International Standard

ISO 25557

Ageing societies — Care quality for older persons at home and in care facilities

Vieillissement de la population — Qualité des soins prodigués aux personnes âgées à domicile et dans les établissements de soins

First edition
2026-03

Sample Document

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Foreword

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The procedures used to develop this document and those intended for its further maintenance are described in the ISO/IEC Directives, Part 1. In particular, the different approval criteria needed for the different types of ISO documents should be noted. This document was drafted in accordance with the editorial rules of the ISO/IEC Directives, Part 2 (see www.iso.org/directives).

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This document was prepared by Technical Committee ISO/TC 314, *Ageing societies*.

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

Introduction

This document supports the United Nations Principles for older persons:

— Older persons should be able to live in environments that are safe and adaptable to personal preferences and changing capacities.

— Older persons should be able to reside at home for as long as possible.

— Older persons should benefit from family and community care and protection in accordance with each society's system of cultural values.

— Older persons should be able to utilize appropriate levels of institutional care providing protection, rehabilitation, and social and mental stimulation in a humane and secure environment.

— Older persons should be able to enjoy human rights and fundamental freedoms when residing in any shelter, care, or treatment facility, including full respect for their dignity, beliefs, needs and privacy and for the right to make decisions about their care and the quality of their lives.

— Older persons should be able to live in dignity and security and be free of exploitation and physical or mental abuse. Older persons should be treated fairly regardless of age, sex, ethnic background, disability, or other status, and be valued independently of their economic contribution.

NOTE 1   The first article of the Universal Declaration of Human Rights states that "All human beings are born free and equal in dignity and rights". The notion of dignity is defined as the inherent and inalienable worth of all human beings irrespective of social status such as ethnicity, sex, physical or mental state. Dignity is deeply embedded in international human rights instruments.

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

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

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

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

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

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

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

A well-supported infrastructure of an aged society includes a comprehensive, holistic framework of health and care services. See Annex A.

There is also a need for a different approach in the way care and support is organized and a change in the way older persons and ageing in general are perceived.

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

NOTE 2   In some countries medical care is separated from care and is provided by organizations from the health care sector. When this is the case, the care provider needs to have systems in place to provide medical services or access to such when needed.

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

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

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

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

To ensure that medical care is provided where people live, including in care homes, networking of medical and care services in cooperation with health care and social care professionals, medical and care services can be provided in an integrated manner in the community.

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

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

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

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

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

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

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

Governmental organizations and policy makers will benefit through:

— the same acceptable equitable level of care being applied regardless of where the older person lives;

— the same set of requirements and recommendations being applied to all within the field regardless of organization (private or public and non-profit);

— more efficient use of tax money.

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

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

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

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

The text in each subclause of this document is divided into three parts, titled "General", "Requirements" and "Recommendations". The text in "General" is written as a vision, a desirable state, that some care organizations are close to achieve while other organizations are still far from. The "General" part of the subclauses is intended to help the provider of care services to reach the goal "Care quality for older persons at home and in care facilities" by applying the requirements and the recommendations in this document in their organization.

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

— describes the organizations service content in a service description, which includes for example a statement of purpose and character of the care and support service, measures for ensuring the older persons' wellbeing and security, the ethical principles, the services and facilities provided, governance and workforce in terms of skills and numbers, methods for quality control and evaluation of the service.

— compares the service description with the content of this document and, when needed, gives a statement that lists what clauses, requirements and recommendations are not in the service description and therefore not applicable to the organization's services.

Ageing societies — Care quality for older persons at home and in care facilities

1 Scope

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

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

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

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

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

2 Normative references

There are no normative references in this document.

3 Terms and definitions

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

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

— ISO Online browsing platform: available at https://www.iso.org/obp

— IEC Electropedia: available at https://www.electropedia.org/

3.1
assistive technology
equipment, product system, hardware, software or service that is used to increase, maintain or improve capabilities of individuals

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

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

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

3.2
audit
systematic and independent process for obtaining evidence and evaluating it objectively to determine the extent to which the audit criteria are fulfilled

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

Note 2 to entry: An internal audit is conducted by the *organization* (3.20) itself, or by an external party on its behalf.

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

[SOURCE: ISO 7101:2023, 3.19]

3.3
care
activities or actions (social, physical, emotional, spiritual, mental) that take place across a variety of settings, including the home, *community* (3.6), institution, and all care settings

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

[SOURCE: ISO 25551:2021, 3.1]

3.4
care home
place of residence for older persons and persons with physical or mental disabilities, or both, who can require nursing *care* (3.3) to perform activities of daily living

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

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

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

[SOURCE: CEN/TS 17500:2021, 3.7, modified — "older persons" has been added to the definition; "daily living activities" has been replaced with "activities of daily living"]

3.5
care plan
personalized statement of planned healthcare activities and social *care* (3.3) services for older persons

[SOURCE: ISO 18308:2011, 3.7 modified — "relating to one or more specified health issues" was changed to "and social care services for older persons".]

3.6
community
group of people with an arrangement of responsibilities, activities and relationships

Note 1 to entry: In the context of this document, a community has defined geographical boundaries.

Note 2 to entry: A city is a type of community.

[SOURCE: ISO 37151:2024, 3.1]

3.7
competence
ability to apply knowledge and skills to achieve intended results

[SOURCE: ISO 7101:2023, 3.9]

3.8
data-driven
informing an activity by evidence

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

3.9
digital device
electronic equipment used to process or store digital data

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

3.10
dignity
recognition by others of one's human rights including the value, worth, and right to ethical treatment

[SOURCE: ISO 7101:2023, 3.35, modified — "inherent value" has been replaced with "human rights, including the value"]

3.11
effectiveness
extent to which planned activities are realized and planned results are achieved

[SOURCE: ISO 7101:2023, 3.13]

3.12
enablement
process of enabling an older person to gain new skills or abilities to manage changes in their *care* (3.3) needs

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

[SOURCE: BS 8606:2019]

3.13
informal carer
generally unpaid person who provides *care* (3.3) from time to time

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

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

[SOURCE: ISO 25552:2022, 3.19, modified — The admitted term "informal caregiver" has been removed.]

3.14
integrated care
methods and strategies for linking and coordinating the various aspects of *care* (3.3) delivered by different care systems, such as the work of general practitioners, primary and specialty care, preventive and curative services, and acute and long-term care, as well as physical and mental health services and social care, to meet the multiple needs of an individual client or category of persons with similar needs

Note 1 to entry: Integrated care includes independence support care services as well as the interface with medical care. In some countries, medical care or acute care can be excluded. It also includes independence support care services in the *community* (3.6) after medical (curative) care has been delivered by professionals.

3.15
integrated health services
continuum of services that are managed and delivered at different levels and sites within the health system

Note 1 to entry: *Care* (3.3) is provided according to the needs of the individual throughout the course of their life.

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

3.16
medical device
instrument, apparatus, implement, machine, appliance, implant, reagent for in vitro use, software, material or other similar or related article, intended by the manufacturer to be used, alone or in combination, for human beings, for one or more of the specific medical purpose(s) of:

— diagnosis, prevention, monitoring, treatment, or alleviation of disease;

— diagnosis, monitoring, treatment, alleviation of or compensation for an injury;

— investigation, replacement, modification, or support of the anatomy or of a physiological process;

— supporting or sustaining life;

— control of conception;

— disinfection of medical devices;

— providing information by means of in vitro examination of specimens derived from the human body;

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

Note 1 to entry: Products which may be considered to be medical devices in some jurisdictions but not in others include:

— disinfection substances;

— aids for persons with disabilities;

— devices incorporating animal and/or human tissues;

— devices for in vitro fertilization or assisted reproduction technologies.

[SOURCE: ISO 13485:2016, 3.11]

3.17
monitoring
determining the status of a system, a *process* (3.25) or an activity

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

[SOURCE: ISO 7101:2023, 3.21]

3.18
nonconformity
non-fulfilment of a requirement

[SOURCE: ISO 7101:2023, 3.17]

3.19
objective
result to be achieved

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

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

[SOURCE: ISO 7101:2023, 3.6, modified — Note 2 to entry was modified by adding "can apply at different levels"; Notes 3 and 4 to entry were removed.]

3.20
organization
person or group of people that has its own functions with responsibilities, authorities and relationships to achieve its *objectives* (3.19)

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

Note 2 to entry: If the organization is part of a larger entity, the term "organization" refers only to the part of the larger entity that is within the scope of the *care* (3.3) for older persons guidelines.

[SOURCE: ISO 7101:2023, 3.1, modified — In Note 2 to entry, "healthcare quality management system" has been replaced with "care for older persons guidelines"; Note 3 to entry was deleted.]

3.21
performance
measurable result

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

Note 2 to entry: Performance can relate to managing activities, *processes* (3.25), products, services, systems or *organizations* (3.20).

[SOURCE: ISO 7101:2023, 3.11]

3.22
personal protective equipment
PPE
device or appliance designed to be worn by an individual for protection against one or more health and safety hazards

Note 1 to entry: PPE includes, but is not limited to, gowns, gloves, respirators, safety glasses, helmets and goggles.

Note 2 to entry: While generally not considered PPE, masks (and face coverings) can provide a level of protection for the user, in addition to their primary purpose as a public health measure to control the spread of transmission and infection.

Note 3 to entry: National regulations can apply with respect to PPE.

[SOURCE: ISO 15384:2018, 3.12, modified — The words "or held" have been removed from the definition and the Notes to entry have been added.]

3.23
person-centred care
way of organizing and conducting *care* (3.3) that promotes the provision of care centred on a specific person's needs and preferences, identity, and their engagement in the care *process* (3.25)

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

[SOURCE: ISO 25552:2022, 3.21]

3.24
policy
intentions and direction of an *organization* (3.20) as formally expressed by its top management

[SOURCE: ISO 7101:2023, 3.5]