	CCHSA	NCSC	ACSA
New initiatives	-Pre-survey self assessment -Standard review project - ORYX – use of outcome indicators -Quality check on the web	-Continuous upgrading of standards, e.g. 1992-Structure Standards 1995-Process Standards 2000-Outcome Standards (AIM standards)	Collection of indicators for policy formulation and sector-wide improvement	-Higher rating award -Full report on the web

Implications for Hong Kong

3.38 It would be advisable for Hong Kong to start with voluntary rather than mandatory accreditation, so that all parties can prepare themselves for the new system over time. The accreditation organization should be independent of the government and possess the expertise to win the sector's respect.

3.39 A non-punitive approach based on continuous quality improvement should be adopted. A stakeholder approach should also be adopted to consult the sector on the improvement to the accreditation system and process.

3.40 A three-year accreditation cycle with annual review are practised by the four countries studied, and should be adopted in Hong Kong.

3.41 Hong Kong should establish an accreditation system building on best practices around the world, while taking into consideration local situations. Due emphases should be placed on quality control of assessors, and on maintaining a transparent system with support from the sector and the public. The aim is to establish an accreditation system that can continuously improve itself and learn from the experience and difficulties encountered by accreditation systems in other economies.

Chapter 4 Review of Quality Systems in Hong Kong

The Trend of Quality Assurance

4.1 The development of a new accreditation system for residential care homes in Hong Kong depends on a proper understanding of the current situation of quality assurance of the related services locally. The present chapter will examine the developments of quality monitoring in RCHEs in Hong Kong. The future accreditation system should fill existing gaps, supplement or complement the existing systems in promoting quality service in RCHEs in Hong Kong.

Government Initiatives

4.2 The operation of RCHEs in Hong Kong is being regulated by a licensing scheme under the provisions of the Residential Care Homes (Elderly Persons) Ordinance, the Residential Care Homes (Elderly Persons) Regulations, and the Code of Practice. LORCHE was established by SWD in April 1995 to enforce the Ordinance and to provide guidance and advice to operators of all RCHEs regarding continuous compliance to the licensing requirements.

Residential Care Homes (Elderly Persons) Ordinance

4.3 The Residential Care Homes (Elderly Persons) Ordinance came into full operation on 1 June 1996. Under the Ordinance, a licensing system administered by the Director of Social Welfare (DSW) was set up to regulate the operation of RCHEs, to ensure residents receive services of acceptable standards that are of benefit to them physically, emotionally and socially. Any premises at which more than 5 persons aged 60 or above are habitually receiving care and accommodation therein must apply for the license. LORCHE is a multi-disciplinary office under SWD and is responsible for assessing the compliance of requirements relating to premises location, design, structure, fire precautions, space and staffing provision, etc. The operators have to apply for renewal of licences. The validity of the licence is for a period of 36 months or such lesser period as indicated by DSW. The licensing system serves a very distinctive role in the protection of the safety and well being of residents in RCHEs. First of all, it covers all RCHEs in operation. Secondly, LORCHE is charged with statutory power of enforcement, which can have a decisive influence in ensuring the compliance of basic requirements by these homes. The focus of licensing is on the structural safety, health and care services and management, including compliance of fire and building regulations, equipment and facilities provision, space and manpower ratio, etc.

The Residential Care Homes (Elderly Persons) Regulation

4.4 The Residential Care Homes (Elderly Persons) Regulation provides more details of legislative requirements on the control, keeping and management of the RCHEs. It stipulates the staffing requirements, duties of the home operators and home managers, the statutory registration of health workers and various requirements related to the location, height, design, area of floor space per resident, accessibility, heating, lighting and ventilation, toilet facilities, etc. It also stipulates the precaution against fire as well as other risks such as storage of medicine, etc.

Code of Practice

4.5 The Code of Practice for Residential Care Homes (Elderly Persons) is issued by the DSW under the statutory provision of the Ordinance, which sets out principles, procedures, guidelines and standards for the operation, keeping, management, or other control of RCHEs. It provides more details on the day-to-day operation for the compliance and reference of the homes.

Multi-disciplinary inspection of RCHEs

4.6 Inspections of RCHEs are carried out by 4 different inspectorate teams of LORCHE, namely fire safety (FSIT), building safety (BSIT), health (HIT) and social work (SWIT), to inspect on various aspects of licensing requirements to ensure full and continuous compliance. The FSIT and BSIT inspectors are seconded from the Fire Services Department and Buildings Department. Each team carries out the inspections according to its own schedule using a risk assessment approach. Each RCHE on average receives up to 6 to 8 inspections per year. Most inspection visits are unannounced with each taking approximately half a day.

4.7 The inspection frequency of SWIT is generally once a year for subvented RCHEs and once every six months for private homes. Private RCHEs joining the EBPS are more frequently visited. They are visited once every three months to ensure their compliance with licensing requirements and the attainment of EBPS standards. On-site inspections would focus on service operation and management issues. Areas of inspection include: floor area, bed numbers, files and records, staff employment and attendance, environmental hygiene, menu, social activities and residents' health records, etc. The inspectors talk to residents and their family members to collect customers' feedback on the home's service provision. The SWIT inspectors serve as the coordinators of all 4 inspectorate teams. They help to facilitate coordinated

communication with home operators and managers and to enforce prosecution action against non-compliant RCHEs under the offence sections of the Ordinance and the Regulations, if and when necessary.

4.8 The inspections on healthcare aspects are carried out by HIT which is staffed by nursing officers. They normally carry out annual inspections for subvented homes and half-yearly inspections for private homes. The focus of the inspection is placed on personal and environmental hygiene as well as healthcare services for maintaining residents' health and prevention of deterioration. Areas of inspection include: kitchen, laundry, equipment and furniture, care of the elderly. They also inspect records of drug prescription and procedures in delivering medication to the residents, record keeping and application of physical restraint, and record of annual medical examination, etc. They provide advice on menu setting, environmental hygiene and other major issues. The HIT inspectors also talk to the elderly residents and their family members to understand more about their satisfaction level and make suggestions on the delivery of personal and health care.

Service Performance Monitoring System

4.9 In 1995 - 1998, SWD appointed the Cooper & Lybrand Consulting Group to conduct a comprehensive review of the social welfare subvention system, aiming at improving the subvention system to enable the Department and NGOs to provide more efficient, customer-focused, accountable and output driven welfare service (Social Welfare Department 2003).

4.10 One of the major recommendations of the review was the introduction of the Service Performance Monitoring System (SPMS). A Service Performance Section (SPS) was set up by SWD in 1997 to implement the new system. Subvented social service units are to be assessed on the basis of the service-specific Funding and Service Agreements (FSAs) and generic SQSs. Service units seek continuous quality improvement through implementing the SQSs, with mechanisms of regular review of service policies and procedures as well as addressing feedback from users, staff and the public. Both self-assessment and review visits are also means for identifying "good practice" and "opportunity for further progress" in service units.

4.11 Performance assessment is based on the performance standards in the FSAs which include Output and/or Outcome Standards, Essential Service Requirements and SQSs. Service units have to submit statistical information on regular basis as specified for each service type and an annual self-assessment report to SWD. Those units that

considered themselves non-compliant with the requirements have to submit action plans to show the procedures and schedule they are taking to meet the performance standards. The assessors of SPS will conduct assessment of the subvented service units and assess their compliance with the requirements.

4.12 To streamline the monitoring process and improve the monitoring effectiveness, enhanced service performance assessment methods are introduced as follows:-

(a) Service operators are required to submit self-assessment reports on SQSs and Essential Service Requirements annually to SWD together with action plans in case of non-compliance.

(b) Besides periodic submission of Statistical Information System (SIS) Forms, service operators are also required to provide reports on variance by the middle of a year and action plans of any unmet Output and/or Outcome Standards by the end of each year.

(c) Review visits are conducted at the selected units, which are random samples at the ratio of one out of ten units by each service operator.

(d) On-site assessment is conducted to service units with new mode of service delivery, suspected problem performance, or having emergency/disastrous/special event.

4.13 While SQSs are generic requirements for ensuring quality management in all of the subvented and government-provided social welfare services, they do not intend to prescribe service-specific details on the concerns related to professional standards of residential services, for example, the quality and outcome of care service provided. Furthermore, SQSs are only applicable to subvented RCHEs and a modified version of the standards is modestly applied to homes joining EBPS.

Quality Improvement Measures Initiated by the Sector

ISO

4.14 ISO is an international quality system with worldwide recognition. Its strength is in the strong document control. Its external assessment and resulting recognition also provides strong incentive to continuously improve its quality. The

agency also provides a variety of generic training, including introductory seminars on the interpretation and application of standards in a particular industry sector and internal auditor training. A number of welfare agencies have participated in the ISO certification. Among them, there are a small number of subvented RCHEs and private homes. The Hong Kong Quality Assurance Agency, a non-profit-distributing statutory organization, which assists industry and commerce in the development of quality management systems, is one of the certifying bodies for ISO.

4.15 According to Wan from Sheng Kung Hui, ISO certification is part of the TQM initiative (Wan 1999). To fulfill the requirements of the standards, Sheng Kung Hui had invested much time and effort in producing the quality manual and policies and procedures, records and other related documents. As ISO standards were generic rather than specific to RCHEs, Wan admitted that they spent considerable time in reading, comprehending and discussing how to apply the standards in the RCHE setting. A number of observations had been made on ISO certification by Wan also: as part of TQM, there should be improvement in documentation, especially in conjunction with SQSs, internal audit process, external audit, and improvement in communication.

4.16 Li (1999), the then superintendent of SWD Begonia Boys' Home (a probation home for juvenile delinquents), stressed the importance of clear positioning, selecting relevant processes, avoiding over-documentation, building on existing system, the involvement of management, professionals and frontline staff, the need to keep up with social trend instead of solely relying on ISO certification.

4.17 To date, ISO certification is not widely applied in RCHEs in Hong Kong because of a number of limitations: the application and procedures related to its certification is expensive for most RCHEs, and the standards are not specific to residential care services for older people.

Five-S (五常法)

4.18 Five-S (5-S) is a technique used to establish and maintain quality environment in an organization. It was originated in Japan and the Hong Kong 5-S Association promotes the practice in Hong Kong. The major ideas of the practice are summarized as follows (Hong Kong 5-S Association 2003):

Table 4.1 Five-S

Japanese	English	Chinese	Meaning	Typical Example
Seiri	Structuralize	常組織	Organization	Throw away rubbish & return to store
Seiton	Systematic	常整頓	Neatness	30-second retrieval of a document
Seiso	Sanitize	常清潔	Cleaning	Individual cleaning responsibility
Seiketsu	Standardize	常規範	Standardization	Transparency of storage
Shitshke	Self-discipline	常自律	Discipline	Do 5-S daily

4.19 About 30 organizations have successfully applied for certification under 5-S. At least four of the organizations are from social service backgrounds, which include a social service centre, a rehabilitation centre, a kindergarten cum child care centre and a RCHE.

4.20 The benefits of implementing 5-S include: providing clear management standards, reducing errors, clean and comfortable working environment, improvement in efficiency, service quality, staff morale and team spirit, facilitation of good customer service, and better preparation for ISO certification, etc. (Ho 2000). According to one RCHE, practicing 5-S had made them very efficient in organizing their filing and inventory system.

4.21 5-S provides a framework for building up a systematic working approach and good working habits, thus achieving a clean, tidy and orderly environment. Its simple and coherent philosophy and slogans are easy to grasp and are particularly effective in accomplishing simple and repetitive tasks. However, there are limitations when the approach is applied in residential care setting. Same as ISO, it is not specifically designed for the residential homes. It does not cover details of care process in residential care homes and does not specify the outcome requirements.

Hong Kong Council of Social Service's Service Quality Indicators for Residential Service

4.22 In 2001, Hong Kong Council of Social Service formulated a set of "Service Quality Indicators (SQI) for Residential Service". SQI measured service quality for the purposes of quality monitoring, quality assurance, and continuous quality improvement.

The measurement covered 3 areas: (1) Structure --- measuring physical environment, human environment, and social environment; (2) Process --- measuring system management, clinical and management performance, and care protocol; (3) Outcome --- measuring satisfaction rate of customers. Collection of self-reported data began in January 2002. 76 RCHEs from 21 operators, representing 60% of the HKCSS's elderly service member agencies and 80% of non-profit-making homes, participated voluntarily.

4.23 It was the first time clinical performance data was collected in RCHEs in Hong Kong. The self-reported data covered areas such as occurrence of pressure sores, skin diseases, infectious diseases, accidents and fall. The data provided useful baseline measurements not only for current performance, but also for future monitoring of care improvements or deterioration. The response reflected the readiness of operators of NGO homes for sector-wide quality improvement initiatives. However, SQI is only a self-reporting mechanism by individual homes without any external audit which is essential in any accreditation system.

Summary of Recent Development in Hong Kong

4.24 The present review of development of quality systems for residential services in Hong Kong helps us to identify the current situation in Hong Kong. The establishment of a licensing system has provided basic standards for RCHEs. Although the licensing requirements are widely regarded as useful in ensuring that residents in RCHEs receive services of acceptable standards that are of benefit to them physically, emotionally and socially, licensing standards do not specify outcome requirements. It is far from being able to reflect the quality required for homes, which should provide more than basic services. SPMS applies only to government-subvented residential places and SQSs are not specific to most of the care process in RCHEs. The application of individual homes to ISO and 5-S certification reflected that operators of RCHEs are committed to striving for a high quality of care service. However, these systems (ISO and 5-S) are not widely used in RCHEs and are not specific to the quality of care process delivered in RCHEs. An accreditation system which can look after the sector-wide needs and formulate standards specific to the care process in residential homes is necessary to promote continuous improvement in the quality of care delivered to elderly residents.

4.25 The coverage of the service-specific clinical process in RCHEs and the focus on optimum standards through CQI enable accreditation to play complementary and supplementary roles to the existing licensing system and SQSs. The licensing system will continue to take up the regulatory role in safeguarding the basic standards of RCHEs, while the accreditation system can provide the incentive for the RCHEs to pursue a higher quality of care acceptable to the operators, professionals and the public.

Chapter 5 Development of Local Accreditation Instrument and Standards

Philosophy and Framework

5.1 The two primary objectives for formulating a set of tailor-made accreditation standards for residential care homes for older people in Hong Kong are as follows:

(a) to promote the quality of care through promulgation of the quality process and outcome monitoring in RCHEs;

(b) to serve as a service quality reference benchmark for the community in the procurement of RCHE service from the private or non-profit-making sectors.

5.2 Designed, constructed and improvised along the lines of accreditation instruments in other economies, the accreditation instrument developed by HKAG is tailor-made for RCHEs in Hong Kong and is absolutely authentic with thorough adaptation to special features of RCHEs in Hong Kong. Built around the concept of Continuous Quality Improvement (CQI) adopted by the National Care Standards Commission (2003) in the UK, the accreditation instrument proposed by HKAG is neither an extension of the statutory requirements prescribed by the Residential Care Homes (Elderly Persons) Ordinance nor a refinement of the SQSs implemented by SWD for all subvented welfare services in a generic manner. Efforts have been made to avoid overlap with licensing inspection and SQSs. The basic philosophy of the accreditation system and instrument proposed by HKAG is to encourage RCHEs to move beyond minimum service standards, as is the world trend, in the provision of residential care services for older people and to practise CQI through peer-learning and review. The approach adopted is both process-oriented and outcome-focused and a balance has been struck between aspirational and prescriptive requirements. The proposed set of optimum quality standards is clearly compatible with the existing practices and guidelines.

5.3 Within the framework of CQI, the accreditation system and instruments will not only maintain service quality but also seek to improve quality through the identification and learning from Good Practices, with a fundamental aim to ensure public safety and to protect users from hazards and risks. The key words for the proposed accreditation instruments are: to move from minimum to optimum standards, to fill existing gaps by supplementing and complementing existing systems in promoting quality service and user-protection in RCHEs in Hong Kong.

Development Process

5.4 The accreditation instrument is developed by HKAG through extensive literature review, internet browsing and study visits to the USA, Canada, the UK and Australia. Reference was also drawn from relevant standards (such as: "8 Principles of Quality Management" developed by ISO, the concepts of "Structure, Process and Outcome Standards" of Donabedian), documents (such as the "Minimum Data Set" of the Centres for Medicare and Medicaid Services) and consultations (such as experience-sharing with the Joint Commission JCAHO in using the "ORYX performance measurement", sessions with SWD staff in LORCHE and SPS).

Contents of the Preliminary Accreditation Instrument

5.5 The preliminary accreditation instrument consists of a core part and a supplementary part. The core part is applicable to all RCHEs and the supplementary part is a simplified version of SQSs specially designed for RCHEs which have not undergone assessments by SWD on the items covered. There are altogether 115 items, which are measured by a 2-point scale of either "compliant" or "non-compliant".

Core part

5.6 Four important categories of standards, viz. "Governance", "Environment", "Care Process" and "Information Management and Communication" are laid down in the core part of the main accreditation instrument. There are 27 sub-domains with 77 items. In each sub-domain, there is a column on "other outstanding areas" for comments on notable achievements.

5.7 The 6 sub-domains with 18 items under "Governance" measure whether administrative systems and processes of the RCHE can promote quality, minimize risks and ensure proper governance. There are 3 sub-domains with 10 items under "Environment" to measure whether facilities and processes of the RCHE can ensure a safe and comfortable environment for as well as quality of life and welfare of its residents and staff. For measuring "Care Process" provided by the RCHE for facilitating physical and mental health and well being of its residents, there are 16 sub-domains with 47 items. Under "Information Management and Communication", systems and processes of the RCHE for collecting feedback from stakeholders for service improvement are measured by 2 sub-domains with 2 items.

Supplementary part

5.8 The supplementary part of the accreditation instrument consists of 12 sub-domains with 38 items, which are also grouped into four domains.

Domains and sub-domains

5.9 Details of the distribution of domains and sub-domains for both the core and supplementary parts of the preliminary assessment instrument are shown below:

Table 5.1 Summary of domains and sub-domains in the preliminary assessment instrument

Domains	**Sub-domains**	
	Core Part	**Supplementary Part**
Governance	• Leadership • Total quality management • Risk management • Purchase of service • Occupational safety • Ethics	• Policy review and revision • Roles and responsibilities • Human resource management • Planning and evaluation • Financial management • Legal responsibilities • Elderly rights
Environment	• Community co-operation • Environment, facilities and service provision • Food and environmental hygiene	• Safe environment
Care process	• Post-admission • Medication management • Continence management • Skin care and bedsore prevention • Falls • Nutrition • Mobility • Use of restraint • Transfer • Infection control • Cognition, emotion, perception and communicatic ability • Chronic pain management • Palliative care • Special procedures • Psycho and social support • Recreational activities	• Entry and exit • Need assessment
Information management and communication	• Information management • Communication	• Record • Provision of Information

Validation of the Accreditation Instrument

5.10 In order to verify how far the accreditation instrument and procedures are applicable to the Hong Kong situation, HKAG launched a research study alongside the developmental and implementation processes of the accreditation instruments and accreditation procedure. The "Validation study on the instruments for the accreditation of residential care services for the elders in Hong Kong" was conducted between April and December 2003 in collaboration with Asia-Pacific Institute of Ageing Studies of Lingnan University with the following objectives:

(a) to collect views on the validity and reliability of the assessment instrument and process;

(b) to test the degree of validity and reliability of the accreditation instruments; and

(c) to make recommendations for enhancement.

5.11 This validation study is both a qualitative and quantitative study. Qualitative views were obtained from assessors, practitioners in the field of residential care of older people, medical professionals, nurses, academics, policy-makers, para-medical professionals, social work professionals, supervisors of services for older people and also users and their relatives. Expert panel and focus groups were formed and views were solicited verbally at panel and group meetings. Structured questionnaires, which also contained space for open-ended answers, were used in the data-collection process. For the quantitative aspect of the study, different dimensions of scales and indices of the assessment instrument were studied. In determining the degree of validity and reliability of the assessment instruments, construct validity, content validity, inter-rater reliability and internal consistency reliability were tested. List of experts of panel for testing the index of content validity is in Appendix 7. Discussant list of the five focus groups is in Appendix 8.

5.12 The following methods were employed in the data-collection process:

- Snowball method --- to select subject participants of expert panel and focus groups.
- 4-point Likert scale --- for judging representativeness of the content items and open-ended questions.

- Cronback's alpha --- to test reliability of Accreditation instrument.
- Statistical Package for Social Science version 11.5 for Windows --- for data inputting and statistical analysis.

Very satisfactory mean scores for the areas tested were achieved as follows:

Table 5.2 Mean scores from validation study

Area for testing	Expected score / Range of score	Mean score from validation study
(a) Construct validity:		
• Degree of agreement	4-point scale	3.35
• Degree of importance	4-point scale	3.28
• Content Validity Index	.80 or over	.95
• Convergent scale	R=(-1) – 1, p<0.05	R=.924, p<0.01
• Divergent scale	N.A.	Insignificant
(b) Internal consistency reliability:		
• 39 Sub-domains	.6 or over	-.3298 to 1.000
• 4 Domains and Supplementary Part	.6 or over	.3850 to .7169
• Overall	.6 or over	.7908
(c) Inter-rater reliability:		
• Correlation coefficients of results obtained by lead assessors and assessor trainees of 29 RCHEs	R=(-1) – 1, p<0.05	R=(-1) – 1, p<0.01
(d) "Checklist before accreditation"		
• Degree of agreement	4-point scale	3.30
• Degree of importance	4-point scale	3.34
• Content Validity Index	.80	.95
• Convergent scale	R=(-1) -1, p<0.05	R=.919, p<0.01
(e) "Pre-assessment statistics"		
• Degree of agreement	4-point scale	3.47 (3.41)
• Degree of importance	4-point scale	3.44 (3.32)
• Content Validity Index	.80	.96
• Convergent scale	R=(-1) -1, p<0.05	R=.927, p<0.01 (R=.783, p<0.01) *
• Divergent scale	N.A.	Insignificant

* Figures in brackets denote correlation of degree of willingness and the need to provide such form.

Results

5.13 From the high mean scores of all aspects of various assessment tools and procedures, it can be concluded that the assessment instruments developed by HKAG are content-valid, reliable and feasible for widespread application to all residential care services for older people in Hong Kong. Certain comments have been received during the course of the study, such as combining or deleting some sub-domains and items, clarifying terms and definitions, ensuring that clinical or management guidelines are practised, etc. and useful views have been incorporated in the refined instrument.

Accreditation Standards

5.14 Based on feedbacks and results of the validation study, a final set of recommended accreditation standards are worked out, with the core instrument applicable to all RCHEs. The supplementary instrument will be applied only to those homes that have not undergone review visits under SPMS:

Core instrument

Domain A: Governance

Standard 1: Total quality management

Standard 2: Service ethics

Standard 3: Risk management

Standard 4: Purchase of service

Standard 5: Occupational safety and health

Domain B: Environment

Standard 6: Environment and facilities

Standard 7: Provision of services

Standard 8: Food and environmental hygiene

Standard 9: Community partnership

Domain C: Service flow and care process

Standard 10: Post-admission care

Standard 11: Medication management

Standard 12: Continence management

Standard 13: Skin care and bedsore prevention

Standard 14: Fall management

Standard 15: Feeding

Standard 16: Nutrition

Standard 17: Mobility assessment and management

Standard 18: Use of physical and chemical restraints

Standard 19: Transfer skills

Standard 20: Infection control

Standard 21: Cognitive, emotional, sensory and communication ability of residents

Standard 22: Pain management

Standard 23: Death and bereavement

Standard 24: Special nursing procedures

Standard 25: Psychological support and social care

Standard 26: Recreational and community activities

Domain D: Information management and communication

Standard 27: Information management

Standard 28: Communication

Supplementary instrument

Standard 29: Provision of information

Standard 30: Review and update policies and procedures

Standard 31: Records

Standard 32: Roles and responsibilities

Standard 33: Human resource management

Standard 34: Planning and evaluation

Standard 35: Financial management

Standard 36: Legal responsibilities

Standard 37: Safe environment

Standard 38: Entry and exit

Standard 39: Assessment of residents' needs

Standard 40: Protection of residents' rights

Please refer to Appendix 5 for a full version of the accreditation standards recommended by HKAG.

Definitions of terms

5.15 In the accreditation standards and accreditation instrument, the terms "essential" and "desirable" are used to classify items for compliance. The former denotes items that are essential and full compliance is expected. The latter provides RCHEs undergoing assessment with useful pointers on further requirements which RCHEs should aim to achieve and comply with.

Chapter 6 Development of the Accreditation Mechanism

Overview

6.1 After collecting overseas experience in the accreditation of residential homes for older people, a tentative framework of local assessment tool and an accreditation process have been formulated. These were put to test in two pilot accreditation exercises conducted in 2003.

6.2 In order to collate fieldwork experience in implementing the proposed accreditation instrument and accreditation process, two pilot accreditation exercises involving RCHEs were undertaken in 2003. At the same time, early engagement of the sector had been made by HKAG. Three sharing seminars for all stakeholders were held in December 2002, October 2003 and June 2004.

First Pilot Accreditation Exercise

Invitation and selection

6.3 The essential working philosophy of the first pilot accreditation exercise was to involve a full range of RCHEs, from subvented to private, and from large to small size, in testing the feasibility of the accreditation methodology in different types of RCHEs. In addition, participating RCHEs were required to contribute at least 2 professional staff to participate in training as external assessors and assist in the development of the accreditation instrument. A total of 47 RCHEs responded to the invitation in November 2002. Out of these 47 RCHEs, 25 RCHEs were able to deploy professional staff to participate in the first pilot accreditation exercise. Members of the Project team paid site visits to assess the readiness of staff of the RCHEs and finally, 8 RCHEs, composed of subvented, private and self-financing RCHEs of various sizes were selected. List of RCHEs is in Appendix 6. Profile of RCHEs responded and selected for the first pilot accreditation exercise is shown in Table 6.1:

Table 6.1 Profile of RCHEs responded and selected for the first pilot exercise

Type of RCHE	Original Quota	No. of Application	Revised Quota
Subvented RCHEs	2	12	2
Self-financing RCHEs	1	3	1
Nursing Homes	1	1	1
Private RCHEs (50 or below)	1	5	0
Private RCHEs (51 to 100)	1	9	1
Private RCHEs (101 or above)	2	17	3
TOTAL	8	47	8

Assessor training

6.4 In the first pilot accreditation exercise, the accreditation assessors were selected from the 8 participating homes. Training of assessors is as follows:

(a) A 3-day programme was held in January 2003 on relevant topics including: concept of accreditation, benchmarking, clinical practice guidelines, risk management and skills in internal assessment. The trainees were also briefed about the conceptual framework of the Assessment Mechanism and content of the preliminary Assessment Instrument so as to familiarize them with the detailed requirements and to facilitate them to prepare the RCHEs for external assessment.

(b) A second training workshop was held in April 2003, which included a 1-day programme on skills in external assessment, and a ½-day programme on how to plan external assessment.

Operation

6.5 The actual operation took the following steps:-

(a) From February to April 2003, staff of the Project held bi-weekly meetings with the selected RCHEs to monitor progress in making preparations for the external assessment, clarify doubts and settle problems.

(b) Staff of the Project provided on-site support through paying visits to RCHEs whenever necessary.

(c) In mid-April, RCHEs submitted self-assessment reports and operational statistics which served as reference materials for assessors.

(d) From April to May 2003, external assessments were carried out by trained assessors. Matching of assessors to RCHEs was made basing on the principle that they would not assess their own RCHEs.

(e) After the external assessment, the assessors were required to complete assessment reports in two weeks.

(f) A panel meeting with experts from medical, health, social welfare and academic fields was held on 31 May 2003. The meeting considered the recommendations of the assessors and decides on granting of accreditation status to individual RCHEs.

On the whole, no major difficulties were encountered by participating RCHEs in attaining the accreditation standards. Out of the 138 "essential items", 5 RCHEs could attain 94.9% of the requirements.

Feedback and follow-up

6.6 In order to collect RCHE-operators' and assessors' views on the first pilot accreditation exercise, a sharing session was held on 20 May 2003 for assessors and RCHE operators. Majority of the assessors considered that RCHEs should be better prepared for external assessment, such as: locating and presenting relevant documents before assessors' visits; obtaining prior consent from staff, residents, and relatives of residents for interviews by the assessors; providing quiet rooms for interviews, etc. On the other hand, some references provided by the Project such as guidelines for interviews were inadequate. The prescribed duration of 3 days for external assessment was considered insufficient. Operators of RCHEs hoped that results of assessment could be announced sooner, attitude of some assessors could be improved, assessors should follow laid-down standards and should respect confidentiality of documentary evidences and personal data, etc.

6.7 Based on comments received by HKAG, the preliminary accreditation instrument and accreditation process were fine-tuned taking into account the following principles:

(a) Strengthening the training of assessors should be made. Assessors should be further trained in their communication skills, interviewing skills, handling of documents and personal data of confidential nature, and time management. They should be required to adhere more strictly to the guidelines and standards and liaise with RCHEs before external assessment, etc.

(b) Project staff should provide pre-assessment checklist and service statistical forms to RCHEs for self-assessment purpose. There should be better definitions for terms such as "essential items", "desirable items", "compliance", and "non-compliance".

(c) RCHEs should make readily available documents for reviews by assessors. They should prepare a list of people whose prior consent have been obtained for attending interviews with assessors and reserve quiet rooms for interviews.

(d) An oral presentation by the external assessor with the RCHE operator in the presence of accreditation Project staff and an external expert from the Pilot Project Working Group should be carried out within 2 weeks after the external assessment to clarify any discrepancies between the assessor and the RCHE. An accreditation committee consisting of experts from the working group should be set up to decide on the granting of accreditation status.

6.8 The preliminary accreditation instrument and accreditation process were amended for the second pilot accreditation exercise accordingly.

Second Pilot Accreditation Exercise

Recruitment

6.9 Invitation was sent out to all RCHEs in May 2003. 29 RCHEs joined the second pilot accreditation exercise from July to October 2003. Three more RCHEs also joined after October 2003. List of RCHEs is in Appendix 6. Their profile is as follows:

Table 6.2a Information on RCHEs recruited for the second pilot exercise (7/03 – 10/03)

Number of Beds	NGO RCHEs	Private RCHEs	TOTAL
201 Beds or more	2	4	6
101-200 Beds	6	13	19
51-100 Beds	1	1	2
50 Beds or less	1	1	2
TOTAL	10	19	29

Table 6.2b Information on RCHEs recruited for the second pilot exercise (11/03 – 5/04)

Number of Beds	NGO RCHEs	Private RCHEs	TOTAL
201 Beds or more	0	0	0
101-200 Beds	2	1	3
51-100 Beds	0	0	0
50 Beds or less	0	0	0
TOTAL	2	1	3

Assessors' training

6.10 As the second pilot accreditation exercise involved accrediting 29 RCHEs in a short period of time, a large number of accreditation assessors were required to carry out the external assessment during the period of July to October 2003. In April 2003, HKAG issued letters to RCHEs and hospitals to invite professionals including registered nurses, social workers, physiotherapists, occupational therapists and physicians with 3 years' experience in elderly care to apply for training courses. 177 applications from 93 organizations were received. From June to July 2003, 4 courses were organized for 131 trainees with the following profile:

Table 6.3 Agency background of trainees

NGOs	Private RCHEs	Hospital Authority	Department of Health	Training Institute	TOTAL
55	18	41	3	14	131
41.98%	13.74%	31.30%	2.29%	10.69%	100%

Table 6.4 Professional background of trainees

Nurses	Social Workers	Physiotherapists	Occupational Therapists	Physicians	TOTAL
78	27	13	9	4	131
59.54%	20.61%	9.92%	6.87%	3.06%	100%

6.11 The training of assessors for the second pilot accreditation exercise had the following added features:

(a) An assessors' manual was produced to facilitate assessor training. On top of the topics covered in the training programmes for assessors in the first pilot accreditation exercise, additional topics, e.g. principles of quality management; use of indicators and benchmarking, and self-assessment; roles, conduct and communication skills; methodology in collecting evidences, handling difficult situations and report-writing were included. Assessors under training were also informed about the possible case-mix of different impairment level. However, such information was provided for their reference only and not for assessment purpose.

(b) Trainees were required to participate in a 3-day external assessment programme to gain fieldwork experience. 125 trainees completed the training courses with excellent attendance of 100%.

(c) Assessors were required to sign an agreement on code of conduct and their performance was monitored by lead assessors.

Operation

6.12 The following steps were taken in the actual operation:

(a) A preparatory meeting was held by the lead assessor with the trainee assessors one day before the actual external assessment of the RCHE to gain an overall view of the RCHE and to decide on division of labour during site visit.

(b) A checklist to test the readiness of RCHEs for assessment was issued for them to fill in.

(c) Briefing sessions were held for RCHE operators so as to introduce and explain to them the gist and mode of accreditation. A guide was distributed to RCHEs to prepare for the assessment.

(d) RCHEs were required to carry out internal audit by using the self-assessment instrument together with the pre-assessment statistics.

(e) External assessment consisted of two parts namely: prior documentation review and 3 days site visit. These involved:

- Scanning of policy papers, procedures, clinical guidelines, plans, records, minutes, etc.
- Making observations on physical setting, facilities and equipment.
- Interviewing staff, managers, residents and relatives of residents, medical and nursing personnel.
- Making care-tracking such as observation of care delivery processes.
- Holding conference, daily briefing and exit conference between assessors and RCHE staff and management.

All assessors were required to submit a report in 4 weeks' time.

(f) Oral presentation sessions were organized for the assessors and RCHE management to clarify findings in the preliminary report compiled by the assessors in the presence of staff of the Project and a representative from the accreditation committee.

(g) An accreditation committee with experts in the field deliberated on recommendations of the assessors and decided on the granting of accreditation status.

(h) A full report on accreditation was sent to individual RCHEs after results were announced.

Accreditation Results

6.13 In the two pilot accreditation exercises, RCHEs were accredited for full compliance of accreditation standards. RCHEs which could not be accredited right away were provided with checklists for improvement and re-assessments were conducted to some of the RCHEs upon recommendation of the accreditation committee in order to review improved items. Up to end-September 2004, 37 RCHEs were accredited. Detailed breakdown is in Table 6.5.

Table 6.5 Accredited RCHEs of the two pilot accreditation exercises as at 30 September 2004

Information on RCHEs		No. of RCHEs	
		Accredited	Not accredited
Size	Under 50	2	0
	51-100	3	0
	101-200	24	1
	Over 201	10	0
	Total no. of RCHEs	*39*	*1*
Types of RCHEs	Subvented	13	0
	Private	23	1
	Self-financed	3	0
	Total no. of RCHEs	*39*	*1*
Geographical distribution	Hong Kong & Islands	11	0
	East Kowloon	5	1
	West Kowloon	13	0
	New Territories East	6	0
	New Territories West	4	0
	Total no. of RCHEs	*39*	*1*

Sector-wide Participation and Consultation

6.14 Throughout the phases of development and implementation of the assessment mechanism, HKAG has placed strong emphasis on sector-wide participation and consultation. It aims to arouse interests, promote understanding and solicit support amongst operators and staff of RCHEs in the setting-up of an accreditation system for improving and enhancing the quality of RCHEs in Hong Kong.

6.15 In the very beginning of the Project, a working group was formed by HKAG to oversee the whole planning and operation of the Pilot Project. Professionals from various fields such as medical, health, para-medical, social welfare, academics and operators of RCHEs with rich experience in care of older people and residential care, were included in the working group to advise on the design, formulation, development and implementation of the accreditation system and mechanism.

6.16 During the actual development and implementation stage, NGOs and private RCHE operators have been allied to join the first and second pilot accreditation exercises. They have been actively involved in the deliberation of the accreditation activities. Their comments have been accepted as far as possible in the refinement of the instruments and process. Although some small-scale RCHEs expressed difficulties in conducting self-assessment due to limited resources, their worries were allayed and one RCHE with capacity under 50 joined the second pilot accreditation exercise. In fact, views from RCHEs and assessors participating in the first pilot accreditation exercise have helped to improve the assessment mechanism.

Consultation sessions

6.17 Professionals in elderly care and front-line staff of RCHE have also been involved extensively in the Project. Professionals, trained assessors and RCHE staff and management participated in a study to validate the accreditation instrument. With their valuable views, refinements of the accreditation instrument and mechanism have been made. Extensive consultations with the sector have been made by the Project. A symposium on accreditation system for residential services was co-organized with the Hong Kong Council of Social Service on 9 December 2002 for 325 participants. A mid-term reporting seminar was organized on 24 October 2003 for 300 participants, and a sharing session was held on 21 June 2004 for 240 participants with assessors and participating RCHEs sharing experiences in different aspects of the pilot project. Programmes are in Appendix 9.

6.18 In the symposium, participants welcomed the piloting of an accreditation system for residential care services for the elders in Hong Kong. They expressed the views that the accreditation system should be a mechanism without duplication with existing quality-control systems. They expected the accreditation system to be customized to suit needs of RCHEs in both the subvented and private sectors. Participants also hoped that a pragmatic approach in designing accreditation standards would be adopted and they looked forward to the publication of clear guidelines and references as well as consultation with relevant stakeholders. Comments collected in the mid-term reporting seminar and a parallel questionnaire survey were favourable and constructive. Participants fully supported the establishment of an accreditation system which, with their experience in the Pilot Project, proved to be feasible in enhancing service quality and arousing awareness of front-line staff in quality management. The multi-disciplinary nature of the team of assessors and localization of service standards and accreditation instruments were recognized.

Feedback from accredited RCHEs

6.19 Besides gathering comments on the accreditation system in the symposium and mid-term reporting seminar, HKAG also conducted an opinion survey among accredited homes in February 2004. Major findings from the returned questionnaires are as follows: 96.1% considered the accreditation standards clear, 70.6% found the accreditation standards appropriate, 88% agreed that sufficient pre-assessment information had been provided to the RCHE operators. The satisfactory rate was high for many areas: external assessment through site visit (100%), exit meeting (96.2%),

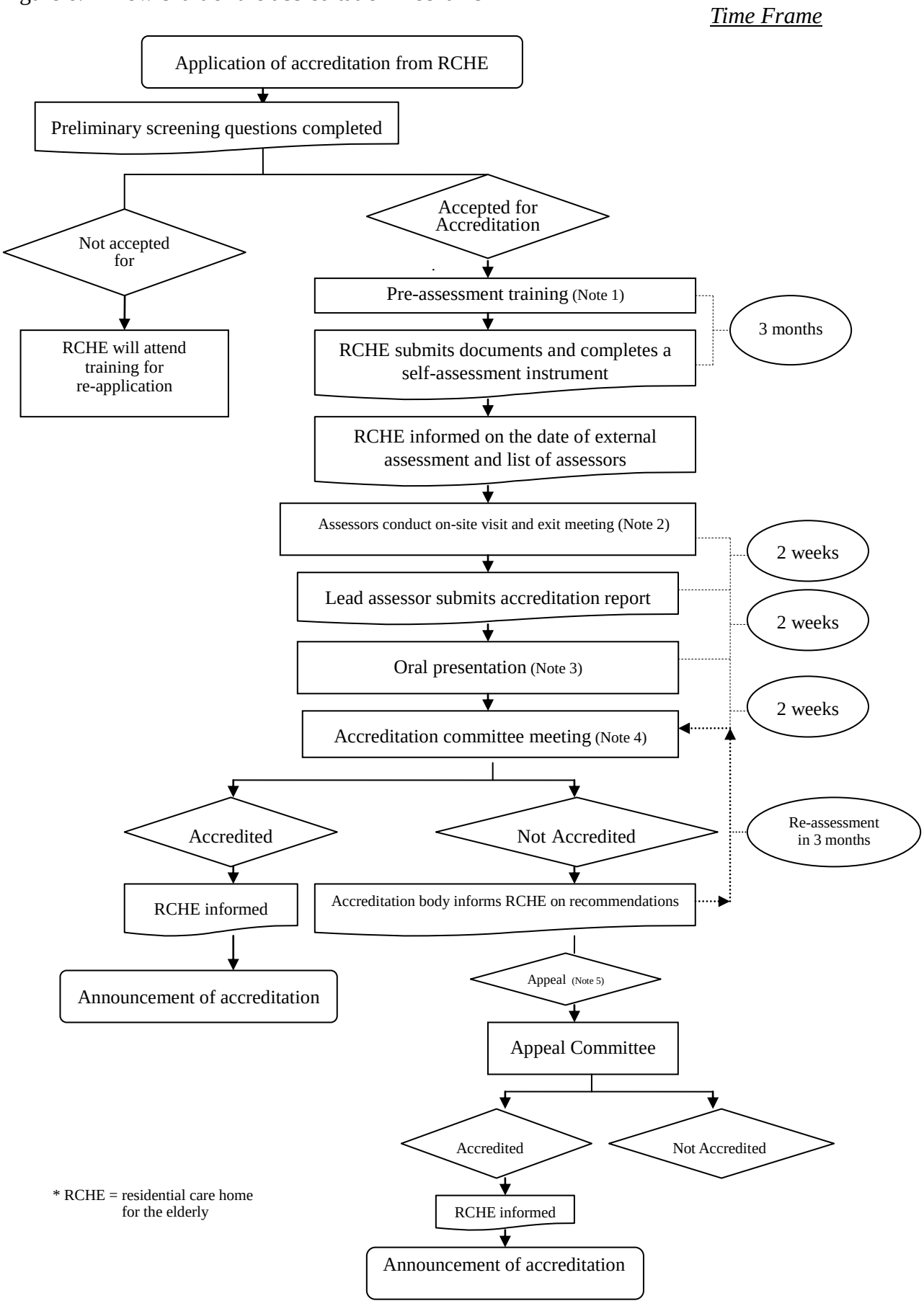
oral presentation (95.8%), performance and conduct of external assessors (96.2%), enhancing overall service quality (96%). All accredited RCHEs showed continuous support to the accreditation system and willingness to recommend other homes to apply for accreditation. Also, face-to-face interviews were held in February and March 2004 with all accredited RCHEs. They provided very positive feedback on the accreditation system, standards, instruments, assessors and the role of HKAG in the implementation of the accreditation system. All of them have expressed that they will continue to join the accreditation system following the pilot project.

6.20 Having established a comprehensive, tailor-made and culturally-appropriate accreditation mechanism by involving active participation of RCHE operators, professionals and all relevant stakeholders, HKAG considers that the Project has successfully gained sector-wide acceptability regarding the implementation of an accreditation system in Hong Kong.

Recommended Accreditation Mechanism

6.21 Based on experiences gained from two pilot accreditation exercises, an accreditation mechanism suitable for application in Hong Kong is established. The accreditation mechanism can best be illustrated in the flow chart in Figure 6.1.

Figure 6.1 Flow chart of the accreditation mechanism



The functions of major steps of accreditation mechanism

Note 1: RCHE Pre-assessment training

1. RCHE staff to attend 1-day training on accreditation process, internal audit requirement, instrument and mode of accreditation.
2. RCHE to submit the following documents to the accreditation body:
   (a) Self-assessment report
   (b) Improvement plan for RCHE operation
   (c) Approval letter from the SWD Licensing Office of Residential Care Homes for the Elderly for service operation
   (d) Documents on 16 Service Quality Standards as required by SWD Service Performance Section
   (e) Pre-assessment check-list
   (f) Operation and service statistics

Note 2: External assessment

1. Assessment team consists of at least 2 assessors from multi-disciplinary background.
2. After collecting all the documents from the RCHE, the lead assessor to conduct meeting(s) with assessors to review documents, to propose date and schedule for on- site visit and to decide on division of labour.
3. External assessment from 3-5 days.
4. Lead assessor to conduct exit meeting on the last day of on-site visit with RCHE operator and staff and to specify areas for improvement in a checklist.
5. Lead assessor to compile accreditation reports and relevant information in consultation with the team of assessors.

Note 3: Oral presentation

1. Accreditation body to conduct an oral presentation meeting with lead assessor, RCHE representative and the accreditation body representative.
2. Meeting objectives are: to clarify findings in the preliminary report, to report on the compliance and non-compliance items and to obtain RCHE's response.

Note 4: Accreditation committee

1. Accreditation committee to hold meeting. Members of accreditation committee are experts from medical, health, nursing, social welfare and academic fields.
2. Accreditation committee to grant accreditation status to RCHEs based on recommendations from assessor and oral presentation results. Accreditation committee to recommend RCHE, which cannot meet all requirements to submit improvement plan and / or to conduct re-assessment.
3. Accreditation body to send report to RCHEs after results are announced.

Note 5: Appeal

1. RCHE to lodge appeal to the appeal committee, with members from the steering committee and the advisory board, within one month upon receiving notice from accreditation body.
2. Appeal committee to hold meeting to consider the appeal.
3. Appeal committee to inform the appellant of the result.
4. The appeal committee's decision will be final.

Chapter 7 Recommendations

7.1 After the first and second pilot accreditation exercises by HKAG, RCHE operators in general have accepted the concept of continuous quality improvement, and are prepared to adopt and practise CQI for service development. Building on such momentum for change and with experiences gained from designing and formulating accreditation standards and accreditation instruments, operation of two pilot accreditation exercises, validation of the accreditation instruments, and feedback and comments from RCHEs and professionals from the medical, nursing, para-medical, health care, and welfare sectors, HKAG considers that it is opportune to set up an accreditation body to introduce an accreditation system for RCHEs in Hong Kong.

7.2 Structure and functions of the accreditation body and the accreditation process are proposed in the following paragraphs.

Structure of Accreditation Body

7.3 The accreditation body can take any of the following forms:

(a) a government body
(b) a statutory body
(c) a non-statutory independent body.

A government body

7.4 If the objective is to introduce a mandatory accreditation system in Hong Kong, it will be most appropriate to appoint a government department to take up the role of an accreditation body, to ensure compliance and community-wide publicity. SWD is currently conducting inspection visits to RCHEs for two purposes --- to ensure that licensing requirements are met and to ascertain whether the SQSs are fully complied with in subvented RCHEs and EBPS homes. In making such inspection and review visits, SWD staff assume well-established duties of a regulatory nature in relation to law enforcement and funding approval and should have the necessary expertise and experience to take on an additional role of accreditation. However, a mandatory accreditation system is not recommended for Hong Kong. Also, the experiences in other economies have shown that governments should focus more on regulation and licensing than on accreditation. Hence, a government body is not the most ideal structure for undertaking accreditation. It is for the same reason that the role of governments in other countries does not normally include accreditation and the emphasis is usually focused on regulation and licensing arrangements.

A statutory body

7.5 Consideration might be given to the setting-up of an independent statutory body similar to the Social Workers Registration Board, Hong Kong Council for Academic Accreditation etc. to oversee implementation of an accreditation system. The merit of a statutory body is that its legitimacy comes from the legislation and that it has the necessary legal backing required in the process of promoting accreditation. Also, the institutional set-up and objectives will be prescribed by legislation. A statutory body also carries greater credibility and accountability. However, the introduction of the accreditation system is still at its novel stage. HKAG is of the view that the scheme would take time to evolve and the elements to be included in the scheme would have to be refined and updated in light of experience and changing circumstances. The statutory approach has the disadvantage of having to require amendments of the law or regulations whenever new justifiable changes are to be brought into the system. This could cause unnecessary delay since legislative change is subject to competing priorities of the Government's overall Legislative Programme. On balance, therefore, there is merit in setting up the scheme without need of legislation at this stage, subject to review once the scheme has been rolled out for a couple of years.

A non-statutory independent body

7.6 In many countries, not-for-profit non-statutory independent organizations are responsible for accreditation of health care facilities and residential care homes. Examples of this form of accreditation include: JCAHO in the USA, CCHSA of Canada and Trent Accreditation of England. ISO is also an independent non-statutory international organization which is involved in accreditation. In addition, most of the successful accreditation systems in overseas countries, such as the USA and Canada, have started with voluntary participation and with non-statutory independent organizations as operating agents. There are many advantages for a non-statutory independent body to operate the accreditation system in Hong Kong. A non-statutory independent body with strong professional background and established history can solicit ready support from the sector as well as advocating and developing effective peer review. Accreditation by such a body can also promote voluntary participation, particularly from private RCHEs. Furthermore, a non-statutory independent organization can liaise and collaborate with other professional bodies and organizations involved in care for older people more freely and flexibly. It will also have the advantage of being able to respond to changes in the sector and the socio-economic

environment more rapidly.

7.7 Having assessed the three options, HKAG recommends that the proposed accreditation body be operated by a non-statutory independent body, at least initially.

Non-statutory Independent Body as Accreditation Body

Nature of the non-statutory independent body

7.8 HKAG proposes that the non-statutory independent body should have long-standing reputation in promoting high quality care of older people and should have built up firm credibility in the field. It should possess comprehensive knowledge and good understanding about the diverse mode of service provision in the local scene and should have well-established relationship with service providers and operating agencies, both in the subvented and private sectors. It would be an added value if the body also has ready linkage with overseas organizations and bodies specializing in accreditation of residential care services. To avoid conflict of interest, the non-statutory independent body should not be involved in providing direct residential services for older people. It should not be a trade organization or functional organization representing operators of RCHEs.

Governance of the accreditation body

7.9 It is recommended that the Board of Directors of the non-statutory independent body operating the accreditation system should comprise members from a wide spectrum of background, including health care, social work, nursing, rehabilitation and academics familiar with services for older people. Apart from a broad representation in its Board of Directors, the non-statutory independent body should appoint a steering committee to oversee the operating mechanism and draw on input from people with experience and expertise in residential care. The steering committee should consist of Directors from the non-statutory independent body and also experienced operators and professionals of both subvented and private RCHEs. The composition of the Working Group of HKAG Pilot Project serves as a good example of this form of composition. Representatives from various Government departments and bodies like SWD, DH and Hospital Authority could be invited as advisors of the accreditation system.

Functions of Accreditation Body

7.10 The accreditation body should carry out three essential functions: to operate an accreditation system, to undertake research for service development and to disseminate information to the public.

(a) Operating an accreditation system --- the accreditation body should have the responsibility to establish and review quality standards related to residential care, to set up the accreditation procedures, to train and accredit assessors, to conduct the accreditation for participating RCHE, to investigate complaints and to apply sanctions as appropriate.

(b) Research and development --- the development of the accreditation system should be a continuous process. There should be a systematic arrangement in monitoring standards and the compliance situation of RCHEs and in tracking international trends in accreditation development by joining international bodies such as ISQua and by participation in international exchanges. The accreditation body should liaise with relevant government authorities and departments to keep up with the latest legislative requirements on residential care services, code of practice and health care standards, service performance qualities, etc. Data collected from the accreditation of RCHEs would constitute useful reference for the government towards policy formulation and service development.

(c) Information dissemination --- accreditation results are important information to users and potential users of residential care services, RCHE operators, professionals and the Government. The public can make informed choices of the kinds of RCHEs best suited to their needs. The accreditation body should disseminate relevant information about RCHE accreditation such as date of accreditation, nature of the accredited RCHEs, location of the RCHEs, best practice, etc. through various channels. It may consider setting up a website, publishing newsletters, and conducting regular publicity campaigns to publicise the accreditation system per se and the profiles of accredited RCHEs. Also, it should develop a corporate identity to enhance public awareness and recognition of the scheme.

7.11 To gain international recognition, the accreditation body may consider seeking accreditation from international accreditation programmes, such as ALPHA administered by ISQua.

Qualification of assessors

7.12 HKAG recommends that assessors should be professionals from any of the five health care and social care fields: registered nurses, registered social workers, physiotherapists, occupational therapists and physicians with at least 3 years relevant aged care or hospital experience. They should be required to attend a 5-day training programme with at least one external assessment programme to gain fieldwork experience. The accreditation body needs to train and monitor the performance of peer assessors regularly. Assessors should attend regular training activities and abide by the code of conduct laid down by the accreditation body.

Summary

7.13 In conclusion, HKAG recommends the setting up of an accreditation system in Hong Kong which is based on the following features:

(a) Voluntary participation --- a voluntary accreditation system to complement rather than to replace the licensing requirement should be less disruptive to all parties concerned and should be readily accepted by RCHEs. With time, the majority of RCHEs would participate in accreditation if they do not want to lose out in the market competition.

(b) Standard-based accreditation --- the accreditation standards should be developed on the basis of internationally recognized standards involving structure, process and outcome measures specially designed for RCHEs in Hong Kong. Reference should also be drawn to existing licensing procedures and SQSs.

(c) Peer review --- the accreditation process should take the form of peer review with properly trained assessors from medical, health and social care fields. The accreditation process should be a comprehensive one comprising four key components:

- use of pre-site visit statistics to identify issues for inspection;

- self-assessment to prepare for accreditation;
- document review; and
- site visits.

(d) Accreditation status --- the accreditation system should be simple and easily understood. RCHEs participating in the accreditation exercise will be graded either as being accredited or not accredited. RCHEs which could fully comply with the essential standards would be granted accreditation status. Non-compliant homes will not be granted accreditation status until they fully comply with all the standards. In the long run, RCHEs with excellent performance in particular service areas could be awarded accreditation status with areas of excellence being specified.

(e) Accreditation cycle --- in line with international trend, a three-year accreditation cycle with annual review is recommended.

Cost Implications

7.14 To implement the accreditation mechanism effectively, the accreditation body should consist of an accreditation division, a research and development division, and an information technology and publicity division. Drawing reference to the staffing requirements in operating the pilot accreditation exercises, it is estimated that the proposed accreditation body will require a start-up cost of $730,000 and an annual recurrent cost of about $3.58 million. Details are as follows:

(a) Initial set-up cost

Fitting-out Cost	$	290,000
Furniture and Equipment	$	440,000
Total	**$**	**730,000**

(b) Recurrent costs per year

1. Accreditation Division

Assessor expenditure for 70 homes ($11,000 per home)	$	770,000
PE(+MPF)	$	1,320,000
Rental	$	360,000
Utility and Other Charges	$	277,000
Sub-total	***$***	***2,727,000***

2. Research & Development Division		
PE(+MPF)	$	312,000
Other charges	$	28,000
Sub-total	***$***	***340,000***
3. IT and Publicity Division		
PE(+MPF)	$	480,000
Other charges	$	34,000
Sub-total	***$***	***514,000***
Total	**$**	**3,581,000**

Accreditation Fee

7.15 HKAG estimates that, initially, there will be about 70 RCHEs participating in the accreditation in a year. On this basis, if the accreditation system is to be totally self-funded, each RCHE will have to pay $51,100 (say $50,000) as accreditation fee.

Transitional Arrangements

7.16 As a transitional arrangement, HKAG recommends that those RCHEs which have successfully completed the accreditation process in the Pilot Project may be considered as accredited by the future accreditation body. Similarly, assessors who have completed training during the Pilot Project may be recognized by the future accreditation body.

Way Forward

7.17 In bringing forward HKAG's recommendations, the Government may, however, wish to further consider the following areas of concern:

(a) how to nominate a body responsible for implementing the proposed voluntary accreditation system; and

(b) how to encourage RCHEs which are less resourceful to participate in the accreditation system.

Chapter 8 Epilogue

8.1 The Pilot Project on Accreditation System for Residential Care Services for the Elders in Hong Kong was successfully completed on 30 June 2004. The Hong Kong Association of Gerontology presented the major findings and recommendations of the Pilot Project to the Elderly Commission and the Legislative Council Panel on Welfare Services on 14 June 2004 and 19 July 2004 respectively. Both supported the establishment and implementation of an accreditation system for residential care services for older people in Hong Kong on a voluntary and peer review basis in general.

8.2 The Hong Kong Association of Gerontology is pleased to present this Report to the Social Welfare Department for further consideration. Also, taking this opportunity, the Association would like to thank all the relevant parties and individuals for rendering assistance and providing advice to the Project Team in the past two years.

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香港安老院舍評審制度先導計劃

督導委員會成員名單及職權範圍

督導委員會成員名單

社會福利署		
梁王珏城女士	副署長（服務） （至 2002 年 8 月 31 日）	（主席）
吳馬金嫻女士	助理署長（安老服務） （由 2002 年 9 月 1 日起）	（主席）
袁鄺鏽儀女士	總社會工作主任（安老服務） （至 2002 年 12 月 1 日）	
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黃月秀女士	高級社會工作主任（安老服務） （至 2002 年 10 月 1 日）	
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醫院管理局		
戴兆群醫生	高級行政經理（醫務發展）	
衛生署		
陳慧敏醫生	助理署長（長者健康服務）	
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香港私營安老院協會		
翁蓮芬女士	主席	

全港私營安老院同業會

陸艾齡女士	主席

香港老年學會（香港安老院舍評審制度先導計劃工作小組）

梁萬福醫生	會長
郭原慧儀女士	義務秘書
李迦密先生	先導計劃總監

督導委員會職權範圍

1. 督導「先導計劃」推行的方向，以配合香港安老住宿照顧服務的政策；
2. 監察「先導計劃」的進度；
3. 為推行「先導計劃」提供所需的支援；以及
4. 審閱及認可「先導計劃」的建議。

香港老年學會先導計劃工作小組名單

梁萬福醫生（主席）	基督教聯合醫院
陳章明教授	嶺南大學
李子芬教授	中文大學
郭原慧儀女士	救世軍
Prof. David Phillips	嶺南大學
顏文雄教授	城市大學
張玉霞女士	聖雅各福群會
李寶滿女士	雅麗氏何妙齡那打素護養院
甘綺玲女士	東華三院方樹泉護理安老院
曾容敏瑤女士	香港老年學會
何永謙先生	香港老年學會
鍾偉棠先生	香港老年學學院

香港安老院舍評審制度先導計劃 – 職員名單

李迦密先生	計劃總監
徐妙玲女士	研究主任 （至 2003 年 8 月 11 日）
鄭美冰女士	計劃主任 （由 2004 年 2 月 16 日起）
趙廸華女士	兼職計劃主任 （2003 年 9 月 1 日至 2003 年 12 月 13 日）
陸鳳蓮女士	兼職計劃主任 （由 2003 年 9 月 15 日起）
勞寶珍女士	計劃主任 （由 2004 年 1 月 1 日起）
鄧鳳祺女士	研究助理

「香港安老院舍評審制度先導計劃」
香港老年學會 – 社會福利署聯合工作小組名單

香港老年學會（香港安老院舍評審制度先導計劃）

梁萬福醫生	會長	（主席）
郭原慧儀女士	義務秘書	
李迦密先生	計劃總監	
徐妙玲女士	研究主任 （至 2003 年 8 月 11 日）	
鄭美冰女士	計劃主任 （由 2004 年 2 月 16 日起）	
趙廸華女士	兼職計劃主任 （2003 年 9 月 1 日至 2003 年 12 月 13 日）	
陸鳳蓮女士	兼職計劃主任 （由 2003 年 9 月 15 日起）	
勞寶珍女士	計劃主任 （由 2004 年 1 月 1 日起）	
鄧鳳祺女士	研究助理	（秘書）

社會福利署

林嘉泰先生	總社會工作主任（安老服務）
郭李夢儀女士	高級社會工作主任（安老服務）
梁綺莉女士	社會工作主任（安老服務）

香港老年學會
香港安老院舍評審制度先導計劃

院舍評審標準

院舍評審標準簡介

「院舍評審標準」是由香港老年學會香港安老院舍評審制度先導計劃訂定的，目的是為提升香港安老院舍的服務質素，並達致持續改善的目標。

「院舍評審標準」共分為兩大範疇：I. 評審主要範疇和 II. 補充評審範疇。 評審主要範疇適用於所有院舍，而補充評審範疇則只適用於未曾參予社會福利署服務表現監察制度外部評核的院舍。

評審主要範疇共包括 4 大範圍，共 28 項標準：
(A) 院舍管治 – 5 項標準
(B) 環境 – 4 項標準
(C) 服務流程／照顧過程 – 17 項標準
(D) 資料管理及溝通 – 2 項標準

補充評審範疇則包括 12 項標準。

注意：

此評審標準中，各項詮釋內所指的：
(1) ‘指引’、‘政策’、‘程序’、‘措施’或‘機制’均需落實執行和存有紀錄
(2) ‘器材’、‘設施’或‘用具’均需在良好狀態

Ⅰ. 評審主要範疇

（A）院舍管治

院舍需要建立有效的管治，發揮領導作用，使院舍員工上下一心，從而促使服務質素得到持續的改善，令院友得到優質的服務。

標準 1：全面質素管理
標準 2：服務操守
標準 3：風險管理
標準 4：購買服務
標準 5：職業安全

（B）環境

院舍需要提供安全、衛生及舒適的環境、設施和服務，保障院友和滿足他們的需要，與社區建立正面的合作關係。

標準 6：院舍環境及設施
標準 7：院舍提供的服務
標準 8：食物及環境衛生
標準 9：社區協作

(C) 服務流程／照顧過程

院舍需要設立一套規劃、監管和改善服務的流程，以符合安全、衛生和護理的要求，切合院友需要，保障他們的權利和私隱。

標準 10：院友入院後照顧
標準 11：藥物管理
標準 12：排泄處理
標準 13：皮膚護理及壓瘡預防
標準 14：摔跌處理
標準 15：餵食

標準 16：營養
標準 17：活動能力評估及處理
標準 18：使用約束物品及藥物
標準 19：扶抱技巧
標準 20：感染控制
標準 21：長者認知、情緒、感官及溝通能力
標準 22：慢性痛症處理
標準 23：臨終處理
標準 24：特別護理程序
標準 25：心理支持及社交活動
標準 26：康樂及社區活動

（D）資料管理及溝通

院舍需要建立有效的資料管理系統，作為院舍決策及持續改善的依據，方便向外界交代和溝通。

標準 27：資料管理
標準 28：溝通

II．補充評審範疇

此部份只適用於未曾參與社會福利署服務表現監察制度外部評核的院舍。

標準 29：資料提供
標準 30：政策檢討及修訂
標準 31：紀錄
標準 32：職務責任
標準 33：人力資源管理
標準 34：計劃及檢討
標準 35：財務管理
標準 36：法律責任
標準 37：安全環境
標準 38：入住及退院服務
標準 39：評估院友需要
標準 40：長者權益保障

Ⅰ. 評審主要範疇

（A）院舍管治

標準 1：全面質素管理

院舍管理層有清晰的理念、方向和目標，使員工能夠了解，並在工作上實踐。
院舍設立清晰的質素改善機制，達致持續改善院舍服務質素的目的。

詮釋

（1） 院舍需訂立服務使命／宗旨／目標。
（2） 員工能了解實踐服務使命／宗旨／目標。
（3） 院舍能提供服務質素改善機制或計劃，並落實執行，包括：
- (a) 持續地監察
- (b) 有服務使用者參與
- (c) 有職員參與
- (d) 改善行動
- (e) 訂立相關成效指標
- (f) 利用成效指標作為改善服務依據

成效指標可包括正面或負面指標，如投訴、院友滿意度調查，院舍可根據指標作出改善，達致提供優質服務。

（4）院舍會利用本身或外間的研究、調查或同業借鑑，以改善服務質素及表現。

標準 2：服務操守

院舍建立一套工作操守的政策，達致誠實、公平、廉正和尊重等目標，並須確保員工在工作上切實依循。

詮釋

(1) 院舍應訂立服務操守的政策，包括：
   (a) 尊重長者尊嚴
   (b) 私隱
   (c) 權利
   (d) 安全
   (e) 並以此來處理事務
(2) 院舍應為職員訂立員工工作操守，並切實執行。
(3) 院舍應訂立員工違反工作操守時的處理程序。
(4) 院舍需落實執行以上的政策和程序。

標準 3：風險管理

院舍設立風險管理機制，及早發現可能出現的問題，作出預防，或把問題出現時的影響減至最低。

詮釋

(1) 院舍需設有風險管理機制，並能：
   (a) 評估潛在問題
   (b) 訂立行動計劃
   (c) 具體實施方案
(2) 院舍應每年購買各類型的保險及設有紀錄。包括：
   (a) 公眾責任保險
   (b) 僱員補償保險
(3) 院舍在院內的重要器材需有安全評估和檢查機制，並落實執行，包括：
   (a) 輪椅
   (b) 位置轉移機
   (c) 後備氧氣設施
   (d) 抽痰機
   (e) 升降機
   (f) 樓梯機
   (g) 其他

標準 4：購買服務

院舍設立機制，監管向外間購買服務的質素，保證提供的服務能達致一定水準及符合院舍的要求，並能依據合約條款落實執行。

詮釋

(1) 院舍如有購買部份服務，應備有政策及程序或指引，以保障服務質素（購買服務可包括清潔、洗衣、復康服務、醫生到診服務、護衛等，但不包括購買器材、物料或食物）。
(2) 院舍需落實執行以上的政策、程序或指引。

標準 5：職業安全

院舍積極推行職業安全，確保員工於工作期間的安全和健康。

詮釋

(1) 院舍能提供職業安全政策，並落實執行，包括：
   (a) 指派職員統籌職安事宜
   (b) 工傷報告機制
   (c) 提供職安培訓
   (d) 提供資源以改善職安問題
   (e) 職員對職業安全的認識
(2) 院舍能提供定期的職業安全訓練計劃及紀錄，如廚房、腰背護理、人力提舉等。

（B）環境

標準 6：院舍環境及設施

院舍的環境及設施，必須符合安全標準，滿足長者的需要。

詮釋

(1) 院舍需提供舒適的環境及設施。包括：
   (a) 可上鎖的儲物櫃
   (b) 呼喚鈴
   (c) 家居式佈置（如客飯廳裝飾，花、鳥、魚等或飼養寵物之設置）
   (d) 空氣調節／通風系統
   (e) 活動室
   (f) 交談的空間（如會客室等）
(2) 院舍需提供各類器材或用具，包括：
   (a) 急救器材
   (b) 運動器材或用具
   (c) 復康治療器材或用具
(3) 院舍能依據長者的不同需要而提供不同的設施，如：
   (a) 老年痴呆症的導向指示
   (b) 預防長者溜走設施／措施
   (c) 視力不佳的長者的指示牌

標準 7：院舍提供的服務

院舍能提供不同的服務，切合長者的不同需要。

詮釋

(1) 院舍必需提供下列服務：
- (a) 醫生到診服務
- (b) 急診及陪診服務
- (c) 院車或其他交通服務安排
- (d) 洗衣服務
- (e) 剪髮服務
- (f) 復康服務

(2) 院舍亦可提供以下的增值服務：
- (a) 飲食營養的諮詢服務
- (b) 中醫到診服務
- (c) 牙科服務
- (d) 足療服務
- (e) 其他（請註明）

標準 8：食物及環境衛生

院舍設立機制，確保食物及環境衛生，保障院友和員工健康，預防傳染病發生和蔓延。

詮釋

(1) 院舍應制訂處理食物措施及指引：
   (a) 廚房員工的個人及食物衛生知識
   (b) 廚房員工處理食物裝備（如口罩、手套、帽、圍裙等）
   (c) 食物儲存：凍肉儲藏／生、熟食物／其他食物
   (d) 膳食預備：烹煮過程、儲存、運送
   (e) 食具處理
(2) 院舍亦應制訂環境衛生的措施及指引：
   (a) 廚房衛生（即清潔程序及時間表）
   (b) 定期滅蟲措施
   (c) 雪櫃清潔衛生
   (d) 通風系統清潔
(3) 院舍需落實執行以上的措施及指引。
(4) 院舍應保持其他環境的衛生，包括：
   (a) 餐廳
   (b) 客廳
   (c) 睡房（定期更換床單）
   (d) 洗手間
   (e) 浴室
   (f) 活動室

標準 9：社區協作

院舍與社區內的其他機構／團體建立正面的合作關係，借助外間的資源及支持，為院友提供更好的服務。

詮釋

(1) 院舍與社區中的其他有關機構／單位應建立固定關係，支持及參予社區發展或提供不同類型的服務。
(2) 院舍需備有與社區中的其他有關機構協調合作的紀錄（計劃、會議文件）。
(3) 院舍與社區中的其他有關機構／單位有證明顯示溝通是有效，及關係是正面的。
(4) 評審員於實地評審時會向社區中的其他有關機構查詢院舍的表現，和與其合作協調的關係。

註：以上各項所指的有關機構即包括社區內醫療、社會服務機構、志願團體或其他社會單位之合作。

(C) 服務流程／照顧過程

院舍需要設立一套規劃、監管和改善服務的流程，以符合安全、衛生和護理的要求，切合院友需要，保障他們的權利和私隱

標準 10：院友入院後照顧

院舍為院友提供適當導向，讓他們知道服務的內容、收費和院友本身的權益。

詮釋

(1) 院舍在新院友入住時，應提供新院友入住導向計劃及跟進其適應。
(2) 院舍應預先通知長者或其家人有關所有額外收費事宜。

標準 11：藥物管理

院舍設立有效的藥物管理機制，保障院友生命和健康，符合法例要求。

詮釋

(1) 院舍需依據現存藥物管理指引及程序：
   (a) 儲存藥物程序
   (b) 派藥程序（包括院友處方藥物儲存、三核五對、覆核和紀錄措施）
   (c) 藥物棄掉程序
   (d) 院友自行服藥程序
   (e) 特別事件報告及跟進程序
(2) 院舍需向職員提供藥物資料手冊作參考。
(3) 所有經院舍處理的藥物皆需註冊中醫／西醫處方。
(4) 如有長者自行購服藥物，院舍應備有處理非處方藥物指引。
(5) 院舍應制訂長者離院或渡假的藥物處理指引（包括院友離世或入院）。
(6) 院舍需落實執行以上的指引及程序。

標準 12：排泄處理

院舍設立監察和處理院友失禁及便秘的機制。

詮釋

(1) 院舍需提供失禁護理指引（大便、小便）。
(2) 院舍需提供便秘處理指引。
(3) 院舍對排泄有問題的院友能提供觀察、紀錄及跟進行動。
(4) 院舍能按個別長者需要作出護理計劃。
(5) 院舍需落實執行以上的指引及計劃。

標準 13：皮膚護理及壓瘡預防

院舍設立皮膚護理機制，預防及處理壓瘡。

詮釋

(1) 院舍需提供皮膚護理程序，使院友的皮膚能處於健康狀態。
(2) 院舍需提供預防及處理不同程度的壓瘡程序，並能切合當時的護理趨勢。
(3) 院舍提供患上褥瘡之院友個人治療計劃，並能切合當時的護理趨勢，包括評估、紀錄、處理及定期檢討。
(4) 院舍需落實執行以上的程序和計劃。

標準 14：摔跌處理

院舍提供安全環境、評估機制和預防措施，減少院友摔跌及損傷。

詮釋

(1) 院舍需提供防跌倒的評估及程序。
(2) 院舍需提供處理跌倒個案程序，包括評估，處理方法及紀錄。
(3) 院舍需落實執行以上的程序。
(4) 院舍能提供跌倒之個案及跟進紀錄，其跟進應切合情況及適當處理。
(5) 院舍需備有意外跌倒紀錄、分析及跟進行動。

標準 15：餵食

院舍為進食困難院友提供評估及處理，確保協助院友進食的過程符合安全及衛生的原則。

詮釋

(1) 院舍應為進食有困難的院友提供評估。
(2) 院舍應制訂口餵食程序指引，並落實執行。
(3) 院舍應制訂管餵食程序指引，並落實執行。
(4) 院舍需確保施行餵食的員工具有相關的訓練及評核。

標準 16：營養

院舍為院友提供均衡飲食，為有需要的院友作出評估、監察及跟進。

詮釋

(1) 院舍應定期更換菜式及選擇菜式機制。
(2) 院舍應制訂特別餐的處理指引。
(3) 院舍應備有收集長者對膳食意見的機制。
(4) 院舍需每月替院友量度體重。
(5) 院舍需為與上月比較，因特別原因而導致體重下降 5%或以上的院友，制訂個別護理計劃及跟進。
(6) 院舍需落實執行以上的機制、指引和計劃。
(7) 院舍需設有檢討指標數據（如脫水、飲食時發生的意外）之機制及跟進行紀錄。

標準 17：活動能力評估及處理

院舍為行動有困難的院友提供評估及處理，須以促進院友活動能力、達致最大程度的獨立性為目標。

詮釋

(1) 院舍需評估卧床或活動不自如的長者之活動能力，對有需要長者提供運動計劃（如：步行計劃、關節運動、集體運動等）及備有執行紀錄。

標準 18：使用約束物品及藥物

院舍在使用約束物品和藥物方面需採取慎重態度，在必須的情況下才使用。 院舍應盡量避免或減少約束物品和藥物的使用，如必須使用時亦要有充分的授權、定期的觀察、紀錄及評估。

詮釋

(1) 院舍需制訂盡量避免使用約束物品和藥物的政策及指引。
(2) 院舍應制訂使用約束物品的措施及指引：
   (a) 使用原因，醫生指示及使用期限
   (b) 評估紀錄
   (c) 長者或長者家屬同意書
   (d) 觀察及紀錄
   (e) 職員及長者家人對使用約束物品的認識
   (f) 定期評估
(3) 院舍亦應制訂使用約束藥物的措施及指引：
   (a) 使用原因，醫生指示及使用期限
   (b) 評估紀錄
   (c) 觀察及紀錄
   (d) 職員及長者家人對使用約束物品的認識
   (e) 定期評估
(4) 院舍需落實執行以上的政策、措施和指引。

標準 19：扶抱技巧

院舍有扶抱技巧指引，對員工提供訓練、督導及定期的考核，保障院友及員工的安全。

詮釋

(1) 院舍需制訂扶抱技巧指引，並落實執行。
(2) 院舍應定期考核員工的扶抱技巧。
(3) 院舍應定期培訓員工的扶抱技巧。

標準 20：感染控制

院舍設立有效機制，預防感染及控制傳播。

詮釋

(1) 院舍應制訂感染控制的程序和指引，以及傳染病爆發的處理。包括：
   (a) 採用正確的無菌換症法
   (b) 懷疑傳染病處理（包括隔離患者、儘早安排院友接受治療、通知有關的政府部門、向衛生署分區辦事處提供資料、通知病人親屬、備存院友及職員的疾病紀錄、身體不適的院友或員工避免參加集體活動、減少不同棲層的院友和員工的接觸，並在編訂更表時，儘量安排同組員工照顧固定的院友）
   (c) 傳染病爆發期處理（包括環境消毒、使用用後即棄的紙巾、用過的紙手巾處理、潔巾處理和被體液處理）
   (d) 預防傳染病處理（個人／食物及環境衛生／防疫注射）
   (e) 正確洗手方法
   (f) 個人防護裝備，包括手套、口罩、護目鏡、面罩和保護衣等
   (g) 處理污染物品（被服處理／儀器）
   (h) 處理尖銳物品和敷料
   (i) 處理棄置醫療廢物
   (j) 照顧高風險長者護理程序：導尿管／鼻胃管／壓瘡／認知障礙
   (k) 處理傳染病爆發期剛出院院友之程序

(2) 院舍應設立監控傳染疾病機制。
(3) 院舍應落實執行以上程序、指引和機制。

以上各項詳情可參考由衛生署長者健康服務訂定的「安老院舍預防傳染病指引」。

標準 21：長者認知、情緒、感官及溝通能力

院舍設立機制，處理在認知、情緒、感官或溝通能力等方面有問題的院友。

詮釋

(1) 院舍需制訂照顧認知及情緒有問題長者的程序指引，包括：
   (a) 老年痴呆症
   (b) 抑鬱
   (c) 有自殺傾向
   (d) 煩擾性行為
(2) 職員會為上述問題的院友提供適當的轉介。
(3) 院舍需舉行個案研討會議，由不同專業人士及長者家人參與，以訂立個別處理計劃。
(4) 院舍應設有感官能力較差（如視力、聽力下降）的院友之轉介程序。
(5) 院舍需落實執行以上的程序、指引和計劃。

標準 22：慢性痛症處理

院舍設立機制，評估及處理患有慢性痛症的院友。

詮釋

(1) 院舍應制訂長期慢性痛症的指引，如評估、預防方法、處理方法／轉介或再評估等，並落實執行。
(2) 院舍需為長期慢性痛症院友作出評估、處理及轉介。

標準 23：臨終處理

院舍為臨終院友提供服務，保障尊嚴，尊重院友及家人的意願，提供相關照顧及心理支持。 需要時，為其他院友、家人及員工提供哀傷處理。

詮釋

(1) 院舍需制訂臨終安排指引，如：護理服務（心理及生理）、環境之安排(如獨立房間)，家人支持、痛症控制、宗教轉介(院牧、佛教、加持等)、專業轉介（舒緩治療、心理治療）等。
(2) 院舍需制訂死亡後之安排指引，如：成立哀傷處理小組，提供親友心理支持，亦可提供小冊子，詳列各項死後家人需要處理的程序，如領取死亡證、領取遺體、殯葬安排、財產安排等。
(3) 院舍需落實執行以上的指引。

標準 24：特別護理程序

院舍設立機制，為有需要的院友提供特別護理程序。

詮釋

（1） 如院舍的院友有下列需要，院舍需提供相應的特別護理指引，如：氧氣治療、造口護理、糖尿病、長期卧床和腹膜透析等。

標準 25：心理支持及社交照顧

院舍設立機制，定期評估院友的心理及社交狀況，訂定發展計劃和提供輔導服務。

詮釋

(1) 院舍應制訂評估長者的心理狀況及社交狀況指引，並落實執行。
(2) 院舍需最少每年一次評估和觀察長者的心理狀況。
(3) 院舍需最少每年一次評估和觀察長者的社交狀況。
(4) 院舍應根據個人心理和社交狀況而訂定服務計劃（如轉介、輔導、加強家人聯繫等），並落實執行。
(5) 院舍需為院友提供心理支持服務（如輔導或轉介輔導服務）。
(6) 院舍亦需為院友提供社交網絡服務或措施，並落實執行。
(7) 院舍需最少每年一次評估院友的生活質素。
(8) 院舍能根據生活質素評估結果提供改善計劃，並落實執行。

標準 26：康樂及社區活動

院舍為院友提供康樂及社區活動，增強心理健康，促進社交生活，維持社會接觸。

詮釋

(1) 院舍能提供定期的文康小組活動或大型團體活動。
(2) 院舍需制訂活動計劃，並落實執行，包括小組活動或團體活動，活動紀錄或活動後的檢討報告。

（D）資料管理及溝通

標準 27：資料管理

院舍需備有資料管理系統，收集、整理、儲存、使用及更新與服務有關的資料，符合相關法例。

詮釋

(1) 院舍需具備有系統的資料管理，包括資料需準確、完備，職員有效率取用及知悉何處可取用或存放（並無規定要用電腦去處理）。

(2) 院舍應備有資料管理系統，並能合乎法例地將資料

(a) 收集

(b) 整存

(c) 取用

有關資料為：

(1) 管理紀錄

(2) 職員會議紀錄

(3) 持續改善紀錄

(4) 內部評審紀錄

(5) 院友會議紀錄

(6) 家屬會議紀錄

(7) 感染控制會議紀錄等

(8) 實施計劃

(9) 其他：

標準 28：溝通

院舍設立與院友、家人和員工溝通的機制。

詮釋

(1) 院舍應備有溝通機制，使服務使用者及職員了解院舍的最新消息，或給予意見，包括：
   (a) 院友
   (b) 家屬
   (c) 員工

II. 補充評審範疇

標準 29：資料提供

院舍確保製備說明資料，清楚陳述其宗旨、目標和提供服務的形式，隨時讓公眾索閱。

詮釋

(1) 院舍應制備載有最新資料的小冊子、手冊或單張，陳述宗旨、目標、提供服務的形式和對象，以及各種收費，並能隨時供公眾取閱。

標準 30：政策檢討及修訂

院舍應檢討及修訂有關提供服務方面的政策和程序

詮釋

(1) 院舍應備有用以檢討及修訂有關政策及程序之機制，及確立一套收集各參與不同人士（包括院友、家屬和員工）意見的書面機制。
(2) 院舍需落實執行以上的機制。

標準 31：紀錄

院舍存備其服務運作和活動的最新及準確的紀錄。

詮釋

(1) 院舍應備有準確和最新的服務運作紀錄（如院友活動、服務通訊、員工及院友紀錄、財政報告、財政預算及收支紀錄等）。

標準 32：職務責任

所有員工、管理人員、 管理委員會和／或理事會或其他決策組織的職務及責任均有清楚的界定。

詮釋

(1) 院舍應備有各職位（如經營者）的職務責任和問責關係。
(2) 院舍應備有組織架構圖，臚列其整體組織架構及問責關係。
(3) 院舍應確保職員、院友及其他人士可查閱以上資料。

標準 33：人力資源管理

院舍實施有效的職員招聘、簽訂職員合約、發展、訓練、評估、調派及紀律處分守則。

詮釋

(1) 院舍應備有以下的人力資源管理政策及程序，包括：
    (a) 招聘、調派、晉升員工
    (b) 制訂聘用合約
(2) 院舍應備有新職員入職導向訓練程序。
(3) 院舍應提供定期員工工作評核。
(4) 院舍應制定職員訓練與發展政策及訓練紀錄。
(5) 院舍應確保以上各項政策及程序均可供職員查閱，並落實執行。

標準 34：計劃及檢討

院舍定期計劃、檢討及評估本身的表現，制定有效的機制，讓院友、家人、職員及其他關注人士就院舍的表現提出意見。

詮釋

(1) 院舍應制訂整體工作計劃及服務方針。
(2) 院舍應備有用以收集和回應院友、職員及其他人士意見的政策、程序和機制。
(3) 院舍應備有用以檢討和評估服務表現，及對質素問題採取跟進行動的機制。
(4) 院舍應確保以上的政策、程序和機制均可供院友、職員或其他人士查閱，並落實執行。

標準 35：財務管理

院舍設有清晰的政策及程序以確保有效的財務管理。

詮釋

(1) 院舍應制訂財政預算及財政報告。
(2) 院舍每年能有核數或審計師查帳，並作出有關改進。

標準 36：法律責任

院舍遵守一切有關的法律責任，在有需要時亦有途徑徵詢法律人士的專業意見。

詮釋

(1) 院舍應備有與運作有關的法例清單及監察程序，以遵守有關法例，並落實執行。
(2) 如有需要時，院舍能具備徵詢專業法律意見之途徑。

標準 37：安全環境

院舍採取一切合理步驟，確保職員、院友和家屬處身於安全的環境。

詮釋

(1) 院舍應提供安全程序指引，並落實執行。
(2) 院舍應訓練職員認識緊急事故的應變方法，並定期進行火警演習，每年至少演習兩次。
(3) 院舍應定期查察及評估鄰近環境之安全，並作出跟進。
(4) 院舍應紀錄及處理其所有意外或受傷事故。
(5) 院舍如提供院車服務，需定期進行檢查和維修，以及遵守道路和交通安全守則。
(6) 院舍應確保所有服務器材得到適當維修及督導使用（如消防設備／急救設備、氧氣等）。

標準 38：入住及退院

院舍確保院友和家人獲得清楚明確的資料，知道如何申請接受和退出服務。

詮釋

(1) 院舍應備有長者入住及退院服務的政策和程序，並落實執行。
(2) 院舍應確保有關政策和程序可供院友或其他人士查閱。

標準 39：評估院友需要

院舍設有機制評估和滿足院友的需要，並能依據實際執行的情況進行更新和跟進。

詮釋

(1) 院舍應提供評估院友之政策和程序。
(2) 院舍應為每位院友制定個人照顧計劃。
(3) 院舍應更新及修訂個人照顧計劃（如：院友之身體狀況轉壞、院友對治療計劃有不良反應）。
(4) 院舍應確保個人照顧計劃能有職員跟進。
(5) 院舍亦應落實執行以上的政策、程序和計劃。

標準 40：長者權益保障

院舍在服務運作和提供服務的每一方面，均應尊重及保障院友的權益，包括知情權、選擇權、
私人財產權、私穩權，且有機制處理投訴及確保長者免受侵犯。

詮釋

(1) 院舍應備有以下保障長者權利的政策和程序，並落實執行。包括：
   (a) 尊重長者知情權及選擇權
   (b) 尊重長者的私人財產權利(如代管金錢、代購物品程序等)
   (c) 尊重長者私隱和尊嚴的政策和程序(如接受個人護理時的私隱指引，以及收集、索取、傳閱、保存或提供資料時的保密機制)
   (d) 處理投訴的政策和程序，以及跟進行動
   (e) 確保長者免受侵犯的政策和程序

評審標準按必須性及可取性分類

評審標準	評審準則	
	必須性	可取性
標準 1：全面質素管理		
(1) 院舍需訂立服務使命／宗旨／目標。	´	
(2) 員工能了解實踐服務使命／宗旨／目標。	´	
(3) 院舍能提供服務質素改善機制或計劃，並落實執行，包括：	´	
(a) 持續地監察	´	
(b) 有服務使用者參與	´	
(c) 有職員參與	´	
(d) 改善行動	´	
(e) 訂立相關成效指標	´	
(f) 利用成效指標作為改善服務依據	´	
(4) 院舍會利用本身或外間的研究、調查或同業借鑑，以改善服務質素及表現。		´
標準 2：服務操守		
(1) 院舍應訂立服務操守的政策，包括：(a) 尊重長者尊嚴	´	
(b) 私隱	´	
(c) 權利	´	
(d) 安全	´	
(e) 並以此來處理事務	´	
(2) 院舍應為職員訂立員工工作操守，並切實執行。	´	
(3) 院舍應訂立員工違反工作操守時的處理程序。	´	
(4) 院舍需落實執行以上的政策和程序。	´	
標準 3：風險管理		
(1) 院舍需設有風險管理機制，並能：	´	
(a) 評估潛在問題	´	
(b) 訂立行動計劃	´	
(c) 具體實施方案	´	
(2) 院舍應每年購買各類型的保險及設有紀錄。包括：	´	
(a) 公眾責任保險	´	
(b) 僱員補償保險	´	
(3) 院舍在院內的重要器材需有安全評估和檢查機制，並落實執行，包括：	´	
(a) 輪椅	´	
(b) 位置轉移機	´	
(c) 後備氧氣設施	´	
(d) 抽痰機	´	
(e) 升降機	´	
(f) 樓梯機	´	
(g) 其他		´
評審標準	評審準則	

	必須性	可取性
標準 4：購買服務		
(1) 院舍如有購買部份服務，應備有政策及程序或指引，以保障服務質素。	´	
(2) 院舍需落實執行以上的政策、程序或指引。	´	
標準 5：職業安全		
(1) 院舍能提供職業安全政策，並落實執行，包括：	´	
(a) 指派職員統籌職安事宜	´	
(b) 工傷報告機制	´	
(c) 提供職安培訓	´	
(d) 提供資源以改善職安問題	´	
(e) 職員對職業安全的認識	´	
(2) 院舍能提供定期的職業安全訓練計劃及紀錄，如廚房、腰背護理、人力提舉等。	´	
(B) 環境		
標準 6：院舍環境及設施		
(1) 院舍需提供舒適的環境及設施。包括：	´	
(a) 可上鎖的儲物櫃	´	
(b) 呼喚鈴	´	
(c) 家居式佈置（如客飯廳裝飾，花、鳥、魚等或飼養寵物之設置）	´	
(d) 空氣調節／通風系統	´	
(e) 活動室		´
(f) 交談的空間（如會客室等）	´	
(2) 院舍需提供各類器材或用具，包括：	´	
(a) 急救器材	´	
(b) 運動器材或用具	´	
(c) 復康治療器材或用具	´	
(3) 院舍能依據長者的不同需要而提供不同的設施，如：	´	
(a) 老年痴呆症的導向指示	´	
(b) 預防長者溜走設施／措施	´	
(c) 視力不佳的長者的指示牌		´
標準 7：院舍提供的服務		
(1) 院舍必須提供下列服務： (a) 醫生到診服務	´	
(b) 急診及陪診服務	´	
(c) 院車或其他交通服務安排	´	
(d) 洗衣服務	´	
(e) 剪髮服務	´	
(f) 復康服務	´	
(2) 院舍亦可提供以下的增值服務： (a) 飲食營養的諮詢服務		´
(b) 中醫到診服務		´
(c) 牙科服務		´
(d) 足療服務		´
(e) 其他（請註明）		´

評審標準	評審準則	
	必須性	可取性
標準 8：食物及環境衛生		
(1) 院舍應制訂處理食物措施及指引：	´	
(a) 廚房員工的個人及食物衛生知識	´	
(b) 廚房員工處理食物裝備（如口罩、手套、帽、圍裙等）	´	
(c) 食物儲存：凍肉儲藏／生、熟食物／其他食物	´	
(d) 膳食預備：烹煮過程、儲存、運送	´	
(e) 食具處理	´	
(2) 院舍亦應制訂環境衛生的措施及指引：	´	
(e) 廚房衛生（即清潔程序及時間表）	´	
(f) 定期滅蟲措施	´	
(g) 雪櫃清潔衛生	´	
(h) 通風系統清潔	´	
(3) 院舍需落實執行以上的措施及指引。	´	
(4) 院舍應保持其他環境的衛生，包括：(a) 餐廳	´	
(b) 客廳	´	
(c) 睡房（定期更換床單）	´	
(d) 洗手間	´	
(e) 浴室	´	
(f) 活動室	´	
標準 9：社區協作		
(1) 院舍與社區中的其他有關機構／單位應建立固定關係，支持及參予社區發展或提供不同類型的服務。	´	
(2) 院舍需備有與社區中的其他有關機構協調合作的紀錄。	´	
(3) 院舍與社區中的其他有關機構／單位有證明顯示溝通是有效，及關係是正面的。	´	
(4) 評審員於實地評審時會向社區中的其他有關機構查詢院舍的表現，和與其合作協調的關係。	´	
(C) 服務流程／照顧過程		
標準 10：院友入院後照顧		
(1) 院舍在新院友入住時，應提供新院友入住導向計劃及跟進其適應。	´	
(2) 院舍應預先通知長者或其家人有關所有額外收費事宜。	´	
標準 11：藥物管理		
(1) 院舍需依據現存藥物管理指引及程序：	´	
(a) 儲存藥物程序	´	
(b) 派藥程序	´	
(c) 藥物棄掉程序	´	
(d) 院友自行服藥程序	´	
(e) 特別事件報告及跟進程序	´	
(2) 院舍需向職員提供藥物資料手冊作參考。	´	
(3) 所有經院舍處理的藥物皆需註冊中醫／西醫處方。	´	
(4) 如有長者自行購服藥物，院舍應備有處理非處方藥物指引。	´	

(5) 院舍應制訂長者離院或渡假的藥物處理指引（包括院友離世或入院）。	´	
(6) 院舍需落實執行以上的指引及程序。	´	
標準 12：排泄處理		
(1) 院舍需提供失禁護理指引（大便、小便）。	´	
(2) 院舍需提供便秘處理指引。	´	
(3) 院舍對排泄有問題的院友能提供觀察、紀錄及跟進行動。	´	
(4) 院舍能按個別長者需要作出護理計劃。	´	
(5) 院舍需落實執行以上的指引及計劃。	´	
標準 13：皮膚護理及壓瘡預防		
(1) 院舍需提供皮膚護理程序，使院友的皮膚能處於健康狀態。	´	
(2) 院舍需提供預防及處理不同程度的壓瘡程序，並能切合當時的護理趨勢。	´	
(3) 院舍提供患上褥瘡之院友個人治療計劃，並能切合當時的護理趨勢，包括評估、紀錄、處理及定期檢討。	´	
(4) 院舍需落實執行以上的程序和計劃。	´	
標準 14：摔跌處理		
(1) 院舍需提供防跌倒的評估及程序。	´	
(2) 院舍需提供處理跌倒個案程序，包括評估，處理方法及紀錄。	´	
(3) 院舍需落實執行以上的程序。	´	
(4) 院舍能提供跌倒之個案及跟進紀錄，其跟進應切合情況及適當處理。	´	
(5) 院舍需備有意外跌倒紀錄、分析及跟進行動。	´	
標準 15：餵食		
(1) 院舍應為進食有困難的院友提供評估。	´	
(2) 院舍應制訂口餵食程序指引，並落實執行。	´	
(3) 院舍應制訂管餵食程序指引，並落實執行。	´	
(4) 院舍需確保施行餵食的員工具有相關的訓練及評核。	´	
標準 16：營養		
(1) 院舍應定期更換菜式及選擇菜式機制。	´	
(2) 院舍應制訂特別餐的處理指引。	´	
(3) 院舍應備有收集長者對膳食意見的機制。	´	
(4) 院舍需每月替院友量度體重。	´	
(5) 院舍需為與上月比較，因特別原因而導致體重下降 5%或以上的院友，制訂個別護理計劃及跟進。	´	
(6) 院舍需落實執行以上的機制、指引和計劃。	´	
(7) 院舍需設有檢討指標數據之機制及跟進行動紀錄。	´	
標準 17：活動能力評估及處理		
(1) 院舍需評估卧床或活動不自如的長者之活動能力，對有需要長者提供運動計劃及備有執行紀錄。	´	
標準 18：使用約束物品及藥物		
(1) 院舍需制訂盡量避免使用約束物品和藥物的政策及指引。	´	
(2) 院舍應制訂使用約束物品的措施及指引：	´	
(a) 使用原因，醫生指示及使用期限	´	
(b) 評估紀錄	´	
(c) 長者或長者家屬同意書	´	
(d) 觀察及紀錄	´	

(e) 職員及長者家人對使用約束物品的認識	´	
(f) 定期評估	´	
(3) 院舍亦應制訂使用約束藥物的措施及指引：	´	
(a) 使用原因，醫生指示及使用期限	´	
(b) 評估紀錄	´	
(c) 觀察及紀錄	´	
(d) 職員及長者家人對使用約束物品的認識	´	
(e) 定期評估	´	
(4) 院舍需落實執行以上的政策、措施和指引。	´	
標準 19：扶抱技巧		
(1) 院舍需制訂扶抱技巧指引，並落實執行。	´	
(2) 院舍應定期考核員工的扶抱技巧。	´	
(3) 院舍應定期培訓員工的扶抱技巧。	´	
標準 20：感染控制		
(1) 院舍應制訂感染控制的程序和指引，以及傳染病爆發的處理。包括：	´	
(a) 採用正確的無菌換症法	´	
(b) 懷疑傳染病處理	´	
(c) 傳染病爆發期處理	´	
(d) 預防傳染病處理	´	
(e) 正確洗手方法	´	
(f) 個人防護裝備，包括手套、口罩、護目鏡、面罩和保護衣等	´	
(g) 處理污染物品（被服處理／儀器）	´	
(h) 處理尖銳物品和敷料	´	
(i) 處理棄置醫療廢物	´	
(j) 照顧高風險長者護理程序：導尿管／鼻胃管／壓瘡／認知障礙	´	
(k) 處理傳染病爆發期剛出院院友之程序定期評估	´	
(2) 院舍應設立監控傳染疾病機制。	´	
(3) 院舍應落實執行以上程序、指引和機制。	´	
標準 21：長者認知、情緒、感官及溝通能力		
(1) 院舍需制訂照顧認知及情緒有問題長者的程序指引，包括：	´	
(a) 老年痴呆症	´	
(b) 抑鬱	´	
(c) 有自殺傾向	´	
(d) 煩擾性行為	´	
(2) 職員會為上述問題的院友提供適當的轉介。	´	
(3) 院舍需舉行個案研討會議，由不同專業人士及長者家人參與，以訂立個別處理計劃。	´	
(4) 院舍應設有感官能力較差（如視力、聽力下降）的院友之轉介程序。	´	
(5) 院舍需落實執行以上的程序、指引和計劃。	´	

評審標準	評審準則	
	必須性	可取性
標準 22：慢性痛症處理		
(1) 院舍應制訂長期慢性痛症的指引，如評估、預防方法、處理方法／轉介或再評估等，並落實執行。		´
(2) 院舍需為長期慢性痛症院友作出評估、處理及轉介。		´
標準 23：臨終處理		
(1) 院舍需制訂臨終安排指引		´
(2) 院舍需制訂死亡後之安排指引		´
(3) 院舍需落實執行以上的指引。		´
標準 24：特別護理程序		
(1) 如院舍的院友有下列需要，院舍需提供相應的特別護理指引，如：氧氣治療、造口護理、糖尿病、長期卧床和腹膜透析等。	´	
標準 25：心理支持及社交照顧		
(1) 院舍應制訂評估長者的心理狀況及社交狀況指引，並落實執行。	´	
(2) 院舍需最少每年一次評估和觀察長者的心理狀況。	´	
(3) 院舍需最少每年一次評估和觀察長者的社交狀況。	´	
(4) 院舍應根據個人心理和社交狀況而訂定服務計劃，並落實執行。	´	
(5) 院舍需為院友提供心理支持服務（如輔導或轉介輔導服務）。	´	
(6) 院舍亦需為院友提供社交網絡服務或措施，並落實執行。	´	
(7) 院舍需最少每年一次評估院友的生活質素。	´	
(8) 院舍能根據生活質素評估結果提供改善計劃，並落實執行。	´	
標準 26：康樂及社區活動		
(1) 院舍能提供定期的文康小組活動或大型團體活動。	´	
(2) 院舍需制訂活動計劃，並落實執行，包括小組活動或團體活動，活動紀錄或活動後的檢討報告。	´	
(D) 資料管理及溝通		
標準 27：資料管理		
(1) 院舍需具備有系統的資料管理，包括資料需準確、完備，職員有效率取用及知悉何處可取用或存放。	´	
(2) 院舍應備有資料管理系統，並能合乎法例地將資料	´	
(a) 收集	´	
(b) 整存	´	
(c) 取用	´	
標準 28：溝通		
(1) 院舍應備有溝通機制，使服務使用者及職員了解院舍的最新消息，或給予意見，包括：	´	
(a) 院友	´	
(b) 家屬	´	
(c) 員工	´	
II. 補充評審範疇		
標準 29：資料提供		
(1) 院舍應制備載有最新資料的小冊子、手冊或單張，陳述宗旨、目標、提供服務的形式和對象，以及各種收費，並能隨時供公眾取閱。	´	

標準 30：政策檢討及修訂		
(1) 院舍應備有用以檢討及修訂有關政策及程序之機制，及確立一套收集各參與不同人士（包括院友、家屬和員工）意見的書面機制。	´	
(2) 院舍需落實執行以上的機制。	´	
標準 31：紀錄		
(1) 院舍應備有準確和最新的服務運作紀錄（如院友活動、服務通訊、員工及院友紀錄、財政報告、財政預算及收支紀錄等）。	´	
標準 32：職務責任		
(1) 院舍應備有各職位（如經營者）的職務責任和問責關係。	´	
(2) 院舍應備有組織架構圖，臚列其整體組織架構及問責關係。	´	
(3) 院舍應確保職員、院友及其他人士可查閱以上資料。	´	
標準 33：人力資源管理		
(1) 院舍應備有以下的人力資源管理政策及程序，包括：	´	
(a) 招聘、調派、晉升員工	´	
(b) 制訂聘用合約	´	
(2) 院舍應備有新職員入職導向訓練程序。	´	
(3) 院舍應提供定期員工工作評核。	´	
(4) 院舍應制定職員訓練與發展政策及訓練紀錄。	´	
(5) 院舍應確保以上各項政策及程序均可供職員查閱，並落實執行。	´	
標準 34：計劃及檢討		
(1) 院舍應制訂整體工作計劃及服務方針。	´	
(2) 院舍應備有用以收集和回應院友、職員及其他人士意見的政策、程序和機制。	´	
(3) 院舍應備有用以檢討和評估服務表現，及對質素問題採取跟進行動的機制。	´	
(4) 院舍應確保以上的政策、程序和機制均可供院友、職員或其他人士查閱，並落實執行。	´	
標準 35：財務管理		
(1) 院舍應制訂財政預算及財政報告。	´	
(2) 院舍每年能有核數或審計師查帳，並作出有關改進。	´	
標準 36：法律責任		
(1) 院舍應備有與運作有關的法例清單及監察程序，以遵守有關法例，並落實執行。	´	
(2) 如有需要時，院舍能具備徵詢專業法律意見之途徑。	´	
標準 37：安全環境		
(1) 院舍應提供安全程序指引，並落實執行。	´	
(2) 院舍應訓練職員認識緊急事故的應變方法，並定期進行火警演習，每年至少演習兩次。	´	
(3) 院舍應定期查察及評估鄰近環境之安全，並作出跟進。	´	
(4) 院舍應紀錄及處理其所有意外或受傷事故。	´	
(5) 院舍如提供院車服務，需定期進行檢查和維修，以及遵守道路和交通安全守則。	´	
(6) 院舍應確保所有服務器材得到適當維修及督導使用（如消防設備／	´	

急救設備、氧氣等)。		
標準 38：入住及退院		
(1) 院舍應備有長者入住及退院服務的政策和程序，並落實執行。	´	
(2) 院舍應確保有關政策和程序可供院友或其他人士查閱。	´	
標準 39：評估院友需要		
(1) 院舍應提供評估院友之政策和程序。	´	
(2) 院舍應為每位院友制定個人照顧計劃。	´	
(3) 院舍應更新及修訂個人照顧計劃。	´	
(4) 院舍應確保個人照顧計劃能有職員跟進。	´	
(5) 院舍亦應落實執行以上的政策、程序和計劃。	´	
標準 40：長者權益保障		
(1) 院舍應備有以下保障長者權利的政策和程序，並落實執行。包括：	´	
(a) 尊重長者知情權及選擇權	´	
(b) 尊重長者的私人財產權利	´	
(c) 尊重長者私隱和尊嚴的政策和程序	´	
(d) 處理投訴的政策和程序，以及跟進行動	´	
(e) 確保長者免受侵犯的政策和程序	´	

香港安老院舍評審制度先導計劃
參與第一期及第二期院舍初步評審名單

第一期（2003 年 1 月至 6 月）

私營院舍	政府資助院舍	自負盈虧院舍
靠背壟護老院	東華三院余振強紀念護理安老院	聖雅各福群會李節街護老之家
頌恩護理院	明愛利孝和護理安老院	
卓健福群護老院	雅麗氏何妙齡那打素護養院	
曉光（土瓜灣）護老中心		

第二期（2003 年 7 月至 10 月）

私營院舍	政府資助院舍	自負盈虧院舍	合約院舍
新大圍劍橋護老院有限公司	東華三院戴麟趾安老院	博愛醫院賽馬會護理安老院	保良局壬午年耆樂居
駱克道劍橋護老院有限公司	東華三院寶鍾全英安老院		
荃灣新劍橋護老院有限公司	東華三院許莫德瑜護理安老院		
新劍橋護老院有限公司	東華三院馬鄭淑英安老院		
上水劍橋護老院有限公司	救世軍德田長者之家		
福榮街劍橋護老院有限公司	溫浩根護理安老院		
新屯門劍橋護老院有限公司	明愛富亨苑		
港泰護老中心	志蓮護理安老院		
北京安老院有限公司			
樂怡護理中心			
新松齡護老中心			
松齡萬年護老中心			
港灣安老院			
兆善護老中心			
頤和園護老中心			
輝濤中西結合安老院			
松柏國際(香港)協會			
鴨利洲護老中心			
東方護老院			

第二期（續）(2003 年 11 月至 2004 年 5 月）

私營院舍	政府資助院舍	自負盈虧院舍
卓健萬基護老院	圓玄護理安老院	耆康會東蓮覺苑長者天地

List of Experts of Review Panel for Index of Content Validity Testing

(Validation on Accreditation Instrument)

Type	Name	Title	Organization
Doctors	Dr. Ng Ngai Sing	Part-time Geriatrician	Haven of Hope Hospital
	Dr. Lum Chor Ming	Consultant	Shatin Hospital
Nurses	Ms. Bonnie Wong	Nursing Officer	CGAT, United Christian Hospital
	Ms. Wong Yuen Yue, Serina	Nurse	Hong Kong Chinese Women's Club Wong Chan Sook Ying Care and Attention Home
Social workers	Ms. Chan Lai Kuen, Vesta	Superintendent	Helping Hand Hongkong Bank Foundation Lok Fu Care Home
	Ms. Yu Chun Ling	Services Supervisor	Salvation Army Po Lam Residents for Senior Citizens
Academics (in gerontology field)	Dr. Chong Ming Lin, Alice	Assistant Professor	Department of Applied Social Studies, City University of Hong Kong.
Superintendents of RCHEs	Ms. Law Ping	Superintendent	Shong Yen Aged Home
	Mr. Bok Kam Lun	Regional Director (HK South)	The Hong Kong Society for the Aged
Assessors of the first pilot	Mr. Lee Hei Yau, Stanley	Operations Manager	Quality Health Care Elderly Services Ltd
	Ms. Pang Yim, Rosalind	Social Worker	Caritas Harold H. W. Lee Care and Attention Home
Representatives of LORCHE	Mrs. Karina Yuen	Inspector (LORCHE)13	LORCHE, SWD
	Mr. Wong Chi Keung	Inspector (LORCHE) 3	LORCHE, SWD
Representatives of SPS	Ms. Lai Yuk King, Lorita	S(SPS) 7	SPS, SWD
	Ms. Fung Shuk Man, Wendy	S(SPS) 6	SPS, SWD
Residents	Ms. Cheung Fung Mui	N/A	Kau Pui Lung Elderly Home Limited
	Ms. Lee Lai Chung	N/A	Caritas Harold H. W. Lee Care and Attention Home
Relatives of RCHEs residents	Ms. Koo Kam Min	N/A	Hiu Kwong (To Kwa Wan) Nursing Centre
	Mrs. Wu Hung	N/A	Quality Health Care Fuk Kwan Elderly Care Home

List of Discussants of Five Focus Groups

(Validation on Accreditation Instrument)

Type	Name	Title	Organization
Residents of RCHEs and their relatives	Ms. Shum Kam Fun	Relatives	TWGHs Fong Shu Chuen Care and Attention Home
	Ms. Chan Heung Chuen	Relatives	St. James Settlement Li Chit Street Home for the Aged
	Ms. Ho Wai Fong	Relatives	TWGHs Yu Chun Keung Memorial Care and Attention Home
	Ms. Kwok Chuk	Resident	TWGHs Fong Shu Chuen Care and Attention Home
	Ms. Tseng Wan	Resident	TWGHs Fong Shu Chuen Care and Attention Home
	Ms. Kwok Shuit Chun	Resident	TWGHs Yu Chun Keung Memorial Care and Attention Home
Professional staff in RCHEs	Ms. Wong Tsui Wan, Wandy	Nurse-in-charge	Buddhist Sum Ma Shui Ying Care and Attention Home for the Elderly
	Ms. Kwok Man Yin, Alice	Nursing Officer.	Beijing Elder Centre
	Ms. Chui Kit Fun	Superintendent	The Salvation Army Tak Tin Residence for Senior Citizens
	Ms. Chan Sau Fan	Senior Administration Coordinator	Culture Homes (Elderly Centre) Limited
	Ms. Chan Sze Wan	Nurse Supervisor	Chi Lin Care and Attention Home
	Ms. Tiu Mei Ha	Registered Nurse	Quality Healthcare – Conifer Victory Elderly Care Home
	Ms. Li Yin Ching	Registered Nurse	Fai-To Sinowest Combined OAH
	Mr. Lau Ming Ball	Occupational Therapist	Caritas Harold H. W. Lee Care and Attention Home
	Ms. Leung Wing Shan, Winnie	Unit-in-charge	The Hong Kong Society for the Aged
Professionals from hospitals	Ms. Pau Mei Lin, Margaret	Nurse Specialist / Deputy Ward Manager	TWGHs Fung Yiu King Hospital
	Ms. Ip Kam Tin	Nurse Specialist	Kwong Wah Hospital
	Ms. Chu Ho Nee, Connie	Project Officer	Hospital Authority Head Office
	Ms. Lau Tak Yin	Nurse Specialist	United Christian Hospital

	Dr. Tong Bing Chung	Senior Medical Officer	Princess Margaret Hospital
	Dr. Kwan Yiu Keung	Senior Medical Officer	Department of Med. & Geri., Tuen Mun Hospital
	Dr. Wong Ching Yuen, Grace	Medical Officer	Kowloon hospital
	Dr. Wu Yee Ming	Senior Medical Officer	Hospital Authority
Superintendents or administrators of NGOs	Ms. Tsang Fook Yee	Deputy Executive Director	The Hong Kong Society for the Aged
	Ms. Lee Pui Ling, Alice	Co-ordinator, Services for the Elderly	Caritas, Hong Kong
	Ms. Ng Wai Sin	Office-in-charge	Mr. & Mrs. Lawrence Wong Second Lutheran Home for the Elderly
	Ms. Ho Chiu Wah, Amy	Superintendent	Kwai Shing East Rhenish Care and Attention Home
	Ms. Hui Yee Man, Esther	Regional Director (East Kowloon)	Hong Kong Sheng Kung Hui Welfare Council
	Ms. Lee Kin Ming, Amy	Service Co-ordinator (Care and Attention Home)	Tung Wah Group of Hospitals
	Ms. Ng Sau Lan, Nina	Operation Manager	Po Leung Kuk
Operators of private RCHES	Ms. Weng Lien Fen	Superintendent	Ting On Home for the Aged Ltd
	Ms. Wong Wan Chu	Director	Siu King Care and Attention Home
	Mr. Yim Ting Kwok	Home Manager	New Pine Care Centre
	Ms. Wong Chau Heung	Superintendent	Wah Fung Nursing Centre Limited
	Ms. Chiu So Lan	Superintendent	Yee On Residence for Senior Citizens
	Ms. Siu Ling	Superintendent	Tung Kong (Wah Fu) Sanatorium Limited
	Ms. Chan Pong Yin	Superintendent	Kwong On Nursing Centre Limited
	Ms. Chan Fong Tai	Superintendent	Kei Tak (Ho Wang) Home for the Aged

「香港安老院舍評審制度先導計劃研討會」

舉行日期： 2002 年 12 月 9 日(星期一)
舉行時間： 上午 9 時至下午 5 時
舉行地點： 香港灣仔軒尼詩道 15 號溫莎公爵社會服務大樓一樓禮堂

研討會內容及講者

服務質素與評審制度	Ms. Liz Brownhill 英國特倫特區醫院評審計劃（Trent Accreditation Scheme）
英國安老院舍的評審制度 –"國家照顧標準委員會"（National Care Standards Commission）	顏文雄博士 香港城市大學　應用社會科學系副教授
美國安老院舍的評審制度 –"醫療衛生組織評鑑聯合委員會"（Joint Commission on Accreditation of Health Care Organizations）及華盛頓州的發牌制度	李迦密先生 香港老年學會　香港安老院舍評審制度先導計劃計劃總監
加拿大安老院舍的評審制度 –"加拿大醫療衛生服務評審聯會"（Canadian Council on Health Services Accreditation）	甘綺玲女士 東華三院　方樹泉社會服務大樓院長 張玉霞女士 聖雅各福群會　院舍及健康服務高級經理
澳洲安老院舍的評審制度 –"安老服務標準及評審機構"（Aged Care Standards and Accreditation Agency）	李寶滿女士 雅麗氏何妙齡那打素護養院　院長
海外安老院舍的評審標準比較	李迦密先生 香港老年學會　香港安老院舍評審制度先導計劃計劃總監
海外安老院舍的評審程序比較	徐妙玲女士 香港老年學會　香港安老院舍評審制度先導計劃研究主任
香港安老院舍評審制度前瞻	梁萬福醫生 香港老年學會　會長

參與情況：

是次活動共有 332 人報名，當日約有 325 人出席。

「香港安老院舍評審制度先導計劃中期匯報會」

舉行日期： 2003 年 10 月 24 日(星期五)
舉行時間： 下午 2 時至 5 時
舉行地點： 九龍亞皆老街 147 號 B 醫院管理局總部 M 字樓演講廳

研討會內容及講者

匯報會簡介	梁萬福醫生 香港老年學會　會長
第一期先導評審的經驗分享	
• 安老院舍的角度	伍梁敏玲女士 頌恩護理院　院長 黃美鳳女士 明愛利孝和護理安老院　副院長
• 評審員的角度	張玉霞女士 聖雅各福群會　院舍及健康服務高級經理
香港院舍評審標準的發展	李迦密先生 香港老年學會　香港安老院舍評審制度先導計劃計劃總監
安老院舍評審過程	趙廸華女士 香港老年學會　香港安老院舍評審制度先導計劃計劃主任
院舍評審的未來發展路向	梁萬福醫生 香港老年學會　會長

參與情況：

是次活動共有 311 人報名，當日約有 250 人出席。

香港老年學會香港安老院舍評審制度先導計劃滙報會

程序表

日期 ： 二零零四年六月二十一日（星期一）
時間 ： 下午二時至五時
地點 ： 九龍亞皆老街 147B 號
醫院管理局總部 M 字樓演講廳

內容 ：

1. *International Trend of Accreditation in Long Term Care*
Mrs. M. Lee Tregloan. International Society for Quality in Health Care (ISQua) C.E.O.

2. *安老院舍評審標準*
趙迪華女士 雅麗氏何妙齡那打素頤康院 院友服務經理

3. *安老院舍評審過程*
陸鳳蓮女士 香港老年學會香港安老院舍評審制度先導計劃 計劃主任

4. *安老院舍評審經驗分享*

余麗芳女士	明愛富亨苑	院長
周燕蘭女士	靠背壟護老院	院長
陳志育先生	頤和園護老中心有限公司	院長
徐潔芬女士	救世軍德田長者之家	院長

5. *安老院舍評審制度的回顧與前瞻*
梁萬福醫生 香港老年學會 會長

6. 台下詢問及發言

參與情況：

是次活動共有 280 人報名，當日約有 240 人出席