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Introduction

This draft standard is based on national and international discussions. Your comments on this draft are invited and will assist in the preparation of the consequent standard.

For international standards, comments will be reviewed by the relevant UK national committee before sending the consensus UK vote and comments to the international committee, which will then decide appropriate action. If the international standard is approved, it is usual for the text to be published as a British Standard.

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Submission of Comments

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- All comments should be submitted online at <https://standardsdevelopment.bsigroup.com/>. You will need to register in order to comment.

Template for comments and secretariat observations

Date: xx/xx/20xx	Document: ISO/DIS xxxx
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1	2	(3)	4	5	(6)	7
MB	Clause No./ Subclause No./Annex (e.g. 3.1)	Paragraph/ Figure/Table/Note	Type of comment	Comment (justification for change) by the MB	Proposed change by the MB	Secretariat observations on each comment submitted
	3.1	Definition 1	ed	Definition is ambiguous and needs clarifying.	Amend to read '...so that the mains connector to which no connection...'	
	6.4	Paragraph 2	te	The use of the UV photometer as an alternative cannot be supported as serious problems have been encountered in its use in the UK.	Delete reference to UV photometer.	



DRAFT International Standard

ISO/DIS 25557

Care quality for older persons at home and in care facilities

ICS: 11.020.10

ISO/TC 314

Secretariat: **BSI**

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This document is circulated as received from the committee secretariat.

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Foreword

ISO (the International Organization for Standardization) is a worldwide federation of national standards bodies (ISO member bodies). The work of preparing International Standards is normally carried out through ISO technical committees. Each member body interested in a subject for which a technical committee has been established has the right to be represented on that committee. International organizations, governmental and non-governmental, in liaison with ISO, also take part in the work. ISO collaborates closely with the International Electrotechnical Commission (IEC) on all matters of electrotechnical standardization.

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This document was prepared by Technical Committee [or Project Committee] ISO/TC [or ISO/PC] ###, [name of committee], Subcommittee SC ##, [name of subcommittee].

This second/third/... edition cancels and replaces the first/second/... edition (ISO #####:#####), which has been technically revised.

The main changes are as follows:

— xxx xxxxxxxx xxx xxxx

A list of all parts in the ISO ##### series can be found on the ISO website.

Any feedback or questions on this document should be directed to the user's national standards body. A complete listing of these bodies can be found at www.iso.org/members.html.

Introduction

This document supports the United Nations Principles for older persons:

- 1) Older persons should be able to live in environments that are safe and adaptable to personal preferences and changing capacities.
- 2) Older persons should be able to reside at home for as long as possible.
- 3) Older persons should benefit from family and community care and protection in accordance with each society's system of cultural values.
- 4) Older persons should be able to utilize appropriate levels of institutional care providing protection, rehabilitation, and social and mental stimulation in a humane and secure environment.
- 5) Older persons should be able to enjoy human rights and fundamental freedoms when residing in any shelter, care, or treatment facility, including full respect for their dignity, beliefs, needs and privacy and for the right to make decisions about their care and the quality of their lives.
- 6) Older persons should be able to live in dignity and security and be free of exploitation and physical or mental abuse. Older persons should be treated fairly regardless of age, gender, racial or ethnic background, disability, or other status, and be valued independently of their economic contribution.

NOTE The first article of the Universal Declaration of Human Rights states that “All human beings are born free and equal in dignity and rights”. The notion of dignity is defined as the inherent and inalienable worth of all human beings irrespective of social status such as race, gender, physical or mental state. Dignity is deeply embedded in international human rights instruments.

This document is based on the concept integrated care that can be described as methods and strategies for linking and coordinating the various aspects of care delivered by different care systems, such as the work of general practitioners, primary and specialty care, preventive and curative services, as well as physical and mental health services and social care, to meet the multiple needs of an individual older person or category of persons with similar needs.

An integrated response to care covers health care, social care, care for cognitive diseases, palliative and end-of-life care, respite care, rehabilitation, services provided at home, in the community, in hospitals or in care homes, public or private-funded, informal care or care by volunteers.

Care is care, regardless of the environment and should be a seamless provision of health and social services which are not divided up into silos.

This document adopts a person-centred approach, outlining that care is to be provided with the older persons' identity and preferences taking priority. Person-centred care planning is made in close consultation with the older person, with a goal to improve, restore, and maintain health and wellbeing so the older person can age with dignity, be respected, and determine how they will live their life while receiving care. For those persons assessed as 'lacking mental capacity' in consultation with appointed chosen decision maker or representative.

Care providers must ensure that the health and wellbeing of the workforce are protected as this impacts the conditions under which care will be delivered to older persons.

Informal caregivers provide a high amount of care and support and are able to do so in culturally appropriate ways that align with the older person's values. The quality of life of the informal caregiver is closely linked to the quality of life of the older person in need of care and support.

Care coordination is needed at a systems level. The integration between social care and health care, both administratively and at the points of use, is crucial to providing high-quality care. The separation of social care and health care services can result in fragmented coverage, gaps in the provision of care and inappropriate use of acute services. This interferes with the rights of older persons to access the support they need to live to their fullest potential.

This document builds upon the work done in IWA 18:2016 ‘integrated community-based life-long health and care services in aged societies’ which discusses care for older persons in multiple environments and elements. A well-supported infrastructure of an aged society includes a comprehensive, holistic framework of health and care services. See “[Annex A](#), The holistic framework of health and care services in ageing societies”.

Early on in the work of ISO/TC 314 this aspect was identified as the increasing population of older persons in need of care and support services. There was also a need for a different approach in the way care and support is organized and a change in the way older persons and ageing in general are perceived.

The concepts of healthy ageing and age-friendly environments stresses the importance of enabling the older person in need of care and support to be involved and empowered to decide how their needs, expectations and preferences can be met to live as autonomously as possible.

This document is based on the principle that care and support for older persons needs to evolve in light of the current social situation. It is important to move away from care that focuses on meeting the basic needs of older persons to challenge broader objectives such as ensuring wellbeing, meaning in life, and that older persons feel respected.

As the birth-rate declines and the population ages, caregiving needs to fundamentally evolve to sustainably meet the growing needs of older persons. The service providers can significantly contribute to promote the older person’s autonomy.

The providers of care services is expected to develop new ways of thinking through digital technology, including result-based quality improvement, productivity improvements that support sustainable systems, and encourage self-determination for users.

It is important to ensure that necessary medical care is provided where people live including care homes. In order to realize this, it is necessary to promote the networking of medical and care services in cooperation with health care and social care professionals. Through networking, medical and care services are provided in an integrated manner in the community.

Care and support ought to play a sustained role in maintaining the functional abilities of older persons and ensuring their dignity, wellbeing, and opportunities for activity and social participation.

The target groups intended to benefit from the results of the proposed document includes:

Older persons in need of care and support as well persons with caregiving responsibilities, e. g. family and close friends and volunteers. The main benefits includes safety and security to the older person receiving care and to their family and friends who support them. The document gives a picture of what the older person as a consumer can expect of the care service. Key benefits to the older person are independence, participation, self-fulfillment, dignity, respect, and inclusiveness.

The provider of care services who provide or deliver care and support will benefit by using the document as a competence-checklist so that all important aspects of the competence needed in the workforce can be described and when relevant provide an image of the necessary skills development needed within the organization. The skills required of the workforce include various important qualities such as emotional resilience, patience, intuition, empathy, and communication skills. These are attributes that, even with the advancement of digital technology, cannot be provided by robots.

The providers of care services are expected to refer to relevant national guidance about how to deliver safe and effective care and to implement this in their services. It’s understood that there isn’t always strong evidence for all aspects of clinical and personal care. However, where there is evidence, services should use this to provide best practice care. This provides the best possible basis for decisions about the type of care provided to meet older persons’ identified needs, as well as the way the provides that care.

Governmental organizations and policy makers will benefit through:

- 1) The same acceptable equitable level of care regardless of where the older person lives.
- 2) The same set of requirements and recommendations apply to all within the field regardless of organization (private or public and non-profit).

3) More efficient use of tax money.

Different local authorities/municipalities do not have to develop their own templates/tender requests but can use the document as a common reference in the whole jurisdiction. It facilitates comparisons if all tenders are arranged in the same way.

An authority which exercises supervision and inspections can use the document as a complement to legislation that sometimes are more general and needs to be interpreted in relation to the actual elements of the care service.

This document is intended to be useful to all types and sizes of providers in the private, public, and non-profit sectors. While not all parts of this document will be of equal use to all types of providers, the principles are relevant to every provider.

This document can be selectively applied by the provider of care services, recognizing that resources and supports available will differ from organization to organization depending on the size and sector of the organization and the jurisdiction.

When starting to use this document, each provider of care services:

- 1) describes the organizations service content in a service description, which includes for example a statement of purpose and character of the care and support service, measures for ensuring the older persons' wellbeing and security, the ethical principles, the services, and facilities provided, governance and personnel in terms of skills and numbers, methods for quality control and evaluation of the service.
- 2) compares the service description with the content of this document and, when needed, gives a statement that lists what clauses, requirements and recommendations are not in the service description and therefore not applicable to the organization's services.

Care quality for older persons at home and in care facilities

1 Scope

This document specifies requirements and recommendations for the provision of health and social care services for older persons provided by healthcare and social care personnel, irrespective of whether the service is provided in the persons own home or in a care home. The services concerned also include short term care e. g. respite care, enablement, and rehabilitation.

Care services are provided in a variety of settings. While this document focuses on services provided in care facilities and care at home, including preventive, responsive, palliative and end of life care, many of the requirements and recommendations can be applied to the provision of care services in any setting.

Service provision is based on the individual needs and preferences of the older person to assist self-determination, participation, safety, and security. The document encompasses the holistic needs of older persons receiving care at home and at care homes and the workforce, taking into consideration principles of equity, diversity, and inclusion.

This document applies to all providers of care and support to older persons irrespective of size, structure, legal set up, or funding model (i.e., public, private or non-profit).

Care homes, also referred to as residential care facilities, assisted living facilities, retirement homes/communities, are settings where the majority of older persons often live with complex care needs. They provide a range of professional health services, lodging, food, and personal care (e.g., assistance with everyday activities) for older persons 24 hours/day, 7 days a week.

NOTE In some countries medical care is separated from care and is provided by organizations from the health care sector. When this is the case the care provider needs to have systems in place to provide medical services or access to such when needed.

The document is structured to provide clear requirements and accountabilities to enable the workforce, governing bodies, and other stakeholders to work together toward a common vision for person-centred, high-quality care services for older persons.

This document is intended to be used in quality assurance and improvement, follow-up, evaluation, and development of such services and can be used as a basis for procurement, training, supervision, and confirmation of level of achievement.

This document does not cover standardization of clinical guidelines, medical devices and building codes (engineering and structural).

2 Normative references

There are no normative references in this document.

3 Terms and definitions

For the purposes of this document, the following terms and definitions apply.

ISO and IEC maintain terminology databases for use in standardization at the following addresses:

- ISO Online browsing platform: available at <https://www.iso.org/obp>
- IEC Electropedia: available at <https://www.electropedia.org/>

3.1

assistive technology

equipment, product, system, hardware, software, or service that is used to increase, maintain, or improve capabilities of individuals

Note 1 to entry: Assistive technology is an umbrella term that is broader than assistive products.

Note 2 to entry: Assistive technology can include assistive services, and professional services needed for assessment, recommendation, and provision.

[SOURCE: ISO/IEC Guide 71:2014, 2.16]

3.2

audit

systematic and independent process for obtaining evidence and evaluating it objectively to determine the extent to which the audit criteria are fulfilled

Note 1 to entry: An audit can be an internal audit (first party) or an external audit (second party or third party), and it can be a combined audit (combining two or more disciplines).

Note 2 to entry: An internal audit is conducted by the organization itself, or by an external party on its behalf.

Note 3 to entry: “Audit evidence” and “audit criteria” are defined in ISO 19011.

[SOURCE: ISO 7101:2023]

3.3

care

activities/actions (social, physical, emotional, spiritual, mental) that take place across a variety of settings: in the home, community, institution, and all care settings

Note 1 to entry: Applies to both paid and unpaid care.

[SOURCE: ISO 25551:2021]

3.4

care home

place of residence for older persons and persons with physical and/or mental disabilities, who may require nursing care to perform activities of daily living

Note 1 to entry: The facility provides 24-h supervision, nursing care, rehabilitation programmes and social activities as well as assisting contact with the social environment, including assistance with asserting rights, justified interests, and handling personal matters.

Note 2 to entry: Care homes are often referred to as nursing homes.

Note 3 to entry: A care home might specialize in certain types of disability or conditions such as dementia.

[SOURCE: CEN/TS 17500:2021, modified - “daily living activities” has been replaced with “activities of daily living”]

3.5

care plan

personalized statement of planned healthcare activities relating to one or more specified health issues

Note 1 to entry: Adapted from EN 13940-1:2007.

[SOURCE: ISO 18308:2011]

3.6

community

place or group of people with an arrangement of responsibilities, activities, and relationships

Note 1 to entry: A location such as a city, town, neighbourhood, village, or rural area, but it can also include groups of people with shared interests or features, such as professional groups, religious organizations, and businesses.

Note 2 to entry: In many, but not all, contexts, a community has a defined geographical boundary.

Note 3 to entry: The following are also considered as stakeholders in the community:

- authorities having jurisdiction within the community
- organizations, congregations, and community groups
- individuals, carers, and families
- persons of interest in education, research, and development
- planners and providers of products, services, the built environment, and the community infrastructures.

[SOURCE: ISO/TS 37151:2015, 3.1, modified — “place or” has been added, Note 1 to entry has been modified, and Note 2 to entry and Note 3 to entry have been added.]

3.7

community-based care

community-based programmes

community-based services

health and social services integration provided to an individual or family at their place of residence or at other non-institutional locations within the community for the purpose of promoting, maintaining, or restoring health, minimizing the effects of illness and disability, and supporting and facilitating autonomy and self-care

Note 1 to entry: Services and programmes can include healthcare workers, befriending services, delivered meals, home care, community mental health, health education, screening, immunizations, family planning, sexual health, advanced care planning, palliative care, end of life care etc.

[SOURCE: ISO/IWA 18:2016, 2.2, modified — “health and social services integration provided to an individual or family at their place” has replaced “blend of health and social services provided to an individual or family in his/her place”, “or at other non-institutional locations within the community” has been added, “on his/her normal lifestyle” has been removed, “and supporting and facilitating autonomy and self-care” has been added, Note 1 to entry has been removed, “community-based programmes” has been added as admitted term, and new Note 1 to entry has been added.]

3.8

competence

ability to apply knowledge and skills to achieve intended results

[SOURCE: ISO 7101:2023]

3.9

data-driven

informing an activity by evidence

Note 1 to entry: Way of making decisions based on the analysis and interpretation of data stored from digital sources.

[SOURCE: ISO/IEC/IEEE 32675:2022, 3.1.14]

3.10

digital device

electronic equipment used to process or store digital data

[SOURCE: ISO/IEC 27037:2012, 3.4]

3.11

dignity

recognition by others of one's human rights including the value, worth, and right to ethical treatment

[SOURCE: ISO 7101:2023, modified "inherent value" has been replaced with "human rights, including the"]

3.12

effectiveness

extent to which planned activities are realized and planned results are achieved

[SOURCE: ISO 7101:2023]

3.13

enablement

process of enabling an older person to gain new skills or abilities to manage changes in their care needs

Note 1 to entry: This might be required, for example, if the individual has to start injecting insulin or learn how to change a stoma bag, with the associated challenges, or following a period of ill health, acute health event such as a stroke, or hospital admission.

[SOURCE: BS 8606:2019]

3.14

informal carer

informal caregiver

generally unpaid person who provides care from time to time

Note 1 to entry: This term does not include trained care providers affiliated with home care agencies when working clients at those agencies.

Note 2 to entry: An informal carer is likely to be a family member, relative, close friend, neighbour, or volunteer. Support provided by an informal carer may include assisting with the activities of daily living and helping with advance care planning.

[SOURCE: ISO 25552:2022]

3.15

integrated care

integrated care services

methods and strategies for linking and coordinating the various aspects of care delivered by different care systems, such as the work of general practitioners, primary and specialty care, preventive and curative services, and acute and long-term care, as well as physical and mental health services and social care, to meet the multiple needs of an individual client or category of persons with similar needs

Note 1 to entry: Integrated care services includes independence support care services as well as the interface with medical care. In some countries, medical care or acute care may be excluded. It also includes independence support care services in the community after medical (curative) care has been delivered by professionals.

[SOURCE: IWA 18:2016 Note 1 to entry modified]

3.16

integrated health services

continuum of services that are managed and delivered at different levels and sites within the health system

Note 1 to entry: Care is provided according to the needs of the individual throughout the course of his/her life

Note 2 to entry: Integrated health services includes health promotion services as well as the interface with medical services but does not include medical (preventive and curative) services provided by professionals.

[SOURCE: IWA 18:2016]

3.17

medical device

instrument, apparatus, implement, machine, appliance, implant, reagent for in vitro use, software, material or other similar or related article, intended by the manufacturer to be used, alone or in combination, for human beings, for one or more of the specific medical purpose(s) of:

- diagnosis, prevention, monitoring, treatment, or alleviation of disease
- diagnosis, monitoring, treatment, alleviation of or compensation for an injury
- investigation, replacement, modification, or support of the anatomy or of a physiological process
- supporting or sustaining life
- control of conception
- disinfection of medical devices
- providing information by means of in vitro examination of specimens derived from the human body

and does not achieve its primary intended action by pharmacological, immunological, or metabolic means, in or on the human body, but which may be assisted in its intended function by such means.

Note 1 to entry: Products which may be considered to be medical devices in some jurisdictions but not in others include: — disinfection substances; — aids for persons with disabilities; — devices incorporating animal and/or human tissues; — devices for in vitro fertilization or assisted reproduction technologies.

[SOURCE: ISO 13485:2016, 3.1]

3.18

monitoring

determining the status of a system, a process, or an activity

Note 1 to entry: To determine the status, there can be a need to check, supervise or critically observe.

[SOURCE: ISO 7101:2023]

3.19

nonconformity

non-fulfilment of a requirement

[SOURCE: ISO 7101:2023]

3.20

objective

result to be achieved

Note 1 to entry: An objective can be strategic, tactical, or operational.

Note 2 to entry: Objectives can relate to different disciplines (such as financial, health and safety, and environmental goals) and can apply at different levels (such as strategic, organization-wide, project, product, and process).

[SOURCE: ISO 7101:2023]

3.21

organization

person or group of people that has its own functions with responsibilities, authorities, and relationships to achieve its objectives

Note 1 to entry: The concept of organization includes, but is not limited to, sole-trader, company, corporation, firm, enterprise, authority, partnership, charity or institution, or part or combination thereof, whether incorporated or not, public, or private.

Note 2 to entry: If the organization is part of a larger entity, the term “organization” refers only to the part of the larger entity that is within the scope of the care for older persons guidelines.

[SOURCE: ISO 7101:2023, modified -healthcare quality management system” has been replaced with “care for older persons guidelines”, and Note 3 to entry deleted]

3.22

performance

measurable result

Note 1 to entry: Performance can relate either to quantitative or qualitative findings.

Note 2 to entry: Performance can relate to managing activities, processes, products, services, systems or organizations.

[SOURCE: ISO 7101:2023]

3.23

person-centred care

way of organising and conducting care that promotes the provision of care centred on a specific person’s needs and preferences, identity, and their engagement in the care process

Note 1 to entry: Person-centred care usually relies on concepts such as individualisation, personalisation, autonomy, participation, and engagement to achieve its goals.

[SOURCE: ISO 25552:2021]

3.24

policy

intentions and direction of an organization as formally expressed by its top management

[SOURCE: ISO 7101:2023]

3.25

process

set of interrelated or interacting activities that uses or transforms inputs to deliver a result

Note 1 to entry: Whether the result of a process is called an output, a product or a service depends on the context of the reference.

[SOURCE: ISO 7101:2023]

3.26

recommendation

expression, in the content of a document that conveys a suggested possible choice or course of action deemed to be particularly suitable without necessarily mentioning or excluding others

Note 1 to entry: Recommendations are expressed using the verbal form “should”.

Note 2 to entry: In the negative form, a recommendation is the expression that a suggested possible choice or course of action is not preferred but it is not prohibited.

[SOURCE: ISO/IEC Directives, Part 2:2021, 3.3.4 – Modified, “forms specified in Table 4” in Note 1 to entry has been replaced with “form “should””]

3.27

requirement

expression, in the content of a document, that conveys objectively verifiable criteria to be fulfilled and from which no deviation is permitted if conformance with the document is to be claimed

Note 1 to entry: Requirements are expressed using the verbal form “shall”.

[SOURCE: ISO/IEC Directives, Part 2:2021, 3.3.3 – Modified, “forms specified in Table 3” in Note 1 to entry has been replaced with “form “shall””]

3.28

risk management

systematic application of management policies, procedures, and practices to the tasks of analysing, evaluating, controlling, and monitoring risk

[SOURCE: ISO/IEC Guide 63:2019, 3.15]

3.29

social participation

a person's involvement in activities that provide interaction with others in the society or the community

3.30

stakeholder

person or organization that can affect, be affected by, or perceive itself to be affected by a decision or activity

Note 1 to entry: Stakeholders can include but are not limited to: Ministry or Department of Health, Finance, Treasury, Education; non-governmental organizations and not-for-profit sector; community groups and civil society organizations; local government, health insurance groups, financial contributors and other healthcare funders; donor and aid agencies, UN agencies (including the WHO), health professions associations, regulatory bodies, health workers' organizations and networks; patients, families, caregivers, and other health service users.

[SOURCE: ISO 7101:2023]

3.31

wellbeing

state of optimal physical, mental, emotional, and social health

[SOURCE: ISO 22886:2020, 3.11.4]

3.32

workforce

staff

personnel

all individuals employed by the organization

Note 1 to entry: This concept includes full-time, part-time, casual or contract, clinical and non-clinical workers.

[SOURCE: ISO 7101:2023]

4 Context of the provider of care services

4.1 Understanding the needs and expectations of interested stakeholders

4.1.1 General

Every organization has a purpose, in this case providing care services to older persons. The organization determines the external and internal needs that are relevant to its purpose and that affect its ability to achieve the intended results. To make sure the organization understands the issues that can affect, either positively or negatively, the organization and its ability to achieve the intended results of its purpose, information is gained and used to guide the planning, implementation, operation, evaluation, and improvement of the provision of care services.

The determined issues represent the main inputs for several other aspects of the operations of the organization. To understand the needs and expectations of interested stakeholders the organization determines:

- the interested stakeholders that are relevant to the organization
- the relevant demands of these interested stakeholders
- which of these demands that will be addressed through the organizations delivery of its services.

The primary interested stakeholders are the older persons that the organization will provide care for.

This means that the organization needs to find out how the population of older persons looks now and in the near future. The future challenges of care are not to focus of all women and men over the age of 65, but above all those in the oldest age groups. It is the oldest-old people who are those with major health and social care needs. The oldest-old population is expected to continue to increase.

NOTE The definition of 'oldest-old people' varies depending on factors such as national regulations, but it is generally defined as those aged 75 or 80 and older.

At the same time, the age composition of the aged population is not the only structural factor affecting the demand for care. So do also factors such as socio-economic factors, tax capacity and public health. Changes in the population structure means that the need for foresight and prioritization in planning and decision-making processes increases.

The care of older persons in the future refers to what the needs look like and how they can be met in the form of home care, care homes, etc. Furthermore, it refers to how the workforce supply is met and how the society works with new technologies. These are issues that together create the conditions for what care for older persons will look like in the future.

The governing body stays informed about changes in laws, regulations, and contractual obligations that may affect the delivery of care services and the qualifications of the workforce. When changes are required in the delivery of care services, the governing body ensures the organization's strategic plans are aligned to those changes.

The provider of care services conducts activities to expand the added expected value by each of the stakeholders in care, while paying attention to their mutual relationships.

For example, these stakeholders and their expected added value may include.

- 1) governments and local governments (stabilization of civilian populations, economic growth through welfare, maintenance of market discipline, etc.),
- 2) communities (seamless and efficient service provision according to life stages),
- 3) financial contributors (improvement of cost effectiveness of financial resources),
- 4) older persons and their relatives (provision of high-quality services), and
- 5) care workers (creation of high-quality employment environment).

4.1.2 Recommendations

The provider of care services should ensure that there is a strategic plan that includes, but is not limited to, the following areas:

- a. plans concerning demographic information on older persons in the community. Where are they located geographically? How many are they? What is their age distribution? What is their health status? What expectations do they have concerning care services?;
- b. housing plans that aim to ensure a safe housing situation for the older persons in the municipality. The housing plans describes, based on the population forecast, the number care homes that will be needed;
- c. workforce and proper skills mix supply plans. The plan provides a description of the current staffing level and based on current staffing and demographic developments, also includes predictions of what the supply of personnel and skills will look like in both the short and long term;
- d. plans for digitalisation and new technology. The plan is a description of the digital technologies that are already in use and a plan for how digitalisation and new technology can be used in the future. This requires digital competence among the workforce and efforts to increase the digital knowledge of the users;
- e. plans for health promotion and preventive work programs on the health and well-being of the older persons;

- f. plans for home care services;
- g. a plan and policy for what constitutes person-centred care for older persons;
- h. environmental factors, equity, diversity, inclusiveness, and other subject areas that are relevant in order to be able to deliver services that comply with relevant legislation and meet the quality demands set by society.

NOTE Understanding of external conditions can be facilitated by the considering issues that have their basis in legal, technical, competitive, market, cultural, social, and economic contexts.

4.2 Integrated care

4.2.1 General

The concept "integrated care" refers to an integrated approach to healthcare and support provided within a local community. Integration of care can be achieved only if services and providers are working towards the single goal of maintaining the older persons intrinsic capacity and functional ability. It is essential that the older person is involved with decision-making and goal setting from the outset, and that goals are set in accordance with the person's needs and preferences.

Regular and sustained follow-up of older people, with integration among different levels of care, is essential for implementing the interventions recommended in this document. Such an approach promotes early detection of complications or of changes in functional status, thus preventing unnecessary emergencies and related inefficiencies. It also provides for a forum for monitoring progress against the care plan, as well as a means for arranging additional support as needed. Follow-up and support might be especially important following major changes in the disease status, treatment plan or social role/situation (for example a change in residence, or the death of a partner).

The requirements and recommendations formed in this document are interrelated and aim to produce synergistic effects on the intrinsic capacities and functional abilities of the older persons and they would be best implemented in the context of a comprehensive needs assessment and an integrated care plan.

In addition to promoting integrated person-centred care, the requirements and recommendations are to be implemented with a view of supporting ageing in place; health services should therefore provide care where people live. The interventions are designed to be implemented through models of care that prioritize primary care and community-based care. This includes a focus on home-based interventions, community engagement and a fully integrated referral system and requires collaboration among municipalities, healthcare and welfare service providers, volunteers, and others to design and provide continuous care and support, with a focus on the following aspects, for older persons with care needs:

1) Community-based approach

A community-based integrated care system promotes individuals receiving care at home and within their local communities. It aims for older persons to live in their communities and receive support from their families and the community whenever possible.

2) Integration of care

In this system, the goal is to provide a comprehensive range of care and support services, including medical care, social care, rehabilitation, mental health support, palliative, and end of life care, in an integrated manner. This enables the provision of personalized and comprehensive care tailored to the needs of patients and users.

3) Prevention and early intervention

A community-based integrated care system also places emphasis on disease prevention, health promotion and wellbeing. It aims to prevent the progression of illnesses through regular health checks and early intervention programs.

4) Team approach

A care team comprising various professionals such as doctors, care workers, nurses, therapists, social workers, and volunteers collaborates to provide appropriate care to the older person. This allows for a customized approach tailored to individual cases.

5) Information sharing and collaboration

A community-based integrated care system utilizes electronic health records and information sharing to enhance collaboration among different care providers. This facilitates the delivery of continuous care.

6) Utilization of community resources

Community-based resources and facilities are leveraged to provide services to older persons. Collaboration with the community, volunteers, and local organizations complements the care system. Older persons who live in the community should be considered a resource and included in the definition of community-based resources.

7) Cost efficiency

A community-based integrated care system, which integrates medical, and care services and provides short-term hospital or facility care, when necessary, promotes cost reduction and efficient resource utilization by emphasizing the use of community-based resources and facilities and by completing care within the community as long as possible. In a community-based integrated care system, administrative agencies, etc. need to systematically balance financial resources and income/expenses of service provision based on dynamic analysis of the population distribution of older persons in the community.

As a result, based on the initiative of local governments, etc., the system is regularly verified by local stakeholders, and the feedback loop functions to optimize community wellbeing.

NOTE “community-based integrated care” is an aggregated concept that consists of the terms [3.7](#) community-based care, community-based programmes, community-based services, [3.15](#) integrated care, integrated care services and [3.16](#) integrated health services.

By combining these two concepts, the integration of public health functions, medical functions, and social services functions at the community level is promoted.

4.2.2 Recommendations

The provider of care services should:

- a. actively and proactively participate in the establishment of the community-based integrated care system to support older persons;
- b. aim to collaboratively provide support services by partnering with municipalities, healthcare institutions, social workers, and others in an integrated manner;
- c. strive for disease prevention and wellbeing among older persons and early intervention in health promotion;
- d. foster collaboration with local experts within the community;
- e. make efforts to facilitate information sharing among municipalities, healthcare institutions, social workers, and others involved in the older persons' care;
- f. effectively utilize community resources by collaborating with local communities, volunteers, and other stakeholders to the extent possible;
- g. in implementing the above a-f, utilize information and communication technology and digital devices to promote the improvement of care quality.

4.3 Governing and guiding documents

4.3.1 General

The provider of care services is expected to have an organizational structure and division of responsibilities that are sufficiently comprehensive to ensure safe and secure delivery of care services the older person.

Governing and guiding documents play an important role as a basis for quality assurance of operations. The purpose of the documents drawn up is to ensure that the activities are managed, planned, implemented, evaluated, and followed up. These documents specify a number of different types of documentation that ensure that the organization can verify that various aspects of the care services are carried out in accordance with the set requirements.

The type of document (i.e. its classification) expresses the degree of control that the management seeks to achieve. Steering documents can describe both approaches and clear rules or contain instructions for a particular process.

A policy expresses the management's overall intentions. A policy should either be complemented with other steering documents or form part of an action plan or a set of guidelines. A policy is not formally binding but establishes the framework for certain conduct and constitutes a strong recommendation on how to act.

A strategy is an overall plan for achieving an established goal. Implementation of a strategy document generally requires one or more decisions stating what has to be done in more practical terms.

Action plans state concrete goals or measures that are to be achieved within a certain area and are strategic in nature. Action plans are to be given a limited term of validity and must be followed up.

Instructions describe a certain way of dealing with a specific matter, activity or process. Instructions can supplement guidelines and rules. Instructions remain in effect unless otherwise decided.

4.3.2 Requirements

The provider of care services shall:

- a. ensure that there is a procedure in place for establishing, reviewing, updating and, when necessary, terminating outdated governing and guiding documents for quality assurance of the care services;
- b. ensure that the workforce is aware of the governing and guiding documents, understand them, and have access to the latest versions;
- c. ensure that documented information of external origin determined by the organization to be necessary for the planning and operations are identified as appropriate and controlled.

4.3.3 Recommendations

The provider of care services should:

- a. ensure that when new or updated governing and guiding documents are introduced, the workforce is provided with guidance and training, as necessary;
- b. ensure that governing and guiding documents are clearly classified according to type and content.

4.4 Quality system for care services

4.4.1 General

A quality manual is a document that defines the organizations intended quality. Quality manuals may vary in format and detail, in order to fit the scope and complexity of the organization. The quality manual shows what the organization wants to be recognized for. The quality manual is expressed in terms that are familiar to the workforce and refer to their daily duties. The quality manual is based on the organization's ethical

principles and quality characteristics including the older person's safety and security. The quality statement provides a framework for quality objectives.

To ensure the quality of life, safety and security of the older person, the provider performs systematic quality work, continuous improvement, development, and innovation, with a focus on data-driven assessment of current conditions and on maintaining and improving the autonomy of older persons.

By selecting and applying relevant quality indicators, treating non-conformities and adverse events, suggestions, and complaints, carrying out self-assessments, internal and, if possible, external audits, trends that may indicate deficiencies in the quality can be identified and addressed. All these procedures give ongoing information on the quality of the care services. The more specific this information is, the less it needs interpretation and the easier it is to understand. Health records contain specific information and, when agreed by the older person, these permit continuous follow-up of the results of the care.

When working to improve the quality of care, it is important to document data on the formulation of plans, the implementation of assistance and the health condition of older persons. The use of documented data is then effective to improve service quality by setting improvement targets with data and monitoring the improvement status with data, which can also be used for governance and monitoring of the workforce.

NOTE 1 See ISO 23592 for information on the acquisition and use of data to understand customer needs, expectations, and desires in service delivery.

NOTE 2 See ISO/TS 23686 for information on data collection for service quality measurement.

NOTE 3 See ISO/TS 24082 for information on service design through data utilization.

The care service can also improve and develop the quality by the assimilation of new knowledge. When new knowledge is implemented in the care process, the daily work can be performed according to up to-date scientific knowledge, proven appropriate experience and evidence-based good practice. This leads to continuous improvement, development and sometimes even innovation of the care.

4.4.2 Requirements

The provider of care services shall:

- a. establish, implement, and maintain policies and procedures to determine, collect and analyse appropriate data to demonstrate the suitability and effectiveness of the care services and to evaluate where continuous improvement of the effectiveness of the care services can be made. This shall include data generated both from the provider's care service and data from other relevant sources. The result is presented in a quality report available to all stakeholders;
- b. develop care plans, record the implementation of care, record data on the health condition and functional ability of the older person, identify the current situation based on the data, set targets, monitor use of the data and provide feedback;
- c. determine and provide the resources necessary to establish, implement, maintain, and continually improve the quality system for care services;
- d. ensure that a quality manual is in place containing all of the organization's policies and procedures concerning quality of care services and available to all interested stakeholders;
- e. determine and provide the workforce (skills and numbers of professionals) necessary to effectively implement the care quality system for care services and to operate and control the process.

4.4.3 Recommendations

The provider of care services should:

- a. present an annual review of quality and safety of care services and make it available to the relevant stakeholders;

- b. ensure that there are procedures to facilitate and encourage participation in research that is pertinent to the status and engagement of older persons, their care and support, health, and wellbeing;
- c. establish, implement, and maintain policies and procedures for reporting to, analysis and use of data from the relevant quality registers and public national databases as part of the organization's knowledge development and quality improvement;
- d. promote data-driven governance in the implementation of processes related to the quality of care services;
- e. ensure that ideas and inputs from the older person, family, close friends, and workforce concerning quality work, improvement and development of the care services are received, considered, and responded to.

5 Leadership of care services

5.1 Ethos of the provider of care services

5.1.1 General

The provider of care services is expected to deliver care services that are inclusive and do not discriminate. Care services are expected to be responsive, inclusive, and sensitive to culturally and linguistically diverse older persons. They are also expected to be responsive, inclusive, and sensitive to older persons who are lesbian, gay, bisexual, transgender, and intersex. Management is also expected to emphasize ethical behaviour and transparency and to demonstrate these values to all members of the care services.

The older person defines their own identity, and this should be respected and not questioned. Respecting the identity, culture, and diversity of an older person, means taking action to understand their needs and preferences. The provider of care services is expected to provide care services that reflect the older person's social, cultural, linguistic, religious, spiritual, psychological, and medical needs.

The organizations and professionals' ethical principles are essential to reinforce fundamental rights of the older person and the commitment to uphold them. Care and support of older person ethical principles ensures:

- 1) living in dignity and with their wellbeing promoted
- 2) self-esteem and confidence in abilities are strengthened
- 3) their private life and integrity are respected
- 4) support is given in self-determination
- 5) person centred focus
- 6) consent is continuously sought
- 7) personal safety and security
- 8) opportunity for an active and meaningful social life
- 9) systematic development of care services to meet changing needs

NOTE Many professional organizations have ethical codes that governs the performance of the occupation e, g nurses, physiotherapists, occupational therapists, physicians, care workers and others.

5.1.2 Requirements

The provider of care services shall:

- a. ensure that ethical principles are included in the organization's statement of purpose.

5.1.3 Recommendations

The provider of care services should:

- a. encourage workforce and professionals' involvement in the adaptation, implementation, evaluation, and development of the organization's and professionals' ethical principles by making the workforce aware of the values;
- b. disclose information about the organization's ethical principles both inside and outside the organization;
- c. support professionals for their development of skills and self-improvement that contribute to the cultivation of professional ethics.

5.2 Leadership and Commitment

5.2.1 General

The governance of the organization is committed to taking the following initiatives:

1) Vision sharing and communication

Clearly communicate and share the vision and goals with the entire workforce. Encourage open dialogue with the workforce through appropriate means of communication.

2) Collaboration with stakeholders

Establish close working relationships with all stakeholders, including government, local government, healthcare providers, senior citizens, and caregivers. Understand the expectations and needs of each stakeholder and reflect them in service and process improvements.

3) Promote innovation and improvement

Conduct regular evaluations and introduce effective improvement measures. Encourage the introduction of new ideas and technologies and pursue industry best practices.

4) Educate and upskill the workforce

Provide necessary training and skill-building opportunities for the workforce to enhance their expertise. Motivate team members and provide opportunities for growth.

5) Quality control and safety

Focus on quality control of services and maintain high standards. Strive to ensure safety and establish and implement a system of risk management.

6) Sustainable growth and financial governance

To practice effective financial governance with the aim of achieving sustainable growth of the care services. Ensure financial stability through appropriate allocation of resources and budget supervision. By exercising these leadership roles, the management can comprehensively supervise the entire organization and provide added value to all parties involved.

5.2.2 Requirements

The provider of care services shall:

- a. ensure that the management has the competences, awareness, experience, knowledge, skills, and abilities required to manage service delivery effectively as described in paragraph 1) – 6) above.

5.3 Governance of care services

5.3.1 General

The governing body of the care services organization is responsible for the delivery of safe and high quality care services. It is expected to promote a culture of safety and quality, openness, and organisational learning, and to include this in the organization's governance systems. The governing body is also expected to drive and monitor improvements to make sure the organization is committed to quality care and services and for providing services that contribute to older persons living independently according to their abilities, including a clear understanding of the risks at the service. How the governing body and governance structures are organised will depend on the organization's setting, size and the nature of care and services being provided.

The key areas for the organization's governance systems are:

1) Information management

Effective information systems and process give appropriate members of the workforce access to information that helps them in their roles. It also makes sure the older persons can access information about their services. These systems cover how the organization maintains, stores, shares, and destroys information and how it controls privacy and confidentiality.

2) Management and control of risk

These systems help the organization to identify where quality and safety are at risk. They also help the organization to respond appropriately and promptly to these risks. The organization is expected to plan for and manage internal and external emergencies and disasters and have effective infection prevention and control procedures in place.

3) Continuous improvement

Continuous improvement systems and processes assess, monitor, and improve the quality and safety of the care and services provided by the organization. This includes the experiences of older persons. The organization has a plan for continuous improvement and check their progress against this plan to improve the quality and safety of care services.

4) Financial governance

Financial governance systems and processes manage the finances and resources that the organization needs to deliver safe and high quality care services. The organization is expected to include the capital and revenue costs of maintaining safety and quality in their financial planning.

While governance systems are a foundation for most organizations, this document is focused on how these systems support the delivery of safe and high quality care services. It is expected that the organization has governance systems in place to assess, monitor and drive improvement in the quality and safety of the care services they provide.

Efficient leadership and the use of available resources is fundamental to provide a person-centred, safe, and effective care service that meets the needs of the older person and respect their dignity and wishes. A well-run care service uses resources effectively and seeks opportunities to provide a sustainable and continuously improved service, which achieves optimum results for the older person. Resource decisions take in account the views and needs of the older person and exemplify person-centred values.

5.3.2 Requirements

The provider of care services shall ensure that at least the following components of governance are documented and implemented:

- a a process of effective communication inside and outside the organization;
- b a definition of the structure of the organization including accountability, roles, and responsibilities of the workforce at all levels of the organization, and objectives and operational policies of the organization;

- c a process for assessing monitoring and mitigating risks relating to the health, safety, and welfare of older persons, workforce, and visitors;
- d a process for carrying out due diligence checks on subcontractors (e. g. providers of associated services such as maintenance) and volunteers;
- e a process to collect and review internal quality and clinical data;
- f a process to review information collated from the external health and social care sector to inform organizational learning and enhanced quality improvement;
- g a quality governance and monitoring system or process;
- h a process for carrying out an annual review of the year's progress against the agreed governance, to reflect upon improvements and identify further areas of development to inform the following year's governance strategy;
- i a process for ensuring that all data systems for personal information and commercially critical information are protected by defined access rights and back-up systems, which shall be audited as part of a process for information governance.

6 Risk management of care services

6.1 Strategy

6.1.1 General

The governing body sets the strategic priorities for the care services. Management will position risk management as a critical component of the care services and emphasize compliance with corporate requirements and regulations.

Policies and procedures describe how the organization manages high-impact or high-prevalence risks to the safety, health, or well-being of consumers.

6.1.2 Recommendations

The provider of care services should:

- a. implement a proactive crisis management plan to prepare for any emergencies such as natural calamity or pandemics;
- b. have clear guidelines and protocols which helps in minimising any interruptions to care services during any emergencies;
- c. ensure that the strategic risk management objectives include value-added improvements that meet the expectations of the organization's stakeholders;
- d. strengthen the organization's risk management, including conducting risk assessments and audits, developing internal controls, and establishing reporting lines for the early detection and response to deviations in the expected outcomes of the care, fraud and illegal activities directed towards the organization;
- e. ensure legal compliance, including accepting appropriate legal advice, developing, and implementing compliance policies and procedures.

6.2 Prevention and handling of risks to the older person

6.2.1 General

The organization can be confronted with risks directly related to care and support procedures when planning and carrying out care. The organization is expected to identify assess, mitigate, and act on opportunities and risks to the satisfaction, health, and safety of older persons. When opportunities for care services improvement or risks are identified, the organization is expected to find ways to improve the services or mitigate risks wherever operationally feasible.

To assess, plan, and provide effective and safe care and services, the workforce is expected to have the relevant skills, qualifications, and knowledge to assess the needs of individual older persons and understand their needs, goals, and preferences.

6.2.2 Requirements

The provider of care services shall:

- a. establish, implement, and maintain policies and procedures to identify, assess, manage, mitigate, monitor, and report all risks within the provider's scope of responsibility regarding the safety of individual older persons;
- b. establish, implement, and maintain policies and procedures to ensure continuity of care and support covering the basic needs of older persons when exceptional circumstances arise;
- c. ensure that risks related to the safety, health, and well-being of the older person are documented in the plan of care/service so that the safety of the older person is not compromised;
- d. establish, implement, and maintain policies and procedures to ensure that mandatory reporting to external regulatory agencies regarding specific types of incidents/accidents is implemented.

6.2.3 Recommendations

The provider of care services should:

- a. ensure that risks related to the safety, health, and well-being of the older person are assessed, discussed with the older person, and included when planning care. If the risk is a decision made by the older person receiving care, it is respected.

6.3 Prevention and handling of risks on organization level

6.3.1 General

Risk management is the identification, assessment and prioritization of risks followed by coordinated application of resources to minimize, monitor and control the probability and/or impact of unfortunate events or to maximize the realization of opportunities.

The care services organization is expected to have systems and processes that identify and assess risks. If risks are found, the organization is expected to find ways to reduce or remove the risks in a timeframe that matches the level of the risk. It's also expected that the organization identifies and evaluates incidents and 'near misses'. A near miss is when an occurrence, event or omission happens that does not result in harm (such as injury, illness, or danger to health) but had potential to do so. It's also expected that the organization uses this information to improve its performance and how it delivers high quality care services.

The organization can also be confronted with general risks concerning general public health issues such as epidemic/pandemic infections. Factors to consider in assessing risks for continuity of care and support should include contingency plans for ensuring adequate care and support (warm, feed and hydration, medication supply) in the event of an environment incident such as power cut, fire, extreme weather incident (heat/snowed in, flood).