Table of Contents

Background .................................................................................................................................. 1
Guiding Principles of Continuing Care Quality Assurance and Audit ............................................. 2
Summary ........................................................................................................................................ 3
Foundational Components to the Guiding Principles ................................................................ 4
- Working Together to Build a High Performing Health System .................................................. 4
- The Wellness Paradigm ........................................................................................................... 4
- Principles Underpinning the Continuing Care Quality Management ........................................ 5
- Patient First Strategy ............................................................................................................... 5
Literature Review of Guiding Principles for Continuing Care Audit and Assurance .............. 7
Other Jurisdictions Continuing Care Quality Assurance ......................................................... 7
- European Union ..................................................................................................................... 7
- United States .......................................................................................................................... 7
- Ontario ..................................................................................................................................... 8
- Saskatchewan ........................................................................................................................ 9
Auditing Process & Other General Functions .......................................................................... 10
- The Three Lines of Defense in Effective Risk Management and Control .......................... 10
- Supervisory Framework ......................................................................................................... 10
- Quality Assurance Principles, Elements and Criteria ......................................................... 11
- Higher Education Quality Assurance Principles for the Asia Pacific Region [Chiba Principles] ......................................................................................................................... 12
Accreditation and other Health Care System Monitoring ....................................................... 14
- Ten Principles of Quality Improvement for High-Quality Healthcare ..................................... 14
- Australian Council on Healthcare Standards (ACHS) .......................................................... 15
- Accreditation Canada and Canadian Home Care Association: Harmonized Principles in Action ........................................................................................................................................ 18
- Accreditation Canada – Qmentum Program ......................................................................... 20
Bibliography ............................................................................................................................... 22
Guiding Principles for the Future State of Quality Assurance and Auditing in Continuing Care

Background

The purpose of this document is to propose guiding principles for the development of efficient and effective quality assurance functions for publicly-funded continuing care. It considers the overarching paradigms and principles that guide the delivery of continuing care services and the infrastructure that support their delivery.

Guiding principles describe the organization’s beliefs and philosophy pertaining to quality assurance and performance improvement. The principles should guide what the organization does, why and how it does it.

Assurance, in general, is a positive declaration intended to give confidence or provide certainty about something. Quality Assurance is both a client / resident / patient / family-driven philosophy and a set of activities aimed at improving performance through the monitoring, evaluation, and improvement of processes, which focus on preventing problems and maximizing quality of care.¹

In the process of developing the guiding principles, the Continuing Care Audit Working Group has completed a literature review of other jurisdictions’ principles of quality assurance, both specific to health care and in general assurance. The results of this literature review are intended to help inform the development of the principles proposed in this document.

Creating and improving efficient and effective quality assurance functions will align with the key system-level paradigms and principles that provide the foundation for continuing care service delivery. These include:

- The guiding principles outlined in the Government of Alberta’s ‘Working Together to Build High Performing Health Systems’ (2013);
- The principles presented in the Government of Alberta’s report ‘A Foundation for Alberta’s Health System’ (2010); and,
- The strategies presented in AHS’ ‘AHS Patient First Strategy’ (2014)

The foundational components are further outlined beginning on page 4.

¹ Health Quality Council definition of Quality assurance, modified.
Guiding Principles of Continuing Care Quality Assurance and Audit Processes

The nine principles are intended to guide the quality assurance and audit functions for publicly-funded continuing care services. They align with the overarching paradigms and foundational principles of continuing care, and take into consideration the results of the literature review.

A. PERSON-CENTERED: Quality assurance and audit processes encompass and are appropriate to all four domains:
   1. Client / resident / patient receiving accommodation and continuing care services, their families and their communities;
   2. Continuing care health care workers;
   3. Continuing care organizations; and
   4. The Continuing care system.
   These four domains are interrelated and promote mutually reinforcing quality assurance in all parts of the system.²

B. COMMUNICATION: Quality assurance and audit processes operate in the spirit of collaboration and open communication. Communication is timely, clear, concise, and uses common language, definitions and reporting processes. The results of quality assurance and audit processes are appropriately accessible by stakeholders in ways that support clear understanding and analysis.

C. CULTURE/SPRIT: Quality assurance and auditing processes operate consistent with a just culture philosophy to promote continuous quality improvement. A just culture is based on being respectful in how we engage with those involved. A just culture is being transparent in the evaluation processes used, holding our system, ourselves and others accountable and, learning from our mistakes and close calls to improve safety and performance.

D. COOPERATIVELY ENDORSED: Clients / residents / patient and their families can easily understand, trust and accept the quality assurance processes. Key stakeholders, governing bodies and their senior managers, endorse the quality assurance and audit processes.

E. TRANSPARENT & ACCOUNTABLE: Quality assurance and audit processes are conducted in the spirit of transparency and are oriented to the client / resident /

---

Guiding Principles for the
Future State of Quality Assurance and Auditing in Continuing Care

patient experience. Clients and stakeholders understand the processes and their accountabilities.

F. COST EFFECTIVE AND SUSTAINABLE: Quality assurance and audit processes support and promote sustainable, affordable, efficient and effective solutions to build, improve and maintain quality in all aspects of continuing care service delivery. The processes are consistent, efficient, coordinated and streamlined. The quality assurance and audit processes provide value to the client / resident / patient, their family, continuing care health care workers and the continuing care organization.

G. PROACTIVE RISK MANAGEMENT: Quality assurance and audit processes are focused on proactively assessing and monitoring potential risk using standardized tools to support sound predictive judgment, to address right time remediation and quality improvement.

H. PROCESS: Quality assurance and auditing processes follow valid, reliable and consistent approaches so that the process and the results are practical and reliable. Appropriate levels of competent, trained individuals and resourcing to support the approach are maintained.

I. FOCUS ON EXCELLENCE: Quality assurance and audit processes recognize achievements in attaining, maintaining and improving quality of continuing care services to clients.

Summary

The guiding principles for continuing care are intended to steer the quality assurance and audit processes for publicly-funded continuing care services. The people and processes involved in, and outputs of, providing quality assurance should follow the spirit and intent of these principles so that they may effectively contribute to the overall quality of continuing care.
Guiding Principles for the Future State of Quality Assurance and Auditing in Continuing Care

Foundational Components to the Guiding Principles

Working Together to Build a High Performing Health System - Government of Alberta

The Government of Alberta drafted the guiding principles set out in the 2013 Working Together to Build a High Performing Health System to inform the governance of Alberta’s health system. Therefore, they are applicable to the quality and audit services designed to support and promote sustainable, affordable, efficient and functions within Continuing Care:

**Principle 1: Leadership**
Transformational change requires leaders who have a shared vision of what can be accomplished and who work together to bring about needed change. Leaders need to focus on the things that are standing in the way of change. Such leadership is required throughout the partner organizations.

**Principle 2: Partnership**
The key organizations involved in the success of Alberta’s health system are partners working together to improve health outcomes. Each has different roles and responsibilities, but the importance of strong, effective solutions to build, improve and lasting partnerships is understood and demonstrated. The partners are aligned around the strategic and maintain operational plans for health and wellness. Processes and protocols for establishing, maintaining and assessing the effectiveness of these partnerships are in place. Sustainable partnerships are characterized by high degrees of trust that come about from the partners having confidence in and respect for each other.

**Principle 3: Transparency and Accountability**
Partners in the health system are committed to transparency and accountability in the execution of their duties. Governance processes are established, clear, accessible by the public and followed by the partners. The partners understand the importance of accountability to the public for their actions and performance.

**Principle 4: Patient-Centred Focus**
The focus of partners in the health system is always on the clients of the system, whether they be patients, residents or citizens. The impact on the clients of decisions and actions must always be the first consideration.

The Wellness Paradigm, Continuing Care Quality Management Framework - AHS

Continuing Care Services are grounded in a wellness paradigm focused on abilities, strengths, and maintaining independence across a person’s lifespan, and based on the following assumptions:

1. Aging is a normal part of the lifespan;
2. health is defined by individuals themselves in terms of their own unique strengths and challenges, value systems, quality in all aspects of of life, and integral interdependent relationships;
3. individuals are responsible for their own lives and make choices in relation to their own health and wellbeing;
4. individuals with chronic illness, frailty related to aging, or disability can, and do, lead healthy and productive lives;
5. restorative care can influence the wellness and independence of even the most health compromised;
Guiding Principles for the Future State of Quality Assurance and Auditing in Continuing Care

6. those with chronic health conditions usually spend more time in caring and supporting themselves than do the health professionals involved in their formal healthcare services;
7. individuals and their families are capable of learning new skills and acquiring new competencies.
8. family and natural support networks are full partners in care and bring their own strengths and resources;
9. most individuals, families and communities value improvements that increase their competence, enhance control over their lives, and promote their functioning at the highest possible level while remaining in their own home or close to home, as long as possible; and
10. inability to recognize and support people’s self-care efforts encourages unnecessary dependency on formal health care services.

Principles Underpinning the Continuing Care Quality Management - Government of Alberta

The following set of principles is the underpinning for continuing care service delivery, quality assurance and continuous improvement:

• Put people and their families at the centre of their health care – “The only true measures of quality are the outcomes that matter to the individual receiving the care and their family”
• Be committed to quality and safety – “All processes and standards drive towards quality improvement for improved patient outcomes”
• Foster a culture of trust and respect – “Transparency in sharing the journey with all stakeholders inclusive of the public is the key to reporting quality outcome”
• Be focused on wellness and public health – “Fostering the shift in mindset and culture from a focus on illness and treatment to recognizing that a person’s quality of life is determined as much or more by their outlook of wellness and independence”
• Enable decision-making using the best available evidence – “Quality assurance and continuous improvement is embedded in everything we do and is integral part of our daily practice and work”
• Ensure equitable access to timely and appropriate care – “Right care in the right place at the right time will be guided by best practices in quality assurance both nationally and internationally”

Patient First Strategy - AHS

Patient- and Family- Centered Care (PFCC) described in AHS’ Patient First Strategy is commitment ‘to improve health care for Albertans’ by partnering with patients and families. It is built on ‘a foundation of respect, listening, empathy and transparency between healthcare providers, patients and their families’. The four sub-themes developed by AHS in the Patient First Strategy are to further guide the organization and healthcare providers in applying the overarching theme of ‘Everything we do in Alberta Health Services must reflect a Patient- and Family-Centred Care approach’.

3 A foundation for a better health system, Alberta Health, January 2010

The sub-themes are:

**Sub-theme 1: Improve communications**
- Provide patients and families, health-care providers and leaders with ongoing training and education focused on PFCC best practices, including the importance of communication between the health-care provider and patient, between the health-care provider and family, and between health-care providers.
- Further optimize and maximize technology that supports a clinical information system that is easily accessible by health-care providers, patients and families.

**Sub-theme 2: Treat people well**
- Add empathy as an eighth core value to further demonstrate the AHS commitment to treating people well and reinforce to health-care providers its importance when interacting with patients, families and colleagues alike.
- The system supports a focus on the patient and provides environments, policies and procedures that enable care providers to focus on the direct care of patients and families. An example is to actively hire individuals who demonstrate PFCC skills/characteristics, such as active listening, having a history of engaging patients (thereby making patients an active part of their own care team) and treating people well.

**Sub-theme 3: Adopt a team-based approach to care**
- Ensure the PFCC approach is implemented at all points of care and is continuous throughout the health care journey; and provide team-based care centred on the needs and wants of the patient and family. Team-based care will be inclusive of all participants to ensure that the needs of the patient and family are at the centre of all care decisions.
- In order to succeed, PFCC must be kept in the forefront of AHS priorities with efficient and effective strategies, while supported by adequate resources (human, development, infrastructure, and financial).

**Sub-theme 4: Provide better transitions in care.**
- Facilitate the development of a standardized, provincial transition process that recognizes the uniqueness of the patients and families we serve in order to provide the highest quality of care.
- Establish shared accountability between care providers for discharge and transitions.
Guiding Principles for the Future State of Quality Assurance and Auditing in Continuing Care

Literature Review of Guiding Principles for Continuing Care Audit and Assurance

A grey literature review was performed (web searches, government websites, etc.) to survey other jurisdictions’ principles around quality assurance. The review found that there are two types of principles guiding quality assurance functions: high-level principles that set a tone, and lower-level principles that set tone and describe the key criteria for their enactment. We have included examples of each to type as they both present valuable insight.

This literature review focused on:
- Best practices in other jurisdictions in continuing care quality assurance;
- Best practices in auditing processes, including general auditing functions; and
- Accreditation and other health care system monitoring.

Other Jurisdictions Continuing Care Quality Assurance

European Union (high-level principles):
Collected from the ‘Quality Management and Assurance in Long-term Care – European Overview’ – Interlinks

Principle 1: Health care organizations are responsible for operating under a quality management philosophy which includes the implementation of quality management systems. (Netherlands)

Principle 2: The role of assurance services is to support and champion quality improvement. (Finland)

Principle 3: Assurance and audit processes will be conducted in the spirit of transparency, efficiency and efficacy (effectiveness) and be oriented to patient experience. The processes will be based on training, stakeholder involvement, and be results-oriented.

United States (lower-level principles):
Principles of Quality in National Clinical Audits (NCA) – Healthcare Quality Improvement Partnership

High quality National Clinical Audits (NCA) are marked by these ten principles:

Principle 1: NCAs are concerned with promoting change and improvement in clinical practice. Although data are managed and analysed centrally, NCAs should be seen as part of a wider process of quality improvement enacted by local care providers, as the suppliers and users of data, and the utility of the project to local providers must be central to the project’s aims and outputs.

Principle 2: NCA topics should be premised on the significance of the national burden of disease and the cost of interventions, the existence of variation in practice and outcomes and the ability to improve quality of care including reduction in practice variation.

---

Guiding Principles for the Future State of Quality Assurance and Auditing in Continuing Care

**Principle 3:** NCAs collect data which are useable or valuable for a variety of purposes, including locally: patient or career choice, good governance, revalidation, clinical improvement, commissioning and for use by regulators. At the national level, NCA data forms part of a range of information useful to support government policy and healthcare practice in areas such as outcome monitoring, research, regulation, advancing clinical standards and in assisting commissioning.

**Principle 4:** All NCAs should be legitimized through leadership or instigation from a suitable professional body or from government. The choice of the topic and the scope of the project should have been agreed nationally by an appropriate professional body representing clinical interests and views, agreed with the Department of Health where centrally funded, and have appropriate clinical leadership.

**Principle 5:** Patients and/or [care providers] should be involved in the leadership and governance of NCA projects.

**Principle 6:** The role of NCAs is to collect and analyze data for use by a range of stakeholders to improve quality of services. This should be achieved through practical audit design and robust statistical analysis, resulting in the dissemination of high quality, reliable and robust data in a suitably analyzed form at a level of detail appropriate to the care area being measured.

**Principle 7:** NCAs must have sound and transparent governance arrangements and a demonstrated framework for their internal quality improvement.

**Principle 8:** From the outset, NCAs must be structured to deliver clear outputs, which could include reports for a range of audiences –clinicians, commissioners, managers, and patients, for example -in a timely and open and understandable manner and in such a form, and with such information, to enable and support changes and quality improvements to be made.

**Principle 9:** NCA outputs such as reports must be published and disseminated widely, with their findings available to public and professional alike, including online accessible data for those who supply it.

**Principle 10:** Data collected for NCAs is managed effectively with regard to patient confidentiality and remains at all times within the current legal frameworks regarding data management.

**Ontario** (high-level principles):
Ontario’s Ministry of Health and Long-term Care provides guiding principles for healthcare system transformation:

**Principle 1:** Leverage and build on existing strengths and relationships within the ministry, and system-wide.

**Principle 2:** Engage our partners in the co-design and delivery of excellent health care.

**Principle 3:** Prompt resolution of issues which present barriers to integration and effective delivery.

**Principle 4:** Foster transparent accountability and governance.
Principle 5: Use evidence to make decisions for person-centred care with a population perspective.

Principle 6: Create effective pathways to align ministry and stakeholders to become solution focused.

**Saskatchewan** (lower-level principles):
Saskatchewan promotes the use of Lean methodology (Hoshin Kanri) to build, promote implement, manage and monitor quality in all areas of its business. Lean promotes the following principles:

**Principle 1:** *Patient first.*
Identify value from the standpoint of the end customer. All activities should be focused on adding value (and respecting/ meeting legal obligations)

**Principle 2:** *Efficient and effective processes.*
All processes and all steps in the system should be aligned creating and building value. Those that are not, should be eliminated.

**Principle 3:** *Continuous Improvement*
All improvement upon healthcare delivery will be based on measures of quality, safety and client satisfaction and use proven continuous quality improvement methods.
Auditing Process & Other General Functions

The Three Lines of Defense in Effective Risk Management and Control (high-level principles) – Institute of Internal Auditors

The Three Lines of Defense is a generic model for managing and controlling risk. It reflects the following principles:

**Principle 1: Tone from the Top**
Implementation of assurance models should be supported and guided by the organizations governing body and senior management in order to be truly effective.

**Principle 2: Co-ordination of duties between assurance functions**
There should be assignment of specific roles and co-ordination between risk management and assurance groups so that there are neither gaps nor duplication of coverage.

**Principle 3: Effective communication between and within groups**
The assurance function(s) must be able to communicate effectively and have a shared understanding of each other’s work to support a co-ordinate approach to risk management.

**Principle 4: Each type/group of assurance providers has a distinct value**
Each group (line of defense) provides a different level and/or type of assurance and the groups should not be combined if they are to be truly effective.


The Supervisory Framework describes the principles, concepts, and core process that OSFI uses to guide its supervision of federally regulated financial institutions. These principles, concepts, and core process apply to all federally regulated financial institution in Canada, irrespective of their size, and accommodate the unique aspects of their [individual] sectors.

Risk assessment—the fundamental work activity of supervision—is undertaken by following seven key principles:

**Principle 1: Focus on Material Risk**
The risk assessment OSFI performs in its supervisory work is focused on identifying material risk to a FRFI, such that there is the potential for loss to depositors or policyholders.

**Principle 2: Forward-looking Early Intervention**
Risk assessment is forward-looking. This view facilitates the early identification of issues or problems, and timely intervention where corrective actions need to be taken, so that there is a greater likelihood of the satisfactory resolution of issues.

**Principle 3: Sound Predictive Judgment**
Risk assessment relies upon sound, predictive judgment. To ensure adequate quality, OSFI management requires that these judgments have a clear, supported rationale.
Principle 4: *Understanding the Drivers of Risk*
Risk assessment requires understanding the drivers of material risk to a FRFI. This is facilitated by sufficient knowledge of the FRFI’s business model (i.e., products and their design, activities, strategies and risk appetite), as well as the FRFI’s external environment. The understanding of how risks may develop and how severe they may become is important to the early identification of issues at a FRFI.

Principle 5: *Differentiate Inherent Risks and Risk Management*
Risk assessment requires differentiation between the risks inherent to the activities undertaken by the FRFI, and the FRFI’s management of those risks – at both the operational and oversight levels. This differentiation is crucial to establishing expectations for the management of the risks and to determining appropriate corrective action, when needed.

Principle 6: *Dynamic Adjustment*
Risk assessment is continuous and dynamic in order that changes in risk, arising from both the FRFI and its external environment, are identified early. OSFI’s core supervisory process is flexible, whereby identified changes in risk result in updated priorities for supervisory work.

Principle 7: *Assessment of the Whole System*
The application of the Supervisory Framework culminates in a consolidated assessment of risk to a FRFI. This holistic assessment combines an assessment of earnings and capital in relation to the overall net risk from the FRFI’s significant activities, as well as an assessment of the FRFI’s liquidity, to arrive at this composite view.

Quality Assurance Principles, Elements and Criteria (high-level principles) - Scottish Qualifications Authority
The Scottish Qualifications Authority sets the principles for providing quality assurance over academic testing within the national educational system. The quality assurance principles are:

**Principle 1:** The SQA assessment and quality assurance system should be understandable to stakeholders, effectively administered, publicly accountable and cost effective to operate.

**Principle 2:** Qualifications should be accessible to all candidates who have the potential to achieve them.

**Principle 3:** The criteria which define the performance required of candidates for them to achieve qualifications should be appropriate to purpose, explicit and in the public domain.

**Principle 4:** Each unit, course and group award should be unique and necessary, and should comply with the relevant qualification specification.

**Principle 5:** Assessments should be valid, reliable and practicable, and assessment results should be in line with qualification criteria.

**Principle 6:** Qualifications should be offered in centres which have the resources and expertise to assess candidates against the qualification’s criteria.
**Principle 7:** Staff in centres should be provided with effective support in assessing candidates for certification.

**Principle 8:** Responsibility for quality assurance should be devolved to centres where this is consistent with the maintenance of national standards.

**Higher Education Quality Assurance Principles for the Asia Pacific Region [Chiba Principles] (high-level principles) – Asia-Pacific Quality Network**

In 2008, the Asia-Pacific Network\(^5\) produced three sets of principles to inform the quality assurance functions of regions’ higher education systems. The principles are split by internal quality assurance functions, external quality assurance agencies and the common activities to internal and external assurance providers. Quality assurance agencies, in this framework, are inclusive of audit and accreditation. The following is synopsis of those principles:

**Internal Quality Assurance Principles**

**Principle 1:** A quality assurance culture is created, defined, supported and promulgated.

**Principle 2:** Quality assurance aligns with and is embedded within the institution’s unique goals and objectives.

**Principle 3:** Internal quality management systems, policies and procedures are in place.

**Principle 4:** A strategy for the continuous enhancement of quality is developed and implemented.

**Principle 5:** Appropriate and current information about the institution, its programs, awards and achievements is made publicly available.

**Quality Assurance Agencies Principles**

**Principle 1:** Quality assurance activities (at institutional and/or program level) are undertaken on a cyclical basis.

**Principle 2:** Standards and criteria are publicly available and applied consistently.

**Principle 3:** Assessment would normally include:

a. Institutional self-assessment;

b. External assessment by a group of experts and site visits as agreed;

c. Publication of a report, including decisions and recommendations;

d. A follow-up procedure to review actions taken in light of the recommendations made.

---

Guiding Principles for the Future State of Quality Assurance and Auditing in Continuing Care

Quality Assessment Principles (for common activities)

**Principle 1:** Are independent and have autonomous responsibility for operations – judgments should not be influenced by third parties.

**Principle 2:** Written mission statement, goals and objectives are clearly defined.

**Principle 3:** Human and financial resources are adequate and accessible.

**Principle 4:** Policies, procedures, reviews and assessment reports are fully and clearly disclosed to the public.

**Principle 5:** Documentation that states standards used, assessment methods, processes, decision criteria and appeals processes are clear.

**Principle 6:** Periodic review of activities, effects and value.

**Principle 7:** Cooperates with other agencies and key players across (the system).

**Principle 8:** Undertake research and provide information and advice.
Accreditation and other Health Care System Monitoring

Ten Principles of Quality Improvement for High-Quality Healthcare

Principle 1: Dimensions of quality must be relevant to and actionable by appropriate stakeholders.
Dimensions of quality must be compatible with QI to help advance it in all settings and models of care. Although some dimensions are clearly relevant to most stakeholders, it is also important to recognize that some may not be applicable in all circumstances.

Principle 2: Quality improvement must be measurable and lead to desired outcomes.
The results of QI must measure health improvements, stabilization, prevention or minimization with active therapies — including drivers of patient and provider satisfaction.

Principle 3: Quality improvement systems must facilitate the delivery of a continuum of care, providing benefits to patients and providers.
Quality improvement systems must be simple and non-intrusive such that they do not interfere, impede or detract from health professionals’ duties, allowing them to provide services throughout the continuum of care. They must not be another bureaucratic layer.

Principle 4: Patient outcomes and provider services should reflect a culture of safety.
Quality and safety go hand in hand; provider behaviours, team dynamics and patient satisfaction are areas that need attention in practice to ingrain a culture of safety.

Principle 5: Lifelong learning, maintenance of competencies and continuous professional development are integral to the quality improvement process.
Physicians enhance their professional skills in the best interests of patients; the practice environment must be conducive to and supportive of ongoing learning. Leadership throughout the spectrum of education, training, professional development and maintenance of competencies needs to constantly invigorate quality improvement in practice.

Principle 6: Governments should support quality improvement by providing incentives and investment and facilitate its development through collaborative mechanisms.
The primary responsibility of government is to provide support for the health care system by engaging all participants of it. Alignment/collaboration/cooperation across various federal-provincial-territorial-municipal governments will improve the sharing of knowledge.

Principle 7: Collaboration, knowledge exchange, transparency and accountability are critical factors in improving quality.
Inter and intra-professional collaboration, patient-centredness and stakeholder involvement are critical factors to improve clinical practices.

Principle 8: Physicians and other providers should embrace system thinking that advocates on behalf of the community of patients.
The greater good recognizes every one’s part in a health care system that is quality oriented for patients.
**Guiding Principles for the Future State of Quality Assurance and Auditing in Continuing Care**

**Principle 9:** *Physicians and other providers need to be accountable for quality improvement practices recognizing their responsibilities within the boundaries of the greater health care system.*

This is an individual component of accountability that does not abdicate responsibility to a greater system; it strikes a balance of shared accountability thus providing the public with greater confidence in the delivery of high-quality health care. Despite increased emphasis on quality and expanded quality improvement science, Canadians highlight quality of health care among their top concerns.

**Principle 10:** *Physicians and other providers need to actively engage in system refinement to improve quality.*

Physicians who embrace their roles as communicators, collaborators, managers, health advocates, scholars and professionals (Royal College CanMEDs framework roles) lend themselves as leaders in promoting and advocating quality improvement for change and continuous clinical practice refinement.


The Six Principles (and a relevant sampling of the criteria within each principle) are provided below:

**1.0 Quality Improvement:**

Standards are designed to encourage healthcare organizations to improve quality and performance within their own organizations and the wider healthcare system.

1.4 The standards require healthcare organizations to inform the public of:
   - the services they provide and
   - the quality and performance of the services.

1.6 The standards require an approach to quality improvement that:
   - is systematic
   - is continuous
   - is organisation-wide
   - covers all aspects of performance
   - supports innovation
   - incorporates monitoring, including of all high-risk processes and procedures, and evaluation.

1.7 The standards require that key care and service processes and outcomes be measured through the use of:
   - performance indicators
   - patient/service user satisfaction surveys/assessments and
   - other performance measures.

1.9 The standards require the evaluation and analysis of data from performance measurement and its use to improve performance and services.

---


7 Note: A 4th Edition was recently released, but only available for a fee.
2.0 Patient/Service User Focus:
Standards are designed with a focus on patients/service users and reflect the patient/service user continuum of care or service.

2.1 The standards cover the rights of patients/service users to:
• dignity and respect
• privacy
• confidentiality and
• safety and security.

a. The standards require a system for receiving, investigating and resolving patient/service user complaints and concerns in a fair and timely way.

b. The standards require staff to involve patients/service users in their own care and services by:
• respecting their preferences and choices;
• informing them about their options for care and treatment; and
• obtaining their informed consent.

c. The standards require the cultural and spiritual sensitivities of patients/service users and their communities to be recognized.

2.6 The standards require that the assessments of patients/service users:
• are comprehensive
• involve relevant disciplines
• are completed and documented in a timely manner.

2.7 The standards require that individual care/service plans are prepared and documented:
• based on the assessment of patient/service user needs, including the results of diagnostic tests where relevant
• involving the patients/service users and their families
• including the goals or desired results of the treatment, care or service.

2.8 The standards require that health professionals:
• follow the care/service plans
• monitor the progress of patients/service users in achieving the goals or desired results of treatment, care or service
• reassess patients’/service users’ needs when indicated
• revise the care/service plan according to results.

2.9 The standards require that referral, transfer of care, discharge or end of service is planned.

3.0 Organizational Planning and Performance:
Standards assess the capacity and efficiency of healthcare organizations.

3.2 The standards require that, for the positions they hold, staff, independent practitioners and volunteers where applicable, have relevant and current:
   • orientation and training
   • education
   • knowledge
   • skills and
   • experience.

3.6 The standards require healthcare organizations to involve patients/service users, their families, staff and where possible the wider community in planning for the provision of services.

4.0 Safety:
Standards include measures to protect and improve the safety of patients/service users, staff and visitors to the organization.

4.3 The standards require healthcare organizations to have processes for reporting and investigating safety incidents, adverse events and near misses affecting patients/service users, staff or visitors and for using findings to improve services.

4.6 Standards require healthcare organizations to ensure that:
   • relevant safety law and regulations are met
   • the buildings, space, equipment and supplies necessary for the stated services are provided and
   • facilities and equipment are inspected, tested, maintained and updated or replaced in a planned and systematic way.

4.8 The standards require healthcare organizations to have a planned and systematic program for preventing and controlling infections which includes at least handwashing and cleaning requirements.

5.0 Standards Development:
Standards are planned, formulated and evaluated through a defined and rigorous process.

5.1 The need for new or revised standards and priorities are established by seeking the views of potential users, professional, purchaser, provider and patient/service user groups and governments and other stakeholders and using evaluation data from the use of previous standards.

5.5 Government, professional, purchaser, provider and service user interests have adequate opportunity for input into the standards development and revision process through direct representation and formal consultation.

5.6 The scope and purpose of the standards are clear in terms of:
Guiding Principles for the Future State of Quality Assurance and Auditing in Continuing Care

- the type of healthcare organization to which they apply;
- whether they are designed for use by a whole organization;
- what range of services they cover;
- the reason the standards are needed and used.

5.12 Information and education are provided to users and assessors of the new and revised standards to enable interpretation and implementation.

6.0 Standards Measurement:
Standards enable consistent and transparent rating and measurement of achievement.

6.1 There is a transparent system for rating an organization’s performance on each standard, criterion or element.

6.2 Guidelines or other information are provided to assist assessors to rate consistently and healthcare organizations to assess their own performance on the standards.

6.4 The satisfaction of healthcare organizations and assessors with the measurement and rating system is evaluated and results used to make improvements.

Australian Council on Healthcare Standards (ACHS) 8

Accreditation systems are considered to comprise five key elements:
1) Governance or stewardship function
2) A standards-setting process
3) A process of external evaluation of compliance against those standards
4) A remediation or improvement process following the review
5) Promotion of continuous quality improvement

Principles of all ACHS programs
The principles upon which all ACHS programs are developed reflect the characteristics displayed by an improving organization. These five principles can be applied to all aspects of service within an organization.

1) A consumer focus in care provision is demonstrated by:
   - Understanding the needs and expectation of present and potential consumers / patients
   - Ensuring consumers / patients are the priority
   - Evaluating the service from the consumer / patient perspective
2) Effective leadership demonstrates responsibility and commitment to excellence in care provision, quality improvement and performance by:
   - Providing direction for the organization / health service

Guiding Principles for the Future State of Quality Assurance and Auditing in Continuing Care

- Pursuing the ongoing, development of strategies, systems and methods for achieving excellence
- Inspiring and motivating the workforce and encouraging employees to contribute, develop and learn
- Considering proposals that are innovative and creative

3) **Continuous improvement** - management and staff demonstrate how they continually strive to improve the quality of care. Continuous improvement assists the organization / health service through:
   - Looking for ways to improve as an essential of everyday practice
   - Consistently achieving and maintaining quality care that meets consumer / patient needs
   - Monitoring outcomes in consumer / patient care and seeking opportunities to improve both the care and its results.

4) **Evidence of outcomes** - organizations depend on the measurement and analysis of performance. Indicators of good care processes or, wherever possible, outcomes of care, demonstrate a commitment to maintaining quality and striving for ongoing improvement by:
   - Providing critical data and information about key processes, outputs and results
   - Reflecting those factors that lead to improved health and/or quality of life for consumers / patients or to better operational performance.

5) **Striving for best practice** - the organization compares its performance with, or learns from, others and applies best-practice principles. Organizations might demonstrate their efforts through:
   - Discovering new techniques and technologies, and using them to achieve world-class performance
   - Learning from others to increase the efficiency and effectiveness of processes
   - Improving consumer / patient satisfaction and outcomes.

Accreditation Canada and Canadian Home Care Association: Harmonized Principles in Action

By participating in Accreditation Canada’s Qmentum program, home care organizations demonstrate their commitment to following the CHCA's Harmonized Principles and to providing safe, high quality services for all Canadians:

**Harmonized Principle 1: Client-and Family-Centred Care**
Clients and their caregivers are at the centre of care provided in the home.

**Harmonized Principle 2: Accessible Care**
Canadians have equitable, appropriate, consistent access to home care, and are fully informed of the care and services options available to them.

**Harmonized Principle 3: Accountable Care**

---

Home care is accountable to clients and their caregivers, providers and the health care system for the provision and ongoing improvement of quality care.

**Harmonized Principle 4: Evidence-Based Care**
Knowledge that is grounded in evidence is used as the foundation for effective and efficient care provision, resource allocation and innovation.

**Harmonized Principle 5: Integrated Care**
Home care facilitates the integration of care across the continuum of health care and with community and social services; care is complementary, coordinated and seamless with a focus on continuity for the client.

**Harmonized Principle 6: Sustainable Care**
Home care contributes to the sustainability of an integrated health system by increasing efficiencies and delivering cost effective care.

**Accreditation Canada – Qmentum Program**[^10]
The Qmentum program supports organizations to adopt principles and implement practices that exemplify a client- and family-centered approach to service delivery. Fostering culture change at all levels is fundamental to success. Principles guiding client-centered work include:

- Dignity and Respect
- Information Sharing
- Partnership and Participation
- Collaboration

The client and family centered approach is exemplified within the eight quality dimensions that serve as the foundation for quality within all Accreditation Canada standards (see next page).

Dimensions of Quality - Accreditation Canada

- **Safety**
  - Keep me safe

- **Client-Centred Services**
  - Partner with me and my family in our care

- **Worklife**
  - Take care of those who take care of me

- **Efficiency**
  - Make the best use of resources

- ** Appropriateness**
  - Do the right thing to achieve the best results

- **Accessibility**
  - Give me timely and equitable services

- **Population Focus**
  - Work with my community to anticipate and meet our needs

- **Continuity**
  - Coordinate my care across the continuum
Bibliography

Foundational Components to the Guiding Principles


Other Jurisdictions Continuing Care Quality Assurance

European Union


United States


Ontario


Guiding Principles for the Future State of Quality Assurance and Auditing in Continuing Care

Saskatchewan


Auditing Process & Other General Functions


Accreditation


