CENTRE PAPER — HANDBOOK

Health Service Accreditation — An International Overview

Ingrid Sketris
Administrative Resident
Quality Assurance Programme
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Dr Ingrid Sketris October 1988

This publication was completed while Dr Sketris was on sabbatical leave from the College of Pharmacy, Dalhousie University and the Victoria General Hospital, Halifax, Nova Scotia, Canada.

Foreword

This handbook is intended as an introduction for managers and professionals to the concept of health service accreditation as it exists in a number of countries with developed health care systems. The models described are not intended as a blueprint for a UK system; what they offer are established working models for organisational audit and as such it is hoped that they may provide a starting point for a discussion of the applicability of a national standard setting exercise in this country.

Tessa Brooks
Director, Quality Assurance Programme.

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Introduction

To provide a 'good quality' service is the shared objective of all those concerned with the delivery of health care, whether they are professionals responsible for individual clinical care or managers responsible for the organisational framework within which that care is made available. While agreement about the goal is comparatively easy, the concept of quality and therefore of what constitutes a good quality service proves elusive and difficult to handle. The most authoritative approach in the UK is still that offered by Robert Maxwell in 1984[56] in which he defines quality as having the following six dimensions:-

- APPROPRIATENESS: the service or procedure is what the population or individual actually needs;
- EQUITY: a fair share for all the population;
- ACCESSIBILITY: services are not compromised by undue limits of time or distance;
- EFFECTIVENESS: achieving the intended benefit for the individual and for the population;
- ACCEPTABILITY: services are provided such as to satisfy the reasonable expectations of patients, providers and the community;
- EFFICIENCY: resources are not wasted on one service or patient to the detriment of another.

While this definition is valuable in developing a conceptual framework for quality, it is less helpful in the context of defining a 'good' service at operational level. However, there is a wide and increasingly co-ordinated framework of mechanisms loosely categorised as quality assurance techniques, which can help the service move towards the achievement of quality. These techniques vary from the clinical/technical (e.g. clinical audit, and the recent Confidential Enquiry into Peri-operative Deaths is an excellent example of this) through the managerial (performance indicators) to the consumer/behavioural (consumer feedback techniques). In some senses, all are concerned with the measurement of the 'actual level of services rendered, plus the efforts to modify when necessary the provision of these services in the light of the result of the measurement'[89]. Central to any definition of quality and to quality assurance therefore, is the acceptance that it implies 'conformity to specified requirements' [27] which in turn implies the design of standards against which measurement can take place.

The National Health Service has started down the long road to standard setting in clinical care, in professional education and for the organisational framework

within which health care delivery takes place: indeed it has been doing so since the inception of the NHS in 1948 (see Appendix I).

However, in spite of the many efforts dealing with quality assurance, a comprehensive system for comparing health services delivery systems with national standards does not exist in the United Kingdom. The system is fragmented and the objectives and standards for the health service are not always explicit. This point was made in the Griffiths Report, in which it was stated 'Whether the NHS is meeting the needs of the patient and the community and can prove that it is doing so, is open to question'[37].

Accreditation

Accreditation is a method which is used to address the issues of evaluating the quality of health services provided. It is the 'professional and national recognition reserved for facilities that provide high-quality health care. This means that the particular health care facility has voluntarily sought to be measured against high professional standards and is in substantial compliance with them' [48]. It differs from both registration and licensing in that it is not a statutory but a voluntary system [38]. Essentially all accreditation systems share the same elements:

1. An accreditation board is constituted of representatives of professional and health care organisations and in some countries of government and consumer interests.

2. Comprehensive standards are developed which reflect the current practice in services and these are extensively reviewed by practitioners with expertise in the area.

3. Surveyors are chosen and trained to apply the standards to a specific health care service. This involves site visits by the surveyors who then make recommendations for improvement and finally make a recommendation to the board on whether or not to grant accreditation.

Some pilot accreditation surveys have been carried out in the UK. For example, in two health districts these were carried out in conjunction with experienced surveyors from the United States [57]. The survey instrument was not transferred literally from that used in the United States but open ended questions were developed to assess both clinical and nonclinical departments. The surveys lasted approximately three days and the surveyors were generally well received. Recommendations that were made from the experience of these pilot surveys suggested that a system designed to assess the quality of health care should contain the following elements:

'1 The system should be voluntary

2 Surveys should be comprehensive in intent

3 Survey teams should be multidisciplinary, based on the principle of peer review

4 Surveying methods, approaches and standards should be stated openly, for public scrutiny and challenge' [57]

The specifics of the systems operating in other countries are discussed in detail in the paper which follows. The information was obtained from the published literature (using the online DHSS-DATA database (1983—1985) and Health Line (1975—1987)) and from interviews and written communication with professionals who have been involved with the accreditation system in other countries. This overview does not attempt to be comprehensive nor does it provide an evaluation of the different models, but offers the reader information about why these systems developed in the way in which they did and how they function at the present time. The accreditation systems in these countries developed differently according to the existing organisation for the delivery and funding of health care and the cultural context in which that care was made available. None of these systems would be likely to be directly transferable to the UK; however, they can provide useful lessons to the UK should it choose to embark on a comprehensive system of standard setting at national level.

Tessa Brooks
Director, Quality Assurance Programme

Accreditation in the United States

Historical Background

The accreditation process in the United States was born of a concern about the quality of care on the part of the American College of Surgeons. In 1915 there was a requirement for fellowship applicants to submit medical records of cases for evaluation. Examination of these records showed that even in well known hospitals, clinical records were poor and did not allow determination of clinical competence[79, 87]. This recognition led to a conference of physicians and hospital administrators who met to define and endorse minimum standards for hospital records and organisation to ensure good patient care[87]. In 1917 a compilation of minimum standards was published[59] and the Hospital Standardisation Programme came into being in 1918. These initial standards were one page in length[79]. The programme, which was voluntary, was financed by the American College of Surgeons and had approved 3,400 hospitals by 1952[87]. The increasing number of hospitals wishing to be accredited, the cost of the process and the increasing complexity of care led to the formation of the Joint Commission on the Accreditation of Hospitals (JCAH)[68]. In 1952, the American College of Physicians, American Hospital Association, American Medical Association and the Canadian Medical Association (which left in 1959 to form its own programme) joined the American College of Surgeons to form the JCAH[2]. The American Dental Organisation joined in 1979 [32]. In 1981, a public member was added to provide a consumer input[73]. This member is appointed annually by the rest of the Board[79]. The name has since changed to the Joint Commission on Accreditation of Health Care Organisations (JCAHO) and the organisation is referred to as the Joint Commission[88].

Following the introduction of Medicare — Medicaid in 1966, the government became increasingly concerned with utilisation review, particularly as it related to unnecessary hospitalisation or unduly long hospital stay. Congress determined that in order for hospitals to participate in these programmes, they must meet specified standards regarding facilities, staff and administration[47]. JCAHO accredited hospitals were deemed to meet these standards. In 1970, a consumer group challenged in the courts the authority of the federal government to rely on the standards of a private agency (JCAHO); the suit was never tried because in 1972, amendments to the Social Security Act were passed to create a mechanism for governments to validate the reliability of JCAHO's accreditation[68].

The government also continued to monitor the quality of care. In 1985, the Consolidated Omnibus Budget Reconciliation Act (COBRA) gave the PROs (the

federal government's Medicare peer review organisations) the power to deny payment of costs if care was found not to comply with standards. At present the penalty for providing care that does not comply with standards is removal of the hospital from the Medicare programme[15]. In 1986, the Health Care Quality Improvement Act legislated for the collection and reporting of all incidents of medical malpractice which provided further motivation for hospitals to assure quality of care[41]. Plans also include the development of an interactive computer database between individual hospitals so that hospitals would be able to make comparisons of their performance[65].

The Joint Commission is attempting to move from examining structure and process criteria to measuring outcomes. Task forces are being formed to develop clinical indicators of outcome which should be pilot tested in 1988 and 1989 and used in accreditation surveys in 1990[41].

In the 1960s, the American Group Practice Association began to discuss the establishment of a national accreditation process for medical group practices and the Accreditation Association for Ambulatory Health Care Inc (AAAHC) was formed in 1975[10].

Structure

The Joint Commission is a voluntary non governmental, non profit-making body which is owned by the American Medical Association, American Hospital Association, American College of Surgeons and American College of Physicians. Corporate members include:

American Medical Association	7
American Hospital Association	7
American College of Surgeons	3
American College of Physicians	3
American Dental Association, and	1
a public member [73].	1

In 1989 the number of members from the public sector will increase to three bringing the total membership up to 24.

The 22-member board of commissioners meets three times a year. Professional and Technical Advisory Committees have been set up to develop standards and conduct accreditation surveys for specific areas[73]. The Joint Commission offers the following accreditation programmes:

Accreditation Programme for Ambulatory Health Care (1975)
Accreditation Programme for Hospice Care (1983)
Accreditation Programme for Long Term Care (1965)
Accreditation Programme for Psychiatric Facilities (1970)
Hospital Accreditation Programme (1952).

The accreditation programme for ambulatory health care surveys such services as:

- ambulatory surgery centres
- community health centres
- family practice centres
- health maintenance organisations.

The accreditation process for home care services is scheduled to begin in 1988. The JCAHO has a staff of approximately 650 employees of whom between 250 and 275 are field surveyors [32] [44].

The membership of the Accreditation Association for Ambulatory Health Care includes representatives from the following organisations:

American Academy of Facial Plastic and Reconstructive Surgery
The American College Health Association
The American Group Practice Association
Federated Ambulatory Surgical Association
Medical Group Management Association
National Association for Ambulatory Care
National Association of Community Health Centres, Inc.
Outpatient Ophthalmic Surgery Society
Society for Office Based Surgery
Group Health Association of America, Inc [10]

Other voluntary accreditation agencies include The American Osteopathic Association, The College of American Pathologists, The Commission on Inspection and Accreditation and The Commission for Accreditation and Rehabilitation Facilities.

Financing

Initially, the cost of the accreditation process was borne by the American College of Surgeons and subsequently by the four founding members of the JCAHO[59]. Since 1964, hospitals have been charged survey fees which are related to the cost of JCAHO operations and which currently account for 60% of total income [59, 43]. The balance is derived from education, publications and contracts (eg. from the Health Care Financing Administration and the WK Kellogg Foundation to study the development of hospice care). The JCAHO had a budget of $35 million[34] in 1988. In order to reduce costs and work more efficiently, the Joint Commission co-operates with other organisations. For example, the approval of laboratories by the College of American Pathologists is recognised by the Joint Commission for accreditation purposes[42].

The Process of Standards Development

Standards have been developed in the areas outlined in Appendix II[43]. An accreditation standard is found in Appendix III.

The Standards—Survey Procedures Committee of the JCAHO's Board of Commissioners is responsible for developing, reviewing and revising standards. The committee membership includes hospital administrators, practising physicians and other health care professionals. Standards are sent for comment to specialty health care organisations, consumers, government and individuals with expertise in the area; individual professionals are also encouraged to submit comments. For example, for one proposed standard over 4000 drafts were sent out for comment to individuals working in the field[42]. The standards are published annually in the following standards manuals:

The Accreditation Manual for Hospitals

Consolidated Standards Manual for Child, Adolescent, and Adult Psychiatric, Alcoholism, and Drug Abuse Facilities and Facilities Serving the Mentally Retarded/Developmentally Disabled

Long Term Care Standards Manual

Ambulatory Health Care Standards Manual

Hospice Standards Manual

The AAAHC publishes its standards in the *Accreditation Handbook for Ambulatory Health Care.*

The Accreditation Process

In order to apply for accreditation by the Joint Commission, hospitals must meet a number of requirements. These include location, control or ownership in the United States or one of its states, territories or possessions, possession of current licenses required by government authorities and provision of specified services [43]. In the first instance, the hospital completes an Application for Survey and pays a nonrefundable processing fee. The hospitals are sent a Hospital Survey Profile (HSP) two to three months prior to the visit of the accreditation team, which they return. This document helps determine the length of the accreditation survey and the composition of the survey team. The hospital is informed of the date for accreditation four to six weeks in advance. The survey team varies according to the type of facility to be surveyed but generally includes a physician, nurse, and administrator, but surveyors with expertise in a particular area (e.g.

rehabilitation medicine or laboratory medicine) may be added[73, 43]. Initially the survey team members have a training session and then are attached to existing teams for several weeks. Every year they attend a surveyor conference and also receive monthly bulletins to update them[42]. The salary for a full-time medical surveyor is approximately $50,000 per annum plus expenses, slightly less for a nursing or administrative surveyor.

The surveys last from two to four days depending on the size and type of the hospital. The basic charge is made on a graduating scale and may range between $5,572 and $45,000. Different pricing codes apply depending upon the accreditation manual in use. The survey team examines various documents and holds interviews with hospital staff. The hospital is required to post, in a public place, an announcement of the survey date and offer the opportunity for members of the public to obtain an interview with the survey team. The surveyors and a representative (or representatives) from the hospital attend these interview sessions[43]. For particular programmes, consultant surveyors may also be sought from amongst practising physicians, surgeons and anaesthetists.

The surveyors assess and report the level of compliance with standards using the following rankings:

1. Substantial compliance, indicating that the hospital consistently meets all major provisions of the standard or required characteristic.

2. Significant compliance, indicating that the hospital meets most provisions of the standard or required characteristic.

3. Partial compliance, indicating that the hospital meets some provisions of the standard or required characteristic.

4. Minimal compliance, indicating that the hospital meets few provisions of the standard or required characteristic.

5. Noncompliance, indicating that the hospital fails to meet the provisions of the standard or required characteristic.

6. Not applicable, indicating that the standard or required characteristic does not apply to the hospital [43].

The visit of the survey team concludes with a "summation" conference with senior hospital staff.

The Joint Commission staff (survey report analysts) evaluate the results of the survey, the recommendations of the survey team and other relevant information and make a recommendation on the accreditation status to the Accreditation Committee of the Board of Commissioners. If the recommendation is to withhold accreditation, the hospital is given notice of the proposed recommendation and an opportunity to discuss areas of noncompliance. The results and recommendations of the survey are provided in confidence to the

hospital. Processing takes about 90 days[73]. The Joint Commission provides information on the accreditation status of the hospital and the accreditation history of a hospital on request.

The performance of the surveyors is ongoing and is evaluated through peer review, the analysis of data from surveys, and feedback from those managers whose health services have been surveyed.

Accreditation Status — Incentives and Sanctions

Three recommendations may be made regarding accreditation status. A hospital may be accredited for three years (with or without certain contingencies), the accreditation decision may be deferred pending a correction of deficiencies or the hospital may be denied accreditation. If a surveyor reports a finding that may endanger public or patient safety, the president of the JCAHO will recommend that accreditation be denied and this action will be reported by telephone and in writing to the hospital's chief executive officer and in writing to the appropriate governmental authorities. If the hospital is accredited with a contingency, the Joint Commission monitors progress in the area of deficiency with the expectation that full compliance will be achieved within the time limits established by the Accreditation Committee. Hospitals are monitored by either submitting progress reports to the Joint Commission or having an on site visit focused on the area of concern[43].

Accreditation status is not the sole criterion for determining whether a hospital is permitted to operate (licensing is a separate process in some states) or whether it will receive reimbursement from Medicare and Medicaid[73]. However, accreditation allows participation in Medicare programmes without an annual Medicare survey. There are agreements between the Joint Commission and about 40 states whereby accreditation may fulfill all or part of the requirements for state licensure[82]. Some insurance carriers are influenced by the Joint Commission or AAAHC's accreditation decisions in payment of claims. Other incentives for accreditation include attracting patients, hiring professionals and guarding against law suits. Professional liability insurance carriers may consider accreditation decisions in evaluating organisations who apply for insurance.

Additional Services

An education division organises approximately 150 seminars and workshops related to various aspects of accreditation each year. Television programmes on topics of interest are presented through a hospital satellite network. Members of a speakers' bureau are available to speak on various aspects of the work of the Joint Commission[65]. The division also publishes a monthly newsletter *Perspectives*, with information about the standards and accreditation process and

a monthly journal, *Quality Review Bulletin*, which discusses quality assurance in general[82].

Evaluation

The Joint Commission is the largest accrediting body in the US, dealing with 5119 general hospitals (84% of the country's hospitals), 1306 nursing home and other long term care facilities and approximately 2000 other types of facilities [44]. The evaluation process has been a key factor in effecting a number of changes including the improvement of the medical staff organisation, granting of privileges to physicians to practice in the hospital and the organisation and content of medical records. However, there are concerns regarding the quality of accredited hospitals. In one accredited hospital the Professional Services Review Organisation (PSRO) was considering stopping the hospital's participation in Medicare. In another, a major medical malpractice suit occurred[47].

Accreditation is an alternative route to licensing in some states, hence lack of accreditation is associated with serious consequences and for this reason the Joint Commission rarely refuses accreditation. Approximately 2% of hospitals are refused accreditation[47] [79].

Several reports have examined the compliance of hospitals with accreditation surveys. One report in 1982 examined the compliance of 1,155 hospitals surveyed with the nursing standards set out in the *Accreditation Manual for Hospitals*. The items generating the most recommendations dealt with nursing care plans and patient education[51]. Another report of 1401 hospitals surveyed in 1984 found that 17 of the 20 most frequently occurring contingencies dealt with deficiency in quality assurance programmes conducted by medical staff[52]. A study in New York City compared public and private hospitals and found very little difference in compliance with standards[40].

The use of full-time surveyors has been criticised because of their lack of clinical credibility. The emphasis on documentation and process criteria rather than outcome measures has also been criticised[32].

Accreditation in Australia

Historical Background

Accreditation in Australia came into being in 1960 with the establishment of a joint committee on hospital accreditation. This committee, which included representatives from the Australian Medical Association (NSW Branch) and Australian Hospital Association (Victoria Branch), was inactive until 1973 when the federal government provided a grant from the Hospital and Health Services Commission which allowed for the appointment of an executive director in February of that year. The organisation was subsequently renamed the Australian Council on Hospital Standards (ACHS),[7, 61, 60] now renamed the Australian Council on Health Care Standards (ACHCS). The first survey was carried out in October 1974, in the state of Victoria. New South Wales joined in its activities in 1978, South Australia in 1978, Tasmania in 1983 and Western Australia in 1984, [74] so that today only the state of Queensland does not participate in the accreditation programme.

Structure

The ACHCS is a non-governmental non-profit organisation[71, 50]. The members of the Council are drawn from the health professions, hospital administration, government, the private hospital sector and from the general public. The membership of the council is made up of nominees from:

Hospital Associations	— Australian Hospital Association — Australian Private Hospitals' Association
Physicians	— Australian Medical Association — The Royal Australasian College of Surgeons — Royal Australian College of General Practitioners — Royal Australasian College of Physicians — Royal Australian College of Obstetricians and Gynaecologists
Administrators	— Royal Australian College of Medical Administrators — Australian College of Health Service Administrators
Nurses	— Royal Australian Nursing Federation
Allied Health	— Australian Council of Allied Health Professionals
Government	— Federal Department of Veterans' Affairs

— Department of Community Service and Health
— New South Wales Department of Health
— South Australian Department of Health
— Western Australian Department of Health
— Health Department of Victoria

Consumers — A consumer representative

The consumer representative is appointed by council. The councillors are nominees, not representatives of their organisations. The full council meets four times a year while the executive committee of 8 members meets every 4-6 weeks[50].

The staff of the ACHCS initially comprised an executive director and secretary; in 1978 a project officer was appointed[31]. The ACHCS Education and Resources Unit has three professional staff[8].

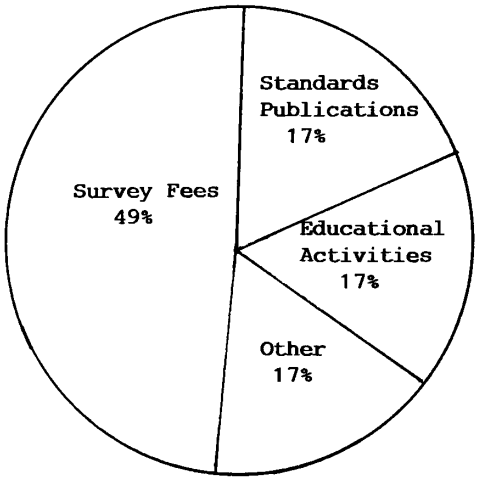
Financing

Although the accreditation scheme initially received funding from a Commonwealth grant and the WK Kellogg Foundation, it is now largely self-financing, earning revenue from accreditation fees paid by hospitals surveyed, seminar workshops, and the sale of publications[61]; the majority of its funding deriving from the fees received by performing accreditation surveys[50]. In 1986/87 a profit of $A 38,348 was made[6].

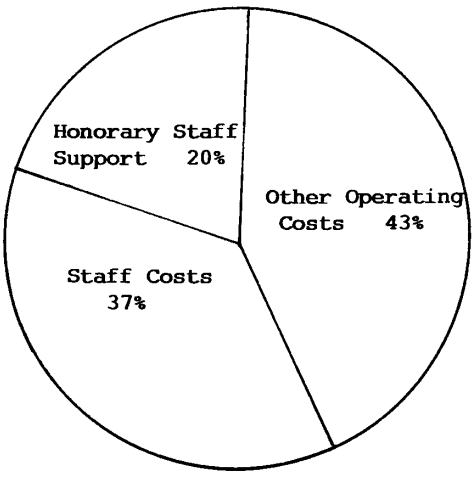
The WK Kellogg Foundation provided grant support, which helped the development of the accreditation programme[31]. The Foundation also assisted in providing Australian Medical Association/Kellogg Fellowships which allowed twelve practising hospital doctors to view hospital accreditation and medical evaluation in North America[93]. A request for a grant from the central government for an accreditation procedure for day surgeries and facilities was submitted in 1986. It was estimated to cost $A 60,000 to start up[74].

Figure 1
Australian Council on Health Care Standards — Income and Expenditure 1987

INCOME



EXPENDITURE



The Process of Standards Development

The areas in which standards have been developed by the ACHCS are found in Appendix II[7]. The standards are developed by a subcommittee of the ACHCS, the Standards Committee, with suggestions from practitioners in the field. The subcommittee is co-ordinated by a member of the ACHCS staff[50]. A draft of the standards is circulated to appropriate professional organisations for comment, after which the Committee produces a final version for publication in the form of *The Accreditation Guide, Standards for Australian Health Care Facilities* which is published annually with revision to a number of sections each year[75]. The standards are developed so that they apply to public and private, small and large facilities. A special guide for long term care facilities has also been developed, [5] as have standards for free standing day procedure facilities and for community health services [6].

The principles of the standards are that they:

'1. reflect essential guidelines that every facility applying for accreditation should meet

2. relate as directly as possible to the quality of care and to the quality of the environment in which care is provided

3. represent a consensus on currently accepted professional practice

4. state objectives rather than mechanisms for meeting objectives

5. be reasonable and surveyable.' [7]

An example of an ACHCS standard is given in Appendix IV.

In addition to the standards which employ structure and process criteria, the ACHCS is working with the Royal Colleges to develop clinical outcome criteria [6].

The Accreditation Process

Hospitals apply to be accredited 6-12 months in advance of the expected date of the accreditation survey. Initially the hospital receives information about the process and an application form which it returns with the fee and confirmation of the survey dates. Three months before the survey, a questionnaire is sent to hospitals to help to identify areas of deficiency[61]. The questionnaire is returned and distributed to surveyors one month before accreditation. Surveys are conducted by an on-site visit to the hospitals; the length of the survey varies from one day (for hospitals under 30 hospital beds) to 5 days (for hospitals over

751 beds) [7]. The cost of the survey is $A 2,400 per day using a three person survey team.

The survey team is composed of an administrator, a physician and a nurse; at least one member of the team is from an institution of similar size or type. (In large teaching or referral hospitals, a clinician may be added to the survey team). The surveyors are full time practitioners in the field and seen as peers[16]. They do not receive payment for their services if they are employees, but those who are self-employed may receive an honorarium. Surveyors attend a yearly two day training workshop and receive the ACHCS newsletter. They are trained in interviewing and report writing techniques[60, 31]. As of March 1988 there were 188 surveyors of whom 51 were administrative, 9 medical clinician, 46 medical administrative and 57 nurse surveyors. The category of surveyor for the remaining 25 was unspecified[6]. Senior surveyors in each state are preceptors to other surveyors.

The survey team examines medical records, reviews the hospital's statistics, minutes of committee meetings and reports, interviews staff members and inspects the hospital's facilities [71, 16]. The accreditation survey is designed as a check list, with space for comments [60]. At the end of the survey, a summation conference with senior hospital staff members takes place to discuss findings and clarify relevant issues. The report is then completed and submitted to council [58].

The survey reports include compliance with standards, commendations, recommendations for improvement, and a recommended accreditation status. The report is distributed to councillors who vote on the appropriate accreditation status. Thereafter the decision and report is confidentially sent to the facility. Notification is usually given within three months of the survey [6]. Facilities which are granted accreditation obtain an accreditation certificate. The chief executive officer of the hospital completes a Survey Report Assessment Form which is returned to the council [31].

Accreditation Status — Incentives and Sanctions

Three recommendations regarding accreditation may be made. These are for three year full accreditation, a one year accreditation and the granting of consultative status. In the case of one year accreditation, most of the standards have been met but there are some deficiencies. Such hospitals will be required to be resurveyed in one year and to obtain full accreditation at resurvey [61]. They cannot receive a one year accreditation twice in a row. Hospitals receiving consultative status have not met sufficient standards to receive accreditation [61]. They are resurveyed when recommendations are implemented [16].

All State Departments of Health (except for Queensland) encourage their hospitals to participate in the accreditation programme. Hospitals seek

accreditation as a mechanism for self-evaluation, to attract patients to the private sector and to demonstrate high standards of care to the public [35]. Lack of accreditation status does not directly affect government funding or certification of physician training programmes. Insurance reimbursement is generally independent of accreditation status [29]. However, some health funds have introduced a $10.00 per day supplement for patients treated in a private hospital which has been accredited [6].

Additional Services

In 1987, an Education and Resource Unit was formally established which provides education programmes (eg. on the process of accreditation and quality assurance), an advisory service to assist in the programmes, and also maintains a speakers bureau [8]. Both publications and audiovisual programmes related to accreditation and quality assurance have been prepared.

Evaluation

By 1984, 25% of all hospitals had been surveyed. Larger hospitals were more likely to have been surveyed than small ones, with 74% of hospitals in the 200-500 bed category having been surveyed. In New South Wales andVictoria, 84% of all public hospital beds had been surveyed. About one quarter of private hospitals and 37% of private hospital beds had also been surveyed [74].

A three-year independent evaluation of various aspects of the accreditation programme in NSW was conducted by the School of Health Services Administration at the University of New South Wales, using the case study approach and questionnaires [31]. Attitudes to accreditation were surveyed by the use of questionnaires to chief executive officers, directors of nursing and, in large hospitals, medical superintendents [30]. One hundred and forty three respondents were surveyed from hospitals who had applied for accreditation and 139 from those who had not applied. The perceived benefits of the accreditation programme to hospitals which had applied for accreditation and the percentage of respondents who perceived the benefit are found in appendix V. Hospitals were generally satisfied with the visit of the survey team and the resulting report. Many respondents felt that the length of survey visits should be increased and some that more attention should be paid to the paramedical services. The process of preparing for accreditation was felt to be extremely valuable; [60] the accreditation process itself was seen primarily as a catalyst for change [16] and in helping overcome staff resistance to change.

In a case study evaluation of 23 hospitals over a 2 year period, a comparison was made between hospitals which had or intended to apply for accreditation (hospitals with contact with ACHCS) and those which had not applied for accreditation [29]. The study found that many changes occurred during preparation for the survey: for example these hospitals revised organisational

charts, job descriptions, policy and procedure manuals, while committees ensured that their minutes were recorded.

Hospitals in contact with ACHCS were more likely to have a systematic approach to decision making, a large number of committees, a more formalised medical structure and more clinical review processes in operation such as infection control committees and tissue audits. Library services were more likely to have improved, and policies regarding safety matters, physical hazards and fire and accident prevention were more likely to have been developed and implemented. However, not all aspects of the evaluation of the accreditation process were positive. Some hospitals felt that the work, time and money involved for the survey visit were not worth the benefits derived. Some felt that the process was used by hospital staff to achieve their objectives and the resultant recommendation was made by staff rather than surveyors. Few hospitals had a formal mechanism to evaluate patient satisfaction. The functioning of the board and delineation of medical staff privileges were not found to have been affected by accreditation.

The effect of accreditation on nursing services has also been studied [30]. Forty-seven consecutive reports written in 1978 and 1979 were analysed and Directors of Nursing and other senior staff members from 23 hospitals were interviewed. Hospitals included those which had applied, were intending to apply or had not applied for accreditation. The interviews suggested that hospitals in contact with ACHCS increased the representation of nurses on selected committees (eg. Infection Control), and introduced nursing histories, progressive nursing notes, nursing care plans, nursing audits, patient dependency ratings and an organised system of continuing education.

In 1979, an analysis of 100 accreditation survey reports found that 57% had an adequate medical staff structure, 60% had adequate medical records and 22% had a peer review or quality assurance programme [71].

It would appear from a consideration of accreditation over its first decade of functioning that standards have improved considerably. For example, the number of hospitals found to be not satisfactory in the medical staff organisation area decreased from 43% in 1979 to 11% in 1983, and in the quality assurance/clinical review area from 78% in 1979 to 33% in 1983. Other examples given of areas in which services have improved are the keeping of medical records, pharmacy drug control systems and drug administration policies, and compliance with electrical safety standards [4].

In 1987, of 51 public hospitals which applied for accreditation, 33 received a 3 year award, 4 a one year and 1 consultative status; 13 are awaiting a decision. Of the 39 private hospitals seeking accreditation, 23 received a 3 year award, 5 a one year, 2 consultative status and 9 are awaiting decision [6].

The cost of implementation of recommendations of accreditation is difficult to ascertain. One accreditation survey in a large hospital in Victoria made a total of 38 recommendations for improvement of services, of which 36 had no cost implications [1].

Accreditation in Canada

Historical Background

In 1919, because of a deficiency in the organisation of medical records and the information contained in them, the American College of Surgeons, with the support of the American Hospital Association and the Catholic Hospital Conference, investigated the medical records kept by approximately 240 hospitals of various types in Canada and the United States. Dr McEachern, the first director of the 'hospital standardisation programme' was a Canadian; hence Canada has been involved since the beginning of the American programme and American health care standards were used in a collaborative procedure until 1958 [90, 49]. In 1952, representatives of the Canadian Medical Association, Canadian Hospital Association, the Royal College of Physicians and Surgeons of Canada and L'Association des Medecins de Langue Francaise met to establish the Canadian Council on Hospital Accreditation (initially called the Canadian Commission on Hospital Accreditation). In 1958, the Secretary of State in Canada gave the Canadian Council on Hospital Accreditation (CCHA) its charter with responsibility for accrediting health care organisations [90]. The federal government has also been directly involved in quality of care issues. In 1972 it convened a Federal Provincial Subcommittee on Quality of Care and Research which drew up guidelines for various special services and has continued to update these [55]. The province of Ontario developed its own accreditation programme for local official health agencies with the formation of the Ontario Council on Community Health Accreditation (OCCHA) in 1981 [66].

Structure

The CCHA is a non-governmental, not-for-profit, voluntary organisation. It has a council made up of national health organisations with 14 board members nominated as follows [92]:

Canadian Medical Association	— 4
Canadian Hospital Association	— 5
Canadian Nurses Association	— 2
Royal College of Physicians and Surgeons	— 2
Canadian Long Term Care Association	— 1

One representative each of the federal and provincial governments is given observer status on the Board. There are five committees of the board: executive and finance, orientation and planning, survey and award, standards and the CCHA advisory committee which was constituted by the Board in 1986. It is composed of representatives of health care organisations with a vested interest in the accreditation standards who are not members of the board. Currently it has representatives from the Canadian Physiotherapy Association, the Canadian Dietetic Association and the Canadian Association of Gerontology.

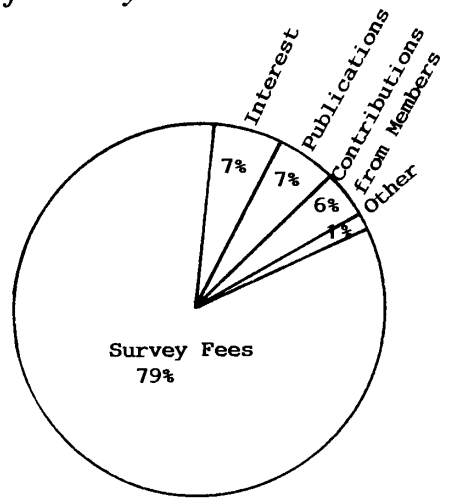
There are 27 headquarters staff.

Figure 2

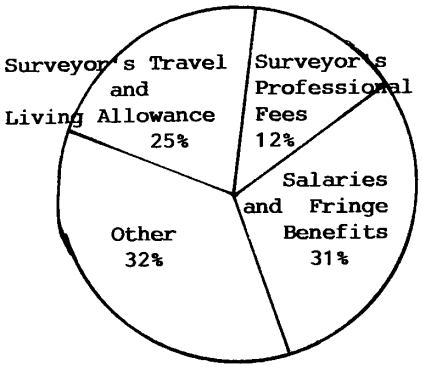
Canadian Council on Hospital Accreditation

Finances for the year ended 31 December 1986

INCOME



EXPENDITURE



Excess of Revenue over Expenditure: $145,612.

The Ontario Council on Community Health Accreditation is also a voluntary independent agency. Its board of directors is made up of one member each from the following organisations:

Ontario Public Health Association Ontario Society of Public Health Dentists Ontario Society of Nutritionists of Public Health Association of Local Official Health Agencies Association of Nursing Directors and Supervisors of Ontario Official Health Agencies Association of Ontario Home Care Associates The Society of Medical Officers of Health of Ontario and The Association of Supervisors of Public Inspectors [66].

Financing

Initially the CCHA was supported by member organisations and the WK Kellogg Foundation which provided financial support for the development of standards [17]. Later, fees were charged to those hospitals which were surveyed with the fee per surveyor day in 1988 being $1,500. The annual expenditure in 1986 was $1,771,035 with the main sources of income being survey fees ($1,507,090), publications ($141,894), CCHA seminars ($130,836) and contributions from members ($126,000). One of the Canadian provinces, Manitoba, gave grants to assist hospitals to achieve accreditation. The Council's costs are estimated to be 0.007% of the cost of health care in Canada [90]. The cost of a three year accreditation from the OCCHA varies according to the population of the health district from approximately $16,000 to $35,000 (1987). The total annual expenditure for 1986—1987 was $129,796 and the staffing level was 2.5 full-time equivalents [62].

The Process of Standards Development

Standards have been developed in those areas outlined in Appendix II [19]. An example of an accreditation standard is found in Appendix VI. The Canadian Council develops and revises standards with input from member organisations, other health care organisations and individual practitioners [19]. Standards are published in the following:

Guide to Accreditation of Canadian Health Care Facilities 1986

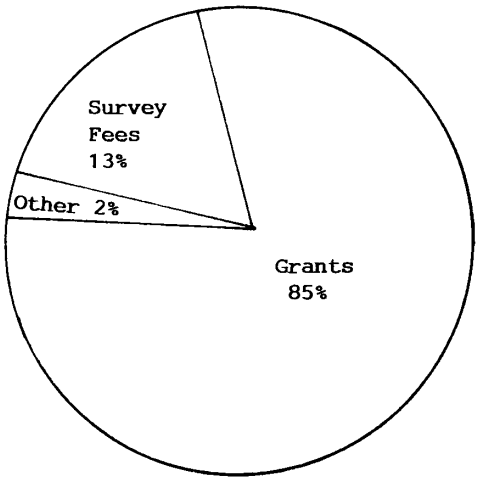
Standards for Accreditation of Canadian Rehabilitation Centres, 1986

Guide to Accreditation of Canadian Mental Health (Psychiatric) Centres 1986

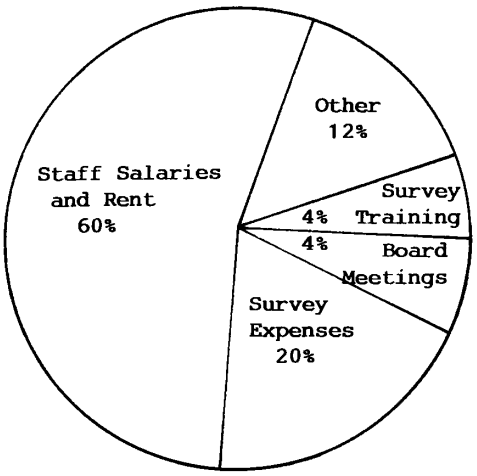
and Guide to Accreditation of Long Term Care Centres 1985 [49].

Figure 3
Finances for The Ontario Council on Community Health Accreditation for year ended 31 March 1987

INCOME



EXPENDITURE



Excess of expenditure over revenue: $4,484.

The Accreditation Process

To be eligible for accreditation by the CCHA, the facility must be registered or listed as a hospital by the Canadian Hospital Association, hold a current license to operate and have specified services [17]. The hospital applies for accreditation and pays a survey fee. The hospital is then sent a Health Care Facility Profile and *Guide to Accreditation of Canadian Health Care Facilities 1986* [19, 22]. The Health Care Facility Profile asks for information on the following functions and must be completed before the accreditation visit:

physical plant
departments
programmes and services
human resources
general statistics (eg. patient days, average length of stay)
clinical profiles (eg. common diagnosis and complications, deaths, nosocomial infections)

The size of the survey team is related to the size of the unit to be surveyed. The surveyors (approximately 130 in 1988) all work full time in the health services and are nurses, physicians or hospital administrators [92]. They do not receive a salary; they receive an honorarium and expenses for the two weeks of the year during which they conduct surveys [92]. In 1987 a Credentials Process for surveyors was approved [21].

The surveyors visit the hospital, examine documents and interview administrators, board members, department heads, staff members and patients [90]. At the end of the visit they meet with senior officials of the hospital to discuss their findings.

The surveyors compile a report, which is sent to the CCHA, where it is examined by the executive and forwarded to a committee of the board for vote. This vote must be unanimous; if it is not, the report is brought to a meeting of the Program and Standards Committee where the status is decided by a majority vote. The hospital is sent a copy of the survey report and if appropriate an accreditation certificate (90). The CCHA publishes and distributes lists of accredited hospitals to professional organisations, government bodies and other interested groups.

For the OCCHA, the size of the survey team is related to the size of the unit; for example, an average unit would be visited by four surveyors. Surveyors only receive honoraria if they do not receive a salary.

Accreditation Status — Incentives And Sanctions

The compliance scale used is non-compliance, initial compliance, partial compliance, full compliance and not applicable.

Accreditation may be not granted or granted for one, two or three years as follows:

Accreditation for three years AX3	Standards are met or surpassed for all essential functions; any weaknesses are of a minor nature. The health care facility is operating in a consistent, progressive manner.
Accreditation for two years with revisit option AX2 — revisit	Standards are met or surpassed in most essential functions with any deficiencies rectifiable within one year. The facility may be granted a partial revisit in one year from the date of survey. If full compliance has been achieved at that time, the award may be extended for an additional year.
Accreditation for two years AX2	Standards are met or surpassed for nearly all essential functions. The health care facility has some weaknesses, but is operating in a consistent, progressive manner.
Accreditation provisional for one year	The health care facility has some more serious weaknesses in essential functions which could and should be remedied within one year. [19]

Accreditation is required for a hospital to be approved for training medical interns and residents, as well as various other health professionals [90]. Although accreditation is not directly linked with financing the hospital, it has been suggested that a request for funding a new programme is more likely to be granted if the hospital is accredited [90]. Hospitals which perform therapeutic abortions must be accredited by the CCHA or receive approval from the provincial Minister of Health (Criminal Code) [81]. Because these standards are being used by plaintiffs and defendants in negligence suits, they are becoming accepted as legally binding [81]. The outcome of an accreditation survey is reported in the press thus demonstrating the quality of service to the public. It can be used to attract patients, especially in cities with more than one hospital.

Additional Services

In addition to the surveys, the CCHA provides national seminars and publications on setting standards and offering guidance on the interpretation of the guidelines. A newsletter is also produced.

Evaluation

As of 31 December, 1986, 621 general (acute) hospitals, 51 mental health services/clinics, and 514 long term care centres were accredited. Details of the number of beds accredited and percentage of eligible beds receiving accreditation are found in Appendix VII. In 1986, 533 surveys were conducted of which 90 were initial surveys. [18]. The award distribution for the 107 completed reports for the time period ending 31 August, 1987 were as follows [21]:

not accredited	1%
AX1	4%
AX2	43%
AX2—revisit	8%
AX3	44%

Approximately a third of facilities surveyed suggested that they would like to have longer surveys so that there was more time for consultation and educational discussions between staff and surveyors. It has been suggested that duplication of the reviews which are conducted by the Royal Colleges should be avoided. The priority issues which have been identified for review include [20]:

1. The involvement of Council in an accreditation process for social agencies which are not classified as 'health care facilities' but which provide a service with health care connections.

2. The appropriate survey time to complete a comprehensive survey and fulfil the expectations of Council and of health care facility staff toward the accreditation process.

3. Those standards which are 'essential' in consideration of the accreditation status of a facility and the mechanism by which Council should identify and weight these essential standards.

4. The development by Council of outcome criteria.

5. The mechanism for bringing the accreditation process closer to the bedside or to the patient.

6. The possibility of a further category of 'clinician' surveyor.

7. The optimum composition of a survey team for any given type and size of health care facility.

Accreditation Systems in other Countries

New Zealand

New Zealand has been interested in the possibility of introducing a formal accreditation programme for a number of years [72]. In 1987, the New Zealand Private Hospital Association (NZ PHA), contacted the Australian Council on Hospital Standards (ACHS) regarding the feasibility of pilot testing the Australian accreditation programme in hospitals in New Zealand [25]. A grant was received from the government and the organisation representing the public sector (Hospital Boards of New Zealand — HBNZ) also became involved. Three hospitals were chosen for pilot testing. An accreditation Pilot Study Coordinating Committee was set up with members drawn from the NZHA, HBNZ, NZ Medical Association, NZ Nurses Association, Australasian College of Surgeons, NZ Institute of Health Administrators, Health Department and staff of participating hospitals [39]. The aim of the pilot project is to determine:

- 'the benefits that the ACHS Accreditation Programme can offer New Zealand;
- the modification to the ACHS programme, if any, required for its application in New Zealand.
- the resource implications of an Accreditation Programme in terms of finance, personnel and facilities;
- how best to introduce and manage a programme of Accreditation within New Zealand' [25].

The pilot project is expected to take 2 years to complete [25].

The Netherlands

The licensing system in the Netherlands developed in the late 1970s[77] is an example of a system using indirect legislation. 'The indirect approach implies the government's setting of a structural and procedural framework within which the functioning of health services should take place' [80]. The government develops conditions and standards for licensing in conjunction with national hospital and professional organisations. Standards have been developed for:

- 'management and organisational aspects

- conditions for co-operation with other health care services
- provisions on auditing
- review
- complaints procedures
- notification of faults
- accidents and near-accidents
- procedures for the delivery of medicines
- food-requirements control
- control of equipment
- hygiene and other general safety measures
- qualification requirements for staff and the like.' (80)

These are examined by the health inspectorate. If the hospital complies it is given an admission certificate for the social health-insurance scheme. Licensing is required in order to receive payment under the Sickness Fund Act and the Exceptional Medical Expenses Act; it is not required for financing by the private sector. There are currently developments in the licensing system which suggest that it may become a true accreditation programme (78).

Quality of care has been a concern of agencies besides the licensing agency in the Netherlands. The Netherlands National Specialists Organisation (LSV) developed a quality assurance plan in 1974. The Secretary of State for Health provided funding for the formation of an independent quality assurance body in February 1979 and the National Organisation for Quality Assurance in Hospitals in the Netherlands (CBO) was formed. This has 15 staff members of whom four are part-time (77). Its governing body has representatives from:

National Association of Medical Specialists
Association for the Advancement of Hospitals
National Hospital Association
Association of the Netherlands Sickness Funds
Commission on National Private Health Insurers
Royal Netherlands Medical Association
Netherlands Association of Hospital Directors
Ministry of Welfare, Health and Culture (Advisory)

The 1985 budget was based on 10 cents per patient bed day (91). The organisation's goal is to promote and monitor quality assurance activities as well as to provide assistance with the procedures of quality assurance (91). Quality assurance procedures have been adopted by consultants in 1976, general practitioners in 1981, clinical nurses in 1986, and physiotherapists in 1987 (77). Recertification of physicians is another method by which quality is monitored. Since 1976 general practitioners have needed to have their registration renewed every 5 years. In 1985 a decision was made to recertify hospital doctors (77).

Spain

Under the constitution of Spain, responsibility for health care services has been transferred to the regional government in the case of two of its 17 territories. The Catalan government assessed this responsibility in 1981. Its Department of Health and Society Security was interested in the accreditation process, and formed an expert committee which recommended that an accreditation system be introduced and that the government be made responsible for its implementation in the absence of an appropriate external body. At the end of 1981 a system of accreditation was introduced by the government and the first hospitals were accredited in 1982 [11, 12].

The accrediting organisation is a government body. It has a committee composed of senior officials from public healthcare administrators [11]. Although the system is voluntary, those hospitals who wish to have a contract with the social security system or receive payment from insurance companies must be accredited [11].

The Committee of Experts have adapted Standards based on the American Joint Commission model. Standards are written as legal codes because the government is the accrediting body [11]. Standards are developed in those areas outlined in Appendix II.

The accreditation process is also similar to that of the American Joint Commission model. The composition of the accrediting team differs, however, in that it is made up only of physicians with experience in hospital administration. There is a right of appeal to accreditation decisions [11] and final decisions are published [36].

Three recommendations regarding accreditation may be made. These are:

1. Complete accreditation of three years' duration
2. Provisional accreditation of one year's duration
3. No accreditation

Up to January 1982, 82% of hospitals and 92% of hospital beds in Catalonia had undergone an accreditation process. None received full accreditation, 61% were granted provisional accreditation and 39% were not accreditated [11].

Yugoslavia

The republic of Croatia in Yugoslavia has established a review committee called the Republic Committee for Health and Social Welfare. On 8 March 1980, this committee was charged to effect three legal obligations:

1. To perform external review of health services and accreditation of health institutions, at least once every four years

2. To arrange that all health organisations institute an internal quality-assurance mechanism

3. To ensure that a patient or consumer, a health insurance organisation, a worker's association or trade union, can demand a performance appraisal of a single health professional, a team of health professionals or a particular health institution [85]

Standards are developed for medical specialties or services by experts in the field and verified by the Republic Committee.

Professional organisations and various medical specialties delegate experts of which there are about 150. For each site visit, the Republic Committee nominates a commission of about 6—8 of these experts. The commission will visit the site and interview staff. Its findings are sent to the Republic Committee. If a major problem is identified, the Republic Committee has the power to close the health facility [85].

Observations

Benefits and Drawbacks

The particular benefits and drawbacks of the accreditation systems currently in place merit careful consideration. The following may provide a few pointers to those areas to which such attention could most usefully be directed.

Potential Benefits

National Health Service

Potential benefits include:

- the development, distribution and updating of national standards
- the provision of a framework for co-ordinated quality assurance activities
- the raising of policy debate by the standard setting exercise
- the identification of 'outlier' health services and avoidance of 'isolation drift' of a particular health service
- the communication of good practices between services
- the establishment of a database to provide information on compliance with the standards and for research purposes
- the provision of information which could be useful in determining which services should be expanded, modified, or reduced
- the comparison of the efficiency of use of resources of various services
- the formation of an interdisciplinary group capable of lobbying for good quality health care

Health Service Organisation

Benefits for the health service itself include:

- an opportunity for self-evaluation and external review, which would help to identify problems, suggest solutions and provide a motive for improvement
- a motivation to confront existing problems
- a means to promote internal communication
- avoidance of a series of accreditation visits and hence duplication by various accreditation bodies evaluating the same services

- a means of demonstrating to the public, the press or politicians that services are of a given quality or that more resources are needed in a given area
- an enhancement of the reputation of the health service (dependent, of course, on the status of the accreditation)
- a means of demonstrating that standards have been met can be useful in cases of litigation
- a method to attract patients and staff in a competitive system
- a means to ensure or help obtain government or insurance company funding in some countries.

Staff

Accreditation can offer benefits to staff as well:

- they are reviewed by peers from outside their organisation, who can provide new ideas, identify areas for further education, and exchange information with them
- they have the opportunity to show that they are excelling in providing their service
- they become involved in planning for the accreditation visit itself which involves working with other disciplines and can in itself be valuable.

The Consumer

Accreditation offers:

- standards for patient safety, treatment and rights
- public assurance that good practice exists
- depending on the composition of the accreditation board and the nature of the site visit, an avenue for patient involvement
- improved quality of care.

Potential Drawbacks

Problems include the following:

- some systems have few sanctions or rewards, resulting in a low participation rate, particularly of small or poor hospitals
- a reluctance to use the sanctions available, such as the closure of a hospital, because of the consequences to patients, the political or financial effect, or the possibility of legal action.

- the credibility of the system may be diminished because accreditation status is rarely withheld.

Standard setting itself is fraught with problems:

- standards must be flexible to allow for regular updating, differences in practice and innovation in service delivery
- the level at which the standards are set must be determined (ie. minimum or optimum)
- compliance with structure and process criteria need to have been demonstrated to correlate with beneficial outcomes for patients
- standards are developed by health professionals, with a potential conflict of interest (standards often need interdisciplinary and consumer involvement in their development)
- standards assume a quasi-legal status, which means that great care must be taken in framing them

Other problems include:

- the risk that the system may become excessively bureaucratic, raising the issue of regulating the regulators
- an increase in time spent documenting activities at the expense of providing health care
- both the survey fees and the staff costs incurred in preparing for accreditation can be considerable as can the cost of implementing standards
- a concern that professionals may feel the accreditation system is being imposed on them by managers or government
- the lack of independence of the accrediting agency if financed by government
- surveyors must have clinical credibility, and their performance must be regularly assessed
- assessing the impact of accreditation on the quality of service
- ensuring the the application of standards gives a valid and reliable evaluation of the system
- ensuring that the health service meets the needs of the population served and maintains good communications with other health and social services

Conclusions

An examination of accreditation as it exists in the health care systems of other countries provides a stimulus for discussion of the appropriateness of such an approach to the United Kingdom. Each of the models described has been developed within a different political and professional climate, health service culture and organisational structure. These variations in background are reflected in the systems which have evolved, in the composition of the accreditation boards, the standards themselves and the individual accreditation processes.

Any discussion of the potential for an accreditation system in the United Kingdom would need to take into account such factors as the organisational structure of health care, current quality initiatives and pressures from the government, professionals or consumers to demonstrate more effectively the quality of care and potential changes to health care (eg. contracting out services). It also needs to give careful thought to alternate methods for ensuring quality (eg. licensing), culture, professional practice, legislation and so on. Nevertheless, the concept of accreditation should be explored as one method which could contribute to the quality of care in the National Health Service.

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Appendix I

SELECTED INITIATIVES TO ENSURE GOOD QUALITY CARE IN THE UK

1 **Legislation**
The Mental Health Act 1959 and its Code of Practice.

2 **Departmental initiatives**
DHSS circulars e.g. on medical records, working party reports, e.g. *Home life: a code of practice for residential care* [26, 9] and others e.g. the Committee on Safety of Medicines.

3 **NHS initiatives**
Performance and quality of care indicators have been developed to examine such areas as the following:
— length of stay
— mortality rates
— ratio of nurses to patients
— waiting lists
— post-operative or hospital-acquired infections
— accident rates [3, 45]

The Health Advisory Service (HAS) monitors facilities for the elderly and mentally il and the National Development Team for Mentally Handicapped People (NDT) monitors institutions for the mentally handicapped [24, 94].

The Management Advisory Service was established to assess and improve managerial performance and to transfer experience from one district to another [46].

Local and health authorities have the responsibility for registering and inspecting private nursing and residential homes and private hospitals (86).

4 **Professional initiatives**
Various projects have examined quality issues involving particular sectors. These include:
— the Confidential Enquiry into Perioperative Deaths
— Maternity Care in Action
— Deaths associated with anaesthesia
— the quality control schemes of clinical chemistry laboratories [14, 70, 53].

5 **Consumer initiatives**
Several initiatives have been developed to allow the patient input into the quality of care. These include:
— Community health councils, which have a right of access to the health authority and the services it provides
— the Ombudsman (Health services commissioner)
— patient satisfaction questionnaires
— locally developed initiatives

6 **Educational initiatives**
Accreditation processes are well established for the training of health professionals (eg. physicians, surgeons, nurses, pharmacists and others). In NHS hospitals in England and Wales, all established medical registrar and senior house officer posts have a method by which standards of training are evaluated. The assessment generally includes a visit to the facility and an assessment of services such as pathology, radiology, medical records, library etc. Potential concerns are that the accreditation systems for the training of health professionals are not very well coordinated resulting in duplication of effort and discussion of the results of the findings with the health authority responsible is sometimes lacking [28].

7 **Organisational initiatives**
Many health care organisations are active in trying to ensure good quality of care. The National Association of Health Authorities in England and Wales (NAHA) has developed guidelines, eg:

NAHA handbook for residential care (64)
Towards good practice in small hospitals (84)

Voluntary organisations involved in quality of care issues include:

National Association for Mental Health (MIND)
The Royal Society for Mentally Handicapped Children and Adults (MENCAP)
National Association for the Welfare of Children in Hospitals (NAWCH)
Age Concern England (National Old People's Welfare Council) (63)

8 **Private sector initiatives**
The private sector has also evolved initiatives dealing with the quality of care. The Registered Nursing Homes Association has set up an accreditation system (33).
The Independent Hospitals Association had a debate on accreditation at their first meeting and set up a registration and Inspection working Party (76).

9 **Other initiatives**
The reader is referred to other references for more information dealing with quality initiatives and issue in the UK (83, 54, 57).

Appendix II

ACCREDITATION STANDARDS: AREAS OF FOCUS

Australia	United States	Canada	Spain
Accident and Emergency Service	Emergency Service	Emergency Services	Casualty Departments
Anaesthetic Service	Anaesthesia Service		Anaesthesia and Resuscitation
Dietetics, Nutrition Department and Food Service	Dietetic Service	Therapeutic Dietary Services Food Services	
Environmental Services	Plant, Technology Safety Management	Plant and Equipment Services Environment Support Services	
Government Body and Management	Governing Body Management and Administrative Services	Governing Body Administration Personnel Services	Administration
Laboratory Service	Pathology and Medical Laboratory Service	Laboratory Services	
Library Service	Professional Library Services	Library Services	Library
Medical Record Services	Medical Record Services	Patients' Clinical Record Services	Medical Records
Medical Services	Medical Staff	Medical Services	Internal Medicine Paediatrics Obstetrics
Operating Room Service			Surgery
Pharmacy Service Services	Pharmaceutical	Pharmacy Services	Pharmacy Services
Physiotherapy Occupational Therapy and Speech Pathology Services			
Quality Assurance	Quality Assurance Infection control Utilization Review	Quality Assurance	Quality Assurance
Radiology Service	Diagnostic Radiology Services Radiation Oncology Services	Diagnostic Imaging Services Nuclear Medicine Services	

Australia	United States	Canada	Spain
Rehabilitation Medicine Services	Rehabilitation Services	Rehabilitation Services	Rehabilitation Services
Social Work Services	Social Work Services	Social Work Services	Social Services
Special Care	Special Care Units	Special Care Units	
Other Services	Home Care Services		
	Hospital Sponsored Ambulatory Care Services	Ambulatory Care Services	Outpatient Departments
	Respiratory Care Services	Pastoral Services	Patient Rights
		Psychology Services	
		Respiratory Technology Services	
		Volunteer Services	
		Psychiatric Services	

Appendix III

EXAMPLE OF A STANDARD FROM THE ACCREDITATION MANUAL FOR HOSPITALS, 1988 (UNITED STATES)

QUALITY ASSURANCE (QA)

Standard		Circle One
QA.1	There is an ongoing quality assurance program designed to objectively and systematically monitor and evaluate the quality and appropriateness of patient care, pursue opportunities to improve patient care, and resolve identified problems.*	1 2 3 4 5 NA
Required Characteristics		
QA.1.1	The governing body strives to assure quality patient care by requiring and supporting the establishment and maintenance of an effective hospitalwide quality assurance program.*	1 2 3 4 5 NA
QA.1.2	Clinical and administrative staffs monitor and evaluate the quality and appropriateness of patient care and clinical performance, resolve identified problems, and report information to the governing body that the governing body needs to assist it in fulfilling its responsibility for the quality of patient care.*	1 2 3 4 5 NA
QA.1.3	There is a written plan for the quality assurance program that describes the program's objective, organization, scope, and mechanisms for overseeing the effectiveness of monitoring, evaluation, and problem-solving activities.*	1 2 3 4 5 NA
Standard		
QA.2	The scope of the quality assurance program includes at least the activities listed in Required Characteristics QA 2.1 through QA 2.5.3 and described in other chapters of this Manual.	
Required Characteristics		
QA.2.1	The following medical staff functions are performed:	
	QA.2.1.1 The monitoring and evaluation of the quality and appropriateness of patient care and the clinical performance of all individuals with clinical privileges through	
	QA.2.1.1.1 monthly meetings of clinical departments or major clinical services (or the medical staff, for a nondepartmentalized medical staff) to consider findings from the ongoing monitoring activites of the medical staff ("Medical staff," Standard MS.3, Required Characteristics MS.3.7 and MS.3.7.1);*	1 2 3 4 5 NA
	QA.2.1.1.2 surgical case review ("Medical Staff", Standard MS.6, Required Characteristic MS6.1.2);*	1 2 3 4 5 NA

* The asterisked items are key factors in the accreditation decision process. For an explanation of the use of the key factors, see "Using the Manual", page ix.

		Circle One
	QA.2.1.1.3 drug usage evaluation ("Medical Staff", Standard MS.6, Required Characteristic MS.6.1.3);*	1 2 3 4 5 NA
	QA.2.1.1.4 the medical record review function ("Medical Staff", Standard MS.6. Required Characteristic MS.6.1.4);*	1 2 3 4 5 NA
	QA.2.1.1.5 blood usage review ("Medical Staff", Standard MS.6, Required Characteristic MS.6.1.5);* and	1 2 3 4 5 NA
	QA.2.1.1.6 the pharmacy and therapeutics function ("Medical Staff", Standard MS.6, Required Characteristic MS.6.1.6).*	1 2 3 4 5 NA
QA.2.2	The quality and appropriateness of patient care in at least the following services are monitored and evaluated:*	
	QA.2.2.1 Alcoholism and other drug dependence services, when provided (Standard AL.4);	1 2 3 4 5 NA
	QA.2.2.2 Diagnostic radiology services (Standard DR.4);	1 2 3 4 5 NA
	QA.2.2.3 Dietetic services (Standard DT.7);	1 2 3 4 5 NA
	QA.2.2.4 Emergency services (Standard ER.9);	1 2 3 4 5 NA
	QA.2.2.5 Home care services (Standard HC.5);	1 2 3 4 5 NA
	QA.2.2.6 Hospital-sponsored ambulatory care services (Standard HO.7);	1 2 3 4 5 NA
	QA.2.2.7 Nuclear medicine services (Standard NM.4);	1 2 3 4 5 NA
	QA.2.2.8 Nursing services (Standard NR.8);	1 2 3 4 5 NA
	QA.2.2.9 Pathology and medical laboratory services (Standard PA.7);	1 2 3 4 5 NA
	QA.2.2.10 Pharmaceutical services (Standard PH.6);	1 2 3 4 5 NA
	QA.2.2.11 Physical rehabiliation services (Standard RH.4);	1 2 3 4 5 NA
	QA.2.2.12 Radiation oncology services (Standard RA.4);	1 2 3 4 5 NA
	QA.2.2.13 Respiratory care services (Standard RP.6);	1 2 3 4 5 NA
	QA.2.2.14 Social work services (Standard SO.5); and	1 2 3 4 5 NA
	QA.2.2.15 Special care units (Standard SP.6); and	1 2 3 4 5 NA
	QA.2.2.16 Surgical and anesthesia services (Standard SA.5).	1 2 3 4 5 NA
QA.2.3	The following hospitalwide functions are performed:*	
	QA.2.3.1 Infection control (Standards IC.1 and IC.2);	1 2 3 4 5 NA
	QA.2.3.2 Utilization review (Standard UR.1); and	1 2 3 4 5 NA

* The asterisked items are key factors in the accreditation decision process. For an explanation of the use of the key factors, see "Using the Manual", page ix.

	Circle One
QA.2.3.3. Review of accidents, injuries, and safety hazards ("Plant, Technology, and Safety Management", Standard PL.3, Required Characteristics PL.3.1.3 and PL.3.1.3.1).	1 2 3 4 5 NA
QA.2.2.12 Radiation oncology services (Standard RA.4);	1 2 3 4 5 NA
QA.2.2.13 Respiratory care services (Standard RP.6);	1 2 3 4 5 NA
QA.2.2.14 Social work services (Standard SO.5); and	1 2 3 4 5 NA
QA.2.2.15 Special care units (Standard SP.6); and	1 2 3 4 5 NA
QA.2.2.16 Surgical and anesthesia services (Standard SA.5).	1 2 3 4 5 NA
QA.2.3 The following hospitalwide functions are performed:*	
QA.2.3.1 Infection control (Standards IC.1 and IC.2);	1 2 3 4 5 NA
QA.2.3.2 Utilization review (Standard UR.1); and	1 2 3 4 5 NA
QA.2.3.3. Review of accidents, injuries, and safety hazards ("Plant, Technology, and Safety Management", Standard PL.3, Required Characteristics PL.3.1.3 and PL.3.1.3.1).	1 2 3 4 5 NA
QA.2.4 The quality of patient care and the clinical performance of those individuals who are not permitted by the hospital to practice independently are monitored and evaluated through the mechanisms described in Required Characteristics QA.2.1 through QA.2.3.3 or through other mechanisms implemented by the hospital ("Governing Body", Standard GB.1, Required Characteristic GB.1.15).*	1 2 3 4 5 NA
QA.2.5 Relevant findings from the quality assurance activities listed in required Characteristics QA.2.1 through QA.2.3.3 are considered as part of	
QA.2.5.1 the reappraisal/reappointment of medical staff members ("Medical Staff", Standard MS.5, Required Characteristic MS.5.3.1);*	1 2 3 4 5 NA
QA.2.5.2 the renewal or revision of the clinical privileges of individuals who practice independently ("Medical Staff", Standard MS.5, Required Characteristic MS.5.3.1);* and	1 2 3 4 5 NA
QA.2.5.3 the mechanisms used to appraise the competence of all those individuals not permitted by the hospital to practice independently ("Governing Body", Standard GB.1, Required Characteristic GB.1.15).*	1 2 3 4 5 NA
Standard	
QA.3 Monitoring and evaluation activities, including those described in Standard QA.2, Required Characteristics QA.2.1 through QA.2.4, reflect the activities described in this standard, Required Characteristics QA.3.1 through QA.3.4.*	1 2 3 4 5 NA

* The asterisked items are key factors in the accreditation decision process. For an explanation of the use of the key factors, see "Using the Manual", page ix.

Required Characteristics	Circle One
QA.3.1 There is ongoing collection and/or screening of, and evaluation of information about, important aspects of patient care to identify opportunities for improving care and to identify problems that have an impact on patient care and clinical performance.*	1 2 3 4 5 NA
QA.3.1.1 Such information is collected and/or screened by a department/service or through the overall quality assurance program.*	1 2 3 4 5 NA
QA.3.2 Objective criteria that reflect current knowledge and clinical experience are used.*	1 2 3 4 5 NA
QA.3.2.1 Each department/service participates in	
QA.3.2.1.1 the development and/or application of criteria relating to the care or service it provides;* and	1 2 3 4 5 NA
QA.3.2.1.2 the evaluation of the information collected in order to identify important problems in, or opportunities to improve, patient care and clinical performance.*	1 2 3 4 5 NA
QA.3.3 The quality of patient care is improved and identified problems are solved through actions taken, as appropriate,*	1 2 3 4 5 NA
QA.3.3.1 by the hospital's administrative and supervisory staffs; and	1 2 3 4 5 NA
QA.3.3.2 through medical staff functions, including	
QA.3.3.2.1 activities of the executive committee,	1 2 3 4 5 NA
QA.3.3.2.2. activities of departments/services,	1 2 3 4 5 NA
QA.3.3.2.3. the delineation and renewal or revision of clinical privileges, and	1 2 3 4 5 NA
QA.3.3.2.4 the enforcement of medical staff or department rules and regulations.	1 2 3 4 5 NA
QA.3.4 The findings, conclusions, recommendations, actions taken, and results of actions taken are documented and reported through channels established by the hospital.*	1 2 3 4 5 NA
Standard	
QA.4 The administration and coordination of the hospital's overall quality assurance program are designed to assure that the activities described in required Characteristics QA.4.1 through QA.4.5 are undertaken.*	1 2 3 4 5 NA
Required Characteristics	
QA.4.1 Each of the monitoring and evaluation activities outlined in Standards QA.2 and QA.3 is performed appropriately and effectively.*	1 2 3 4 5 NA

* The asterisked items are key factors in the accreditation decision process. For an explanation of the use of the key factors, see "Using the Manual", page ix.

		Circle One
QA.4.2	Necessary information is communicated among departments/ services when problems or opportunities to improve patient care involve more than one department/services.*	1 2 3 4 5 NA
QA.4.3	The status of identified problems is tracked to assure improvement or resolution.	1 2 3 4 5 NA
QA.4.4	Information from departments/services and the findings of discrete quality assurance activities are used to detect trends, patterns of performance, or potential problems that affect more than one department/service.*	1 2 3 4 5 NA
QA.4.5	The objectives, scope, organization, and effectiveness of the quality assurance program are evaluated at least annually and revised as necessary.*	1 2 3 4 5 NA

* The asterisked items are key factors in the accreditation decision process. For an explanation of the use of the key factors, see "Using the Manual", page ix.

The "Quality Assurance" chapter was approved by the Joint Commission Board of Commissioners in April 1984 and became effective for accreditation purposes on January 1, 1985.

Appendix IV

EXAMPLE OF A STANDARD FROM THE ACCREDITATION GUIDE STANDARDS FOR AUSTRALIAN HEALTH CARE FACILITIES 1987

MEDICAL SERVICES

STANDARD 1 — ORGANISATION AND ADMINISTRATION

The medical staff is organised to provide clinical services to patients in the health care facility, to represent the professional needs of the medical staff and to ensure that they are involved in the formulation of policies and procedures concerning patient care.

CRITERIA

Association of Medical Staff

1.1 There is an association of medical staff, however named, which is responsible for representing the professional needs of the medical staff.

INTERPRETATION

The complexity and format of the association of medical staff may vary and will depend on the size and type of facility and the scope of the activities of the medical staff.

1.2 There is an executive committee which is empowered to act on behalf of the medical staff between meetings of the medical staff association.

INTERPRETATION

In facilities where there is a small number of medical staff it may not be necessary to form a separate executive committee. In these cases it may be feasible for the medical staff to function effectively as a whole and thus assume the role of the executive committee.

1.3 There is documented evidence that the association of medical staff and its executive meet with sufficient regularity and with an adequate quorum to ensure effective communication with the Governing Body, administration and all medical staff.

1.4 The functions and responsibilities of the association of medical staff/executive committed include:

(a) to act in an advisory role to the governing Body and to the administration;

(b) to co-ordinate the activities and general policies of the medical staff;

(c) to make recommendations to the Governing body on matters concerning clinical practice;

(d) to provide representatives on all committees requiring medical participation;

(e) to ensure professionally ethical conduct in compliance with the Australian Medical Association's Code of Ethics and the World Medical Association's Declarations.

1.5 The association of medical staff and its executive committee are established under the by-laws of the facility and are in keeping with statutory regulations.

1.6 Signed and dated minutes of meetings are kept.

1.7 Where the range and volume of clinical services so requires, the medical staff is also organised into a departmental/divisional system for effective delivery of the clinical services.

INTERPRETATION

This may range from clinical committees to a formal departmental/ divisional structure.

1.8 Where a formal departmental/divisional structure exists a departmental/divisional head is designated. The responsibilities of the designated head may include but need not be limited to:

(a) administrative arrangements within the department/division;

(b) continuing surveillance of the professional activities of all medical staff in the department/division;

(c) co-ordinating the development by the medical staff of criteria for clinical privileges in the department/division;

(d) ensuring that the quality and appropriateness of patient care provided within the department/division are monitored and evaluated.

Medical Administration

1.9 There is a medical administrator who may be full-time or part-time, depending on the scope of the organisation. If neither of these situations apply, the Governing Body should designate a medical practitioner to undertake the necessary duties and should also seek to establish access to, and the advice of, an appropriately skilled medical administrator for consultation as required.

1.10 The medical administrator is responsible to the Governing Body for the highest possible quality of patient care and for administration of the medical and other professional services of the facility. the duties may include but need not be limited to:

(a) policy development and implementation;

(b) integration, planning and co-ordination of clinical services;

(c) medical services staff development and training;

(d) surveillance of standards of clinical care, including medico-legal matters affecting the facility.

1.11 The medical administrator is a member of the senior management team, and attends all meetings of the Governing Body.

1.12 Where there is a full-time medical administrator it is desirable that the medical administrator has, or is working towards, management qualifications.

1.13 The medical administrator has ex-officio membership of the association of medical staff, the various medical departments/ divisions (where applicable) and all committees pertaining to the function of medical and allied health services.

1.14 Where appropriate, the medical administrator has responsibility for the preparation and management of the budget for the Medical Services in consultation with the medical staff.

INTERPRETATION

Departmental/divisional heads, both medical and allied health, are involved in the preparation of their budgets and have responsibility for remaining within budgeted expenditure. To achieve this, department/divisional heads will have to receive regular, accurate and appropriately apportioned statements of current expenditure and resource utilisation.

Lines of Communication

1.15 Clear lines of communication and responsibility between the association of medical staff, its executive committee, departmental/divisional heads, medical administration, the chief executive, and the Governing Body are documented.

1.16 There is a mechanism to ensure effective interaction between the medical staff and the Governing Body on all medical aspects of health care and other relevant matters in the facility.

INTERPRETATION

This mechanism is defined in the by-laws of the Governing body and may be accomplished through (a) attendance of a medical representative appointed by the association of medical staff at board meetings or (b) formal board and medical staff liaison meetings.

1.17 Medical staff are represented on all committees where medical and patient care matters are discussed.

INTERPRETATION

Apart from medical committees, medical staff are also represented on interdisciplinary committees such as: Patient Care Committee, Quality Assurance Committee, Medical Records Committee, Infection Control Committee, Research and Ethics Committee, Pharmacy Committee.

Medical Staff in Training

1.18 Where there are medical staff in training their responsibilities for patient care and their training needs are recognised and appropriate supervision and training is given by medical staff concerned.

STANDARD 2 — STAFFING AND DIRECTION

Medical staff are appointed to the health care facility and clinical privileges are defined.

CRITERIA

Appointments and Delineation of Clinical Privileges

2.1 Appointments to the medical staff are made by the Governing Body on the advice of a selection committee consisting of representatives of the medical staff. Where appropriate the committee may also include representatives of the Governing Body, the university and other learned bodies as well as regional representation of medical practitioners.

2.2 Delineated clinical privileges are granted by the Governing body to each member appointed to the medical staff on the advice of a committee consisting of representatives of the medical staff. Where appropriate the committee may also include representatives of the university and other learned bodies as well as regional representation of medical practitioners.

2.3 The mechanism for determining appointments and clinical privileges is specified in by-laws.

INTERPRETATION

A common method is to establish an appointments/credentials committee of medical practitioners which meets regularly to make recommendations on the appointment, re-appointment and clinical privilege of each member of the medical staff.

2.4 Considerable flexibility may exist in the approach taken by the facility in determining appointments and privileges. Whatever mechanism is used the following should be in evidence:

(a) the mechanism is objective, fair and impartial;

(b) appointments and privileges should each be granted for a specified interval of time;

(c) when appropriate, temporary appointments and privileges may be granted for a limited period of time according to a policy approved by the Governing Body;

(d) appointments and privileges are allocated in such a way that each medical practitioner functions within a specified area of competence.

2.5 Criteria for determining appointments and privileges are specified, are uniformly applied to all applicants and are based on the following principles:

(a) the criteria are designed to assure the medical staff and Governing Body that patients will receive quality care;

(b) the criteria include, at least, evidence of current competence, relevant training and/or experience and current registration;

(c) other criteria may apply, e.g. the needs of the facility;

(d) no applicant is denied appointment to the medical staff on the basis of sex, race, colour, creed, national origin, nor on the basis of any criterion other than that related to professional competence;

(e) peer recommendations are taken into account when recommendations for individual appointments and privileges are being considered;

(f) the relevant department and/or major professional service should be represented when recommendations for individual appointments and privilege are being considered. Wherever possible the relevant professional discipline should be represented.

Re-appointments

2.6 There is a mechanism for re-appointment to the medical staff and for a review of clinical privileges, which is detailed in by-laws.

INTERPRETATION

(a) The individual's professional performance, peer recommendations and other reasonable indicators, (e.g. participation in quality assurance programs, maintenance of adequate medical records) of current competence are taken into account.

The mechanism allows for additional privileges to be granted as well as continuation or curtailment of existing privileges as appropriate.

(b) In states where a re-appointment interval is not specified there must be evidence that the performance of all medical practitioners is reviewed regularly.

Appeals

2.7 There is a mechanism, specified in by-laws, for appeal when recommendations on clinical privileges and re-appointment are adverse to the applicant.

INTERPRETATION

This mechanism provides for review of decisions when requested by the practitioner. The final decision in all cases must be taken by the Governing Body, and within a fixed time.

STANDARD 3 — POLICIES AND PROCEDURES

The medical staff participates in the development of by-laws, rules and regulations pertaining to the medical staff.

CRITERIA

3.1 There are by-laws, rules and regulations which state the policies under which the medical staff regulates itself and provides patient care.

3.2 The by-laws, rules and regulations include, but are not limited, to the following:

(a) description of the organisational structure of the medical staff;

(b) specification of qualifications and procedures for appointment to, and retention of, medical staff membership;

(c) specification of the method of the delineation of clinical privileges;

(d) provision of an appeal mechanism in relation to medical staff re-appointments and clinical privileges;

(e) requirement for an undertaking by each medical practitioner that patient care will be conducted in accordance with the proper ethical traditions of the Australian Medical Association's Code of Ethics and the World Medical Association's Declarations.

3.3 There is an mechanism for, and evidence of, a periodic review and revision where necessary of the by-laws, rules and regulations, and members of the medical staff are provided with written copies of the revised texts.

3.4 Each member shall, on application for appointment to the medical staff, sign an agreement to abide by the current by-laws, rules and regulations of the facility.

3.5 The responsibilities of the medical staff in relation to internal and external disasters is documented, and known to the medical staff.

3.6 There is a mechanism to ensure that medical practitioners are familiar with the facility, staff and equipment.

INTERPRETATION

Certain procedures requiring the use of sophisticated equipment will, for reasons of patient safety, require that medical practitioners are familiar with such equipment.

STANDARD 4 — STAFF DEVELOPMENT AND EDUCATION

The facility and the members of the medical staff demonstrate an on-going commitment to medical education.

CRITERIA

4.1 Larger facilities provide a program of continuing medical education for their own medical staff as well as for the staff of related smaller facilities.

INTERPRETATION

There is evidence that the results of medical-care evaluation studies are taken into account in the planning of education programs.

4.2 The facility encourages and facilitates the attendance of the medical staff at appropriate medical education programs, either within the facility or outside.

4.3 Medical practitioners document their continuing medical education activities in support of applications for appointments, re-appointments and delineation of clinical privileges.

4.4 In facilities where trainee medical practitioners or medical under-graduates are present, provision is made for their adequate training.

STANDARD 5 — FACILITIES AND EQUIPMENT

Adequate facilities are available for the medical staff to function effectively.

CRITERIA

5.1 There is a suitable meeting place for the association of medical staff.

5.2 There is appropriate clerical assistance to allow the association of medical staff to deal with its business and to record its proceedings.

5.3 There are facilities for medical staff members to meet with each other.

STANDARD 6 — QUALITY ASSURANCE PROGRAM

The medical staff ensures the provision of high quality patient care by on-going involvement in quality assurance activities.

CRITERIA

6.1 There is a written plan for the quality assurance program.

6.2 The medical staff provide an appropriate peer group structure for performing the quality assurance functions.

INTERPRETATION

The formal means established to accomplish medical care evaluation is dependent on, and varies with, the size and organisational structure of the facility. The medical staff may undertake reviews:

(a) as a committee of the whole

(b) in multidisciplinary committees within the facility

(c) in departmental committees

(d) in a variety of purpose-specific committees such as deaths and complications and infection control.

In smaller facilities, it may be appropriate for there to be joint meetings of medical and departmental staff of neighbouring facilities.

Whatever structure is utilised, provision is made for review and analysis of the clinical work of each individual clinical department, unit or facility.

6.3 The quality assurance program may evaluate concepts of justification, process and outcome of patient care. Any aspect of patient care may be reviewed.

INTERPRETATION

(a) case reviews including tissue audit, infection rate statistics and morbidity and mortality; such reviews are performed to assure that the treatment given was justified and of high quality;

(b) drug and therapeutic reviews including blood usage; such reviews are performed to evaluate the appropriateness of the use of drugs and/or therapies prescribed and to analyse errors in drug administration and all significant drug reactions;

(c) *utilisation reviews of health facility resources such as length of stay; and the use of diagnostic and therapeutic resources;*

(d) *multidisciplinary reviews: such reviews might examine care involving multiple consultations or situations where health professionals combine in providing care, e.g. intensive care, rehabilitation.*

6.4 Quality assurance activities include the following elements:

(a) monitoring: the routine collection of information about important aspects of patient care;

(b) assessment: the periodic assessment of this information in order to identify important problems in patient care and opportunities to improve care;

(c) action: when important problems in patient care or opportunities to improve care are identified, actions are taken;

(d) evaluation: the effectiveness of actions taken is evaluated to ensure long-term improvements;

(e) feedback: the results of activities are regularly communicated to the medical staff.

6.5 Appropriate documentation of quality assurance meetings is kept and confidentiality of medical practitioners and patients is preserved.

Appendix V

Adapted from Reference 31

PERCEIVED BENEFITS OF AN ACCREDITATION PROGRAMME TO HOSPITALS APPLYING FOR ACCREDITATION

Perceived Benefit	Percent of Responders
External objective assessment and comparison with other hospitals	41%
Confer recognition and status in community	37%
Encouragement and motivation of staff to participate in upgrading of services	34%
Constructive evaluation of services	33%
Education of staff including suggestions for improvement	29%
Improvement of standards and quality of care	25%
Improved communication in the hospital	6%
Sense of achievement because of recognition by external organisations	6%
Improved utilization of resources	6%
Pressure to bring about awareness of needs on health authorities	2%
Better work environment for staff	1%
Continued financial support from government	1%

Appendix VI

EXAMPLE OF A STANDARD FROM GUIDE TO ACCREDITATION OF CANADIAN HEALTH CARE FACILITIES, 1986

FOOD SERVICES

PRINCIPLE

FOOD SERVICES SHALL BE ORGANIZED TO PROVIDE OPTIMAL NUTRITION FOR PATIENTS AND STAFF

STANDARD 1 GOALS AND OBJECTIVES

THERE SHALL BE CLEARLY STATED GOALS AND OBJECTIVES FOR THE PROVISION OF FOOD SERVICES.

		Compliance
1.	Goals and objectives shall be developed by food services personnel.	NC 1 P F
2.	Goals and objectives shall be consistent with the overall goals of the facility.	NC 1 P F
3.	Where food services are provided to the facility by an external agency, the contract shall include a requirement to maintain pertinent standards set by the Canadian Council on Hospital Accreditation.	NC 1 P F

STANDARD II ORGANIZATION AND ADMINISTRATION

THERE SHALL BE A CURRENT WRITTEN PLAN DESCRIBING THE ORGANIZATION OF FOOD SERVICES.

1.	There shall be a written organizational chart which delineates the current responsibilities within the service.	NC 1 P F
2.	There shall be a written description of:	
	2.1 the relationships and formal lines of communication within the service;	NC 1 P F
	2.2 the relationships of the service with other services/ departments within the facility.	NC 1 P F
3.	The organizational plan shall be reviewed annually, revised as necessary and dated accordingly.	NC 1 P F
	Give date of last review/revision: _____	
4.	The organizational plan shall be available to all staff.	NC 1 P F

NC = Non-compliance; 1 = Initial; P = Partial; F = Full
Circle appropriate response

5. Food services shall be represented in planning, decision making and formulation of policies that affect the operation of the service. NC 1 P F

STANDARD III DIRECTION AND STAFFING

FOOD SERVICES SHALL BE DIRECTED BY A QUALIFIED INDIVIDUAL AND STAFFED BY SUFFICIENT NUMBERS OF PROFESSIONAL, TECHNICAL AND CLERICAL PERSONNEL TO MEET THE STATED GOALS AND OBJECTIVES.

1. Food services shall be directed by an individual who is knowledgeable in food services administration. NC 1 P F

2. If the director is not a qualified dietitian, there must be effective and regularly available consultation with a qualified dietitian. NC 1 P F

3. Dietitians should fulfill the requirements for membership in the Canadian Dietetic Association or a provincial equivalent. NC 1 P F

4. There shall be sufficient numbers of professional, technical and clerical staff to efficiently fulfill the duties and responsibilities of the service. NC 1 P F

5. The duties and responsibilities of all staff in food services shall be specified in job descriptions. NC 1 P F

STANDARD IV FACILITIES, EQUIPMENT AND SUPPLIES

FOOD SERVICES SHALL HAVE ADEQUATE SPACE, FACILITIES, EQUIPMENT AND SUPPLIES TO ACCOMPLISH ITS FUNCTION IN AN EFFICIENT, SAFE AND SANITARY MANNER.

1. The food services area shall be appropriately located and equipped to ensure the efficient, safe, and sanitary preparation and distribution of food. NC 1 P F

2. The layout shall provide for efficient work flow from receiving of food supplies to their transfer, storage, preparation and distribution. NC 1 P F

3. At least the following precautions shall be taken to ensure adequate safety and sanitation: NC 1 P F

   3.1 Appropriate health regulations shall be met in:

   3.1.1 the refrigeration and storage of food; NC 1 P F

   3.1.2 the preparation of food; NC 1 P F

   3.1.3 the holding, transfer and disposal of garbage. NC 1 P F

   3.2 There shall be an established mechanism to monitor:

   3.2.1 the environment; NC 1 P F

   3.2.2 the working efficiency of equipment; NC 1 P F

   3.2.3 appropriateness of methods pertinent to safety and sanitation. NC 1 P F

4. There shall be adequate work space for supervisory and clerical personnel. NC 1 P F

STANDARD V POLICIES AND PROCEDURES

THERE SHALL BE CURRENT WRITTEN POLICIES AND PROCEDURES GOVERNING ALL FOOD SERVICES OPERATIONS.

1. Written policies and procedures for food services shall be developed to guide all personnel in the performance of their duties. NC 1 P F

2. Policies and procedures should be developed in co-operation with personnel from other departments or services as appropriate. NC 1 P F

3. Policies and procedures shall be reviewed annually, revised as necessary and dated accordingly. NC 1 P F

   Give date of last review/revision: _____

4. Policies and procedures shall be available to all staff. NC 1 P F

5. Policies and procedures shall relate at least to the following:

   5.1 formulation of department goals and objectives; NC 1 P F

   5.2 organizational plan; NC 1 P F

   5.3 staffing; NC 1 P F

   5.4 responsibility and authority assigned to the director; NC 1 P F

   5.5 duties of food services personnel with functions for various classifications; NC 1 P F

   5.6 personnel policies related to health and grooming; NC 1 P F

   5.7 administrative policies covering budget, menu planning, specifications for purchase of food and equipment, ordering and control of food supplies, storage, preparation, safety and fire prevention, sanitation procedures, waste disposal; NC 1 P F

   5.8 housekeeping and maintenance in food services areas; NC 1 P F

   5.9 statistics and cost accounting procedures. NC 1 P F

STANDARD VII QUALITY ASSURANCE

THERE SHALL BE PROCEDURES ESTABLISHED AND IMPLEMENTED TO EVALUATE THE QUALITY OF SERVICE AND PERFORMANCE OF PERSONNEL.*

1. Procedures shall be established to evaluate the systems for provision of food services, using various approaches to assess structure, process and outcome. NC 1 P F

2. Evaluation processes may include, but are not limited to, the following:

2.1 review of goals and objectives;	NC 1 P F
2.2 review of policies and procedures;	NC 1 P F
2.3 review of incidents;	NC 1 P F
2.4 audits;	NC 1 P F
2.5 staff performance appraisals;	NC 1 P F
2.6 individual supervision.	NC 1 P F

3. Criteria for staff performance appraisal should be developed from the relevant job descriptions. NC 1 P F

4. Staff shall receive the results of such evaluations. NC 1 P F

5. Staff shall participate in plans to overcome deficiencies. NC 1 P F

6. Reports of such quality assurance activities shall be transmitted to the governing body and administration through identified reporting channels. NC 1 P F

QUESTIONNAIRE SECTION COMPLETED BY:

Signature_____

Title_____

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* For further interpretation of this standard, refer to sections on "Quality Assurance" and "Personnel Services".

Appendix VII

CANADIAN COUNCIL ON HOSPITAL ACCREDITATION

COMPARISON OF NUMBER OF ACCREDITED FACILITIES TO TOTAL AVAILABLE FACILITIES

Type of Health Care Facility	Total Accredited Facilities	Percentage Accredited Facilities	Total Accredited Beds	Percentage Accredited Beds
General (Acute) Hospitals	621	69%	123,179	92%
Mental Health Centres	51	80%	13,636	61%
Long Term Care Centres	514	31%	70,309	43%

From the Canadian Council on Hospital Accreditation Annual Report 1986

Appendix VIII

SELECTED PUBLICATIONS AVAILABLE FROM, AND ADDRESSES OF, ACCREDITATION AGENCIES

From the Joint Commission on Accreditation of Healthcare Organisations
875 North Michigan Avenue
Chicago, Illinois 60611

Telephone: 312-642 6061

Standards Manuals

Accreditation Manual for Hospitals
Ambulatory Health Care Standards Manual
Hospice Standards Manual
Long Term Care Standards Manual
Consolidated Standards Manual for Child, Adolescent, and Adult Psychiatric, Alcoholism, and Drug Abuse Facilities and Facilities Serving the Mentally Retarded/Developmentally Disabled

Other

Quality Assurance in Long Term Care
Monitoring and Evaluation in Nursing Services
Quality Review Bulletin

From the American Association for Ambulatory Care
9933 Lawler Avenue
Skokie, Illinois 60077

Telephone: 312 - 676 9610

Accreditation Manual for Ambulatory Health Care, 1987—88 Edition.

From the Australian Council on Hospital Standards
1st Floor
7-9a Joynton Avenue
Zetland
N.S.W. 2017
Australia

Telephone: 02 - 662 2311

Standards Manuals

The Accreditation Guide: 6th Edition
Day Procedure Facilities Standards
Area Health Services Supplement to the Accreditation Guide

Other

Survey Report for a health care facility
Quality Assurance Program Implementation — an Introductory Manual for Hospital Staff

From the Canadian Council on Hospital Accreditation
1815 Alta Vista Drive
Ottawa,
Ontario
Canada K1G 3Y6

Telephone: 613 - 523 9154

Standards Manuals

Guide to Accreditation of Canadian Health Care Facilities, 1986
Standards for Accreditation of Canadian Health Care Facilities — An interpretation with special reference to the need of the small general hospital (revised 1987; 67 pages)
Standards for Accreditation of Canadian Long Term Care Centres, 1985 (1985; 143 pages)
Standards for Accreditation of Canadian Rehabilitation Centres, 1985 (1985; 170 pages)
Guide to Accreditation of Canadian Mental Health (Psychiatric) Centres 1986 (1986; 175 pages)

Other

The Canadian Program of Health Care Facilities Accreditation: An Overview, 1986
Proceedings of the Seminars on Quality Assurance (1984)

From the Ontario Council on Community Health Accreditation
Suite 480
151 Bloor Street
West Toronto,
Ontario
Canada M5S 1T3

Telephone: 416 — 968 9130

Standards Manuals

Accreditation Principles and Standards, Glossary Agency
Guide to an Accreditation Survey
Surveyor Guide to an Accreditation Survey A Brief Overview

King Edward's Hospital Fund for London is an independent charity founded in 1897 and incorporated by Act of Parliament. It seeks to encourage good practice and innovation in health care through research, experiment, education and direct grants.

The King's Fund Centre has a particular role in promoting advances in policy and practice in relation to problems of health and related social care. Its chief aims are to provide a forum for discussion and study, and to help to accelerate the introduction of good new ideas and practice in the planning and management of health and social services. The Centre also houses a number of projects, including Quality Assurance which aims to stimulate the assessment and promotion of quality in health care.