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Dimensions and Components of Accreditation Standards of the Home Health Care Facilities: The Perspective of Experts and Stakeholders

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Abstract

Objectives: Considering the significant increase in the need for home healthcare services and the necessity of developing accreditation standards, this study investigated the viewpoints of experts and stakeholders about the dimensions and components of accreditation standards for home healthcare facilities.

Materials and Methods: This qualitative study used a directed content analysis approach. Fourteen dimensions resulting from reviewing American, Australian, Canadian, and American Nurses Association (ANA) home care standards were used as a basis for the interview framework and a matrix for data analysis. Through purposive sampling, six home healthcare and accreditation experts, one policymaker, four service providers, and two service recipients were selected. Data were collected through in-depth, face-to-face, and semi-structured interviews, each lasting 45 to 60 minutes.

Results: Each transcription was broken into the smallest meaningful unit (code), and 742 codes were identified and classified into main categories extracted from the literature review. Ten dimensions and 79 components were identified for the home healthcare accreditation standards. Client comprehensive evaluation, client access to services, healthcare clients' rights and Promotion of ethical standards, client training and empowerment based on scientific evidence and needs analysis, human resource management, patient and family safety management, home care services quality Improvement, communication and Information management, management and leadership, and healthcare center facilities. 4-14 components were determined for each dimension.

Conclusions: This study extracted the main dimensions and components of accreditation standards based on international experiences and opinions of experts and stakeholders. This can be used to develop accreditation standards for home healthcare facilities.

Keywords: Home care services, Accreditation, Standards, Qualitative research

Introduction

The demand for home health care (HHC) services has substantially risen in recent decades. The home is evolving into a safe and satisfactory place to provide primary, secondary, and tertiary care (1). Aging, a high elderly population, and the prevalence of chronic diseases and disabilities in recent decades have posed a variety of challenges to nations (2). The reports show that by 2050, 30% of the Iranian population will be over 65 years old (3), and chronic diseases account for nearly 82% of deaths in Iran. Chronic disease management is one of the primary challenges in countries such as Iran (4). HHC is a strategy to manage this situation (5), allowing clients to receive complete nursing care, medicine, and prevention and rehabilitation programs at home (6). HHC providers ought to display their capability to provide (7) and guarantee high-quality healthcare services to vulnerable people. It is also highly likely that those aged over 85, with only a few chronic diseases and limited daily activities, are the group with the greatest need for access to such centers (8). On the other hand, the positive outcomes of HHC, such as improved health status, higher quality of life, a short length of hospitalization, reduced care costs, and prevention of readmission, are secured only by high-quality services (9). Thus, it is of utmost significance to ensure clients receive quality healthcare and medical services (8).

Experts in the field of HHC maintain that there are more than a thousand centers for HHC and counseling centers in Iran. The absence of standards and means to review and monitor the performance of these centers has been a significant challenge, resulting in consequences such as unqualified personnel and illegal actions. Nevertheless, establishing standards from the perspective of healthcare professionals has been presented as a solution to such defects and their consequences (10). Accordingly, setting standards that conform to the country's needs and experts' opinions can be effective. In this study, we investigated the

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Key Messages

- The absence of standards to monitor the performance of HHC centers has been a significant challenge.
- This study extracted the main dimensions and components of accreditation standards based on the country's needs and experts' opinions.

viewpoints of experts and stakeholders on HHC facility accreditation standards in the national context.

Materials and Methods

This article is an excerpt from the main study on HHC facility Accreditation Standards in the national context implemented in four stages:

1. The present status of accreditation standards for HHC facilities in the world,
2. Examining viewpoints of experts and beneficiaries on HHC facility accreditation standards in the national context,
3. Compiling the Accreditation Standard's initial draft and, eventually,
4. Validating the standards lasted.

This article revolves around the second stage of the main study.

Study Design and Setting

It is a directed qualitative content analysis (DQlCA) in which the analysis matrix is based on previous works, theories, models, or literature review (11). This study examined and compared the home care standards in the United States, Australia, Canada, the American Nurses Association (ANA), and Iran. The aim was to identify the most critical components addressed in the above-mentioned documents. The commonalities between the standards were integrated, leading to 14 components, including client assessment, access, clients' rights and responsibilities, client education, staff competency and training, quality in practice and quality and safety enhancement, communication and information management, governance and leadership, client satisfaction, infection prevention, environmental management and safety, sustained client care services, physical space, (medical/non-medical) equipment. They were extracted as both a framework for the interview and a matrix for data analysis.

Study Participants

The participants were selected using purposive and snowball methods. Consequently, policymakers and experts in the field, as well as healthcare providers and clients, were invited for interviews and divided into experts and stakeholders. The experts' group comprised HHC and accreditation experts, policymakers, and faculty members experienced in teaching or researching home healthcare. The stakeholders' group contained HHC center managers, nurses working in the home care unit with at least one year of work experience, and HHC center clients and their families who had employed HHC services more than once and were willing to supply information.

Data Collection

The data was collected using a semi-structured interview whose instruction was prepared by a research team consisting of two Ph.D. holders in Health Services Management and one Ph.D. holder in Nursing based on 14 components extracted from reviewing the scientific research documents. The interviews were performed by the first author (NM). At first, the researcher introduced himself, stated the research objectives, and obtained informed written consent. Then, he specified the time and place of the interview as agreed by the participants. Participants preferred their workplace as the interviewing place. The interviews were conducted in person in a private room to control factors such as noise and the movement made by others. During all stages of the interview, health protocols were observed due to the outbreak of the COVID-19 pandemic. Before the interview, participants were informed of the interview's approximate time so that they could modify their daily timetable. As participants were informed of the research procedure and consented, interviews were recorded and transcribed via note-taking as a data collection option. The interview sessions lasted for almost 80-45 minutes. Three participants were interviewed more than once for clarification reasons and to obtain more information. The interviews continued until the data was saturated, i.e., until the data was repetitive without any new data extracted.

After the demographic information was obtained, the interview started with an open-ended item such as "Explain the status of HHC in Iran," and followed with items such as "One of the significant items in the evaluation of HHC is personnel competency; what should the center's officials consider when employing their personnel?". They were then enquired about dimensions extracted from the research documents. Following the interview, other questions, such as "What do you mean by ..., exemplify please?" were used to guide the interview. In the end, participants were asked to state if they had anything in mind other than those mentioned regarding the HHC center accreditations.

Data Analysis

The current study employed deductive or DQlCA proposed by Hsieh and Shannon (12). In this method, the interviews (listened to several times) were transcribed, and the prescription for each interview was regarded as a content analysis unit. After reviewing the texts several times, excerpts relevant to the previous 14 components were highlighted. In the subsequent step, two authors encoded the highlighted sections independently of each other (NM) and (TNG). They were then compared with

each other to notice if there were any differences. The 14 components extracted from base articles were the basis on which the data analysis codes were classified. Therefore, these components were positioned under the developed codes, and if the participants' answers resembled each of them, the relevant quotations were provided below each dimension. Considering that the researchers were not merely aiming to confirm the dimensions obtained from reviews, an effort was made to identify, report, and encode new points or cases separately. Ultimately, 742 codes were extracted and placed in 79 primary classes after initial classification, integration of repetitive codes, and juxtaposition of similar ones. No new category was added to the 14 components, of which four were removed due to integration. Two other researchers analyzed the coding process (AA, RZ).

Trustworthiness

This study employed the criteria for developing the trustworthiness of a qualitative inquiry proposed by Lincoln and Guba, known as credibility, dependability, confirmability, and transferability (13). The principle of diversity in research participation was employed to increase the likelihood of producing factual and credible results. To make all the research phases confirmable (data collection, data analysis, coding, and code classification), they were documented in detail so the research team could review them. Likewise, concerning the transferability of the research results, the research process was pre-planned, and examples of participants' citations were provided, allowing others to pursue the research path. Regarding dependability, after generating the initial codes from the interview transcriptions, interview excerpts were selectively provided to two researchers outside the research group familiar with qualitative research and asked for their opinions.

Results

Participants

The interviews were performed with 13 participants, the majority of whom were females (nine female and four male), with a mean age ranging from 30 to 68 years. All participants had a university education. Demographic details of the participants are given in Table 1.

Participants' Viewpoints on Dimensions and Components of HHC Services Accreditation Standards in the National Context

The interviews were analyzed, resulting in ten dimensions and 79 components. In this section, ten categories were obtained from the interviews, and the components of each dimension are described using examples from participants' quotations. The relationship between the literature review findings and participants' views is shown in Table 2, with more examples of their citations.

Client Assessment (Client Comprehensive Assessment)

From the participants' point of view, four components, i.e., physical and functional assessment, client health history, comprehensive environmental assessment in terms of health services and facilities, and eventually psychological, social, cultural, and economic assessment, should be considered regarding client comprehensive assessment. For example, Participant 12 stated:

> *"The family should be examined culturally. It does not take much time. An overview will show the cultural boundaries of the family, i.e., the type of disease they have, as well as the stage of the disease. The family's history of diseases is important. "Their economic status should also be examined."*

Access (Client Access to Services)

From the participants' point of view, there are six

Table 1. Demographic Characteristics of the Participants

Code	Sex	Age	Educational Level	Role	Accreditation/HHC Work History
P1	Male	41	Ph.D.	Policy maker	2 Years (Accreditation)
P2	Female	45	Bachelor	Expert in HHC and accreditation	2 Years (Accreditation/HHC)
P3	Female	40	Bachelor		3 Years (Accreditation/HHC)
P4	Male	40	Ph.D.	Faculty member	3 Years (Accreditation)
P5*	Female	58	M.Sc.	HHC director	13 Years (HHC)
P6	Female	68	Ph.D.	Faculty member	20 Years (Accreditation/HHC)
P7*	Male	42	Ph.D.	HHC director	15 Years (HHC)
P8	Female	42	M.Sc.	HHC nurse	5 Years (HHC)
P9	Female	55	Bachelor	Client relative	At least 5 times of care receiving
P10	Male	30	Bachelor	Supervisor and HHC nurse	6 Years of nursing/ 3 years of supervising
P11*	Female	50	Bachelor	Client	At least 4 times of care receiving
P12	Female	46	Bachelor	Expert of HHC centers in the Deputy of Treatment	5 Years (HHC)
P13	Female	48	Bachelor		15 Years (HHC)

*Interviewed more than once.

components in the dimension of access to services, namely: easy access to the services, time access, financial access, information channels for accessing the services, providing information about the type of services available, and supplying personnel information for example, regarding client access to services, Participant 10 said:

"The healthcare centers are better not placed on high floors without elevators because the elderly will likely come and go in this building. This way, they will not need to go up 20 to 30 steps."

Likewise, participant 7 considered access to the information on the center's personnel as necessary, stating:

"Take a look at the website of our healthcare center. You will see all the information about the officials and personnel: their educational degree, years of work experience, and specialization".

Client's Rights and Responsibilities (HHC Clients' Rights and Promotion of Ethical Standards)

Participants in this dimension have seven components, including respect for the client's privacy (right to privacy) and respect for the principle of confidentiality, respect for the client and their family according to their culture and ethnicity, the client's right to learn more about themselves and receive information, freedom of choice, obtaining informed written consent to provide any services, ethical considerations in performing research and support for client chart of rights and responsibilities. For example, participant 2 said:

"Healthcare service personnel should treat the family well and respectfully and respect the patient's right to know what is being performed on them. I think informed consent is a basic necessity for any area."

Participant 4, concerning ethical considerations, said:

"We should not require patients to deliver their information without consent or knowledge and use it in their research."

Client Education (Training and Empowerment Based on Scientific Evidence and Needs Analysis)

Participants believed that attention to seven components improved client and family involvement in care decisions and care processes. These components were purposeful education to promote client self-care and independence, family-centered education, up-to-date education based on client characteristics and learning capacity, education based on educational needs, and education with appropriate training strategies. For example, participant 8 stated,

"Training should focus on promoting self-care; it should be taught such that the person can cope with his/her illness independently of anyone."

Regarding the importance of considering client characteristics, Participant 3 asserted,

"The patient should reach a stage where he/she is open to training. If the patient is attentive, young, and mentally capable, then he /she will naturally accept the training".

Staff Competency and Training (Human Resource Management)

The participants enumerated 12 components in this dimension, namely: clarity of general employment conditions, clarity of specialized employment conditions, attention to individual and communication skills, observance of professional ethics and behaviors, holding employee training service, specialism, and meritocracy (i.e., selection of competent individuals for a job), improvement of staff skills, establishing an encouragement and staff welfare system for enhanced satisfaction, attention to salaries, securing HHC staff safety, and documentation of personnel information.

Regarding employment status participant 3 highlighted:

"Our nurses should have experience working in a medical center, and the home care unit supervisor should make a background check on potential employees."

Concerning specialism and meritocracy participant 5 said:

"Our clinical supervisor technically interviews a nurse to see how competent he/she is and gives him/her a score, based on which we later send that person to different patients," said

Client and Family Safety Management

The client and family safety management dimension was constructed from the combination of three dimensions: quality and safety improvement, infection prevention, and environmental management and safety. Fourteen components were identified for this dimension as noted by participants: identification, evaluation, and analysis of potential safety hazards, reduction, elimination, or transfer of HHC risks, prevention of justified errors, training, and support for human resources, and error reporting system, identification, and evaluation of HHC errors, taking measures in case of errors, proper segregation, and disposal of infectious waste, clear infectious waste disposal approaches, safe prescription, client falls prevention, bed sore and Infection prevention and control, maintaining the psychological security of the client and family during home care and maintaining the client's financial security.

Participant 8 stated about assessing potential safety hazards:

"The nurse should identify any danger that threatens the patient while he/she is at the patient's bedside. For example, if the patient is likely to trip over the carpet, he/she should remove it".

Participant 1 said on error prevention:

"I believe any medical, nursing or care mistake during home care should be considered an irremediable, thus eliminated."

HHC Services Quality Improvement

The combination of two dimensions, namely, sustained

client care services and client satisfaction, resulted in nine components from the participant's point of view: services quality monitoring/assessment, good-quality service provision implications, client and family satisfaction, quality improvement strategies in terms of manpower and service provision, clarifying the client expectations and service provider responsibilities, care oriented to client HHC needs, delivering client-centered care, HHC provider selection tailored to client abilities and needs, and addressing client complaints. Participant 10 considered client satisfaction with the quality of care and stated:

"We survey them by calling the patient's family. In my opinion, the patient satisfaction index improves the quality of care".

Participant No. 4 assumed the clarity of the service provider's responsibilities as effective in the quality improvement, stating:

"The care service providers should, from the beginning, specify the duties of our personnel toward clients and clients' responsibilities towards the personnel. These should all be made clear with no further expectations".

Communication and Information Management

In this dimension, the participants introduced seven components: effective communication with clients and their families, effective communication barriers identification, effective communication consequences, client information recording, preservation, exchange, and retrieval. In this regard, for example, Participant 9, regarding effective communication, stated:

"If the nurse who comes home can establish a good relationship, it will lead to both her job facilitation and client cooperation. The nurse is expected to spend enough time on the client and avoid evasiveness".

Participant No. 4 expressed some points about client information preservation:

"What medications the patient is taking; the patient's personal information and treatment process should be kept confidential and provided to people who want to work with that person again."

Management and Leadership

Nine components were discussed in this dimension from the participant's point of view: staff performance monitoring and evaluation, comprehensive staff performance assessment, survey results analysis and feedback presentation, staff, and care team guidance and motivation, caregivers' duty definition, employment of the right people for the right job, a strategic plan for the healthcare center, along with a client care plan. Regarding comprehensive staff performance assessment and feedback presentation, participant No. 4 stated:

"A manager must be able to evaluate people's performance, equipped with tools, like a questionnaire to deliver it to the clients and their family so that they could rate staff performance."

Participant No. 2 pointed out team leadership and stated:

"They all become a team. So, they need a leader who unites and leads them to offer better care."

Regarding the management dimension, participant No. 9 brought up the healthcare staff job descriptions and stated:

"Well, (a manager) should specify healthcare staff job description, i.e., their duties and areas of activity. If such stuff is specified, they will learn how entitled they are to perform an act".

Healthcare Center Facilities

This dimension is the result of combining two other dimensions, i.e., physical space and medical and office equipment obtained from the literature reviews. According to the participants, this dimension contained four components: physical space applicability, attention to the details of the physical space, and the supply of medical and office equipment.

Participant 10 said about physical space applicability:

"I think the healthcare service space should be very clean and stylish. If the space is messy or an old building, it conveys the idea that this center cannot provide good health services,"

Participant 8 said:

"Even a nurse dispatched to prove healthcare should carry at least a bag containing the least equipment like a sphygmomanometer or any other care-based device, namely, a glucometer, a thermometer. Also, large equipment is suggested to be provided via contracts with medical equipment centers."

Discussion

A localized framework for HHC centers' accreditation standards consisting of 10 dimensions and 79 components was obtained after interviews were analyzed. In this study, all 14 dimensions obtained from reviewing the scientific article excerpts were confirmed by the findings of the interviews. After the categories obtained from the interview were integrated, 10 dimensions were identified, including client comprehensive assessment, client access to services, HHC clients' rights and promotion of ethical standards, client training and empowerment based on scientific evidence and needs analysis, human resource management, client and family safety management, HHC services quality improvement, communication and information management, management and leadership, and HHC center facilities.

One of the dimensions obtained in the present study was comprehensive client evaluation. Participants believed that the HHC nurse should perform a physical, functional, environmental, psychological, social, cultural, and economic assessment of the client to identify the needed services. This procedure is of utmost significance, as shown by related studies. Such an evaluation should consider the client's home environment, needs, and

Table 2. Relationship Between the Dimensions Obtained From Reviewing the Literature and the Views of the Participants

Dimensions (Literature Review)	Dimensions (Interview)	Components	Participants' Examples
Client assessment	Client comprehensive assessment	Physical and functional assessment, client health history, comprehensive environmental assessment in terms of health services and facilities, and eventually psychological, social, cultural, and economic assessment	*"The nurse should inspect the patient's vital signs."* *"The extent to which a patient can do his/her tasks and where help is needed should be examined."* *"Family history of diseases, patient's disease, and the stage of the disease should be examined."* *"Examine patients from an economic point of view to see if they can fulfill medical recommendations."*
Access	Client access to services	Access to services, namely: easy access to the services, time access, financial access, information channels for accessing the services, providing information about the type of services available, supplying personnel information	*"The patient has easy access to HHC services."* *"The patient can easily access the centers that provide HHC services."* *"We should have fast and convenient access to people whose help is urgently needed, i.e., services are provided quickly."* *"Patients could visit us through our website, containing the center's complete information"* *"List the stuff they can do, namely, body dressing to other work."*
Client's rights and responsibilities	HHC clients' rights and promotion of ethical standards	Respect for the client's privacy (right to privacy) and respect for the principle of confidentiality, respect for the client and their family according to their culture and ethnicity, the client's right to learn more about themselves and receive information, freedom of choice, obtaining informed written consent to provide any services, ethical considerations in performing research and support for Client Chart of Rights and Responsibilities	*"The most important issue is confidentiality. The person should be confidential and not relate what they learn in clients' home."* *"We have different ethnic groups in our country; each has its own customs and social indicators, and these should be well observed, and the beliefs should be respected."* *"Informed consent must be obtained for every event."*
Client education	Client training and empowerment based on Scientific Evidence and needs analysis	Promote client self-care and independence, family-centered education, up-to-date education, education based on client characteristics and learning capacity, education based on educational needs, and education with appropriate training strategies	*"With training, the patient can reach a stage where he/she can take care of him/herself independently of any therapist and caregiver."* *"The nurses should have updated information to assure the client that they are well informed, alleviating the need to refer to anyone else."* *"Depending on the disease of the clients, the staff should be respectively trained."* *"Education for the patient and his family should be defined in a step-by-step and chain-like manner, starting from the basics onwards."*
Staff competency and training	Human resource management	Clarity of general employment conditions, clarity of specialized employment conditions, attention to individual and communication skills, observance of professional ethics and behaviors, holding employee training service, specialism, and meritocracy (i.e., Selection of competent individuals for a job), improvement of staff skills, establishing an encouragement and staff welfare system for enhanced satisfaction, attention to salaries, securing HHC staff safety, and documentation of personnel information	*"The head of the Home Care unit should perform a background check on employees, i.e., whether or not you approve of their professional, scientific, and ethical qualifications."* *"They should be examined and subject to a scientific interview at the time of employment through scientific questions to see how good they are."*

Table 2. Continued

Dimensions (Literature Review)	Dimensions (Interview)	Components	Participants' Examples
Quality and safety enhancement	Client and family Safety management	Identification, evaluation, and analysis of potential safety hazards, reduction, elimination, or transfer of HHC risks. Prevention of justified errors, training, and support for human resources, an error reporting system, identification and evaluation of HHC errors, taking measures in case of errors, proper segregation and disposal of infectious waste, clear infectious waste disposal approaches, safe prescription, client falls prevention, bed sore and Infection prevention and control, maintaining the psychological security of the client and family during home care and maintaining the client's financial security.	*"The first time my supervisor visits a patient, he pays attention to a few things, i.e., as regards the risk of the patient falling, he well inspects the house to see where the bathrooms are located and to see if the patient can move on his own or he may fall. The supervisor informs the nurse on such stuff."* *"As soon as we sign an employment contract with staff, I tell them that if there is task evasion or injury to the patient, the employee is to blame and should be held accountable according to the type of problem created, and the center has the authority even to fire that person."*
Infection prevention			*"A nurse who visits the client's home will provide sterile care. They should provide that care appropriately to protect the patient against additional infections."* *"Some tools such as scrubs, masks, hand washing, etc., along with body instruction are provided so that they do not become infected themselves and so as not to worsen the condition of their patients."*
Environmental management and safety			*"The person visiting clients to offer HHC must take a container for sharp objects."* *"Contaminated equipment from patient care, including contaminated syringes and needle heads, must be returned to the center and not mixed with household waste."*
Sustained client care services	HHC services quality improvement	Services quality monitoring/assessment, good-quality service provision implications, client and family satisfaction, quality improvement strategies in terms of manpower and service provision, clarifying the client expectations and service provider responsibilities, care oriented to client HHC needs, delivering client-centered care, HHC provider selection tailored to client abilities and needs, and addressing client complaints	*"Careful monitoring of the patient is important. We should talk to the patient and their family as much as possible. The patient and his family should not think that the home care center only dispatches forces and does not follow up."* *"They need to ensure the center is responsive 24 hours a day and supports its workforce."*
Client satisfaction			*"The center should be in direct contact with the clients themselves. After the first day or the first week, ask for their opinions on whether they were satisfied, what the good points were, and what the bad ones need to be modified."*
Communication and information management	Communication and information management	Effective communication with clients and their families, effective communication barriers identification, effective communication consequences, patient information recording, preservation, exchange, and retrieval	*"The nurse-client relationship should comply with the framework of the care program. The patient has paid to receive care or training. "This time should not be spent on non-care professional matters, and the nurse should receive information irrelevant to what she wants to do." "Patient information should be recorded, and if another person is sent to care, they should be able to see the patient's records,*
Governance and leadership	Management and leadership	Staff performance monitoring and evaluation, comprehensive staff performance assessment, survey results analysis, and feedback presentation, staff and care team guidance and motivation, caregivers duty definition, employment of the right people for the right job, a strategic plan for the healthcare center, along with a client care plan	*"They all become a team. They need a leader and guide to bring them all together to provide better care."* *"To monitor whether a manager is doing the task properly, they should first know who should do what. I think the staff duties should be specified."*
Physical space	Healthcare center facilities	Physical space applicability, attention to the details of the physical space, and the supply of medical and office equipment	*"It should be in such a way that its appearance is almost stylish and acceptable to me who wishes to visit the center."*
Medical equipment, and office equipment			*"Our institutions may not financially afford large devices, in which case a contract with medical equipment organizations is the best option."* *"Office equipment and furniture are required, and the computer should have a personnel folder."*

physical, cognitive, psychosocial, economic, and cultural status (14,15). HHC services accessibility is another dimension that was obtained in the present study. Participants highlighted easy and convenient access to care services and information expected to be provided by the care center. Effortless and low-cost access to HHC services has been accentuated in some studies (16) as in Ritchie et al study (14), which have described some standard HHC centers in terms of low-cost, timely, and easy access to HHC services and marketing and information services.

In terms of HHC clients' rights and the promotion of ethical standards, the participants highlighted respect for the client's privacy, dignity, and respect for his wants, maintaining that clients are entitled to make their own decisions and be provided with information on their rights, benefits, and care risks.

In previous studies, in addition to great focus on clients' suitable care, their freedom of choice, and respect for their preferences regarding HHC clients' rights dimension (16), care staff cooperation with insurance supervisors during their visit to the HHC center has also been accentuated. Such collaboration is suggested to include information on client problems, treatment plans, and the measures needed for improving the client's condition (17). This area was not extracted from the interviews since HHC services are not covered by insurance in Iran.

Client training and empowerment are other dimensions addressed in the present study. In this regard, participants underscored providing up-to-date and purposeful training tailored to the client's needs regarding their independence. In one study, client training and instruction were regarded as one of the HHC quality indicators (6). Likewise, another study introduced standards to provide training focused on clients' educational needs and improve their understanding of the HHC program (18). The HHC center staff's knowledge, awareness, and skills pose significant challenges in this field (17).

The HHC center staff constantly needs to be updated about HHC services (16). Similarly, their multiple competencies in client problem diagnosis and management are emphasized (14). As in the present study, participants emphasized the HHC staff's updated knowledge and skills at the beginning of employment. They developed their competencies through in-service training in the staff competency and training dimension. Other studies have introduced in-service training as a solution, although due to the high speed of scientific change in the field of HHC, other methods such as regular journal sharing and reading, especially the latest ones in the field of HHC and sharing learning experiences between colleagues have also been emphasized (17).

Providing such information resources in Iran can also be essential to improving the HHC staff's competence. Client and family safety management was another dimension in which participants referred to issues such as identifying, analyzing, and reducing safety risks. They also focused on HHC error management through prevention, during-care staff support, training error-making staff, and a specified error reporting process.

Regarding safety indicators, they pointed to the correct drug administration and prevention of falls, bed sores, and infection in the client. At the same time, the participants emphasized the elimination of infectious waste and its separation from household ones. In addition to placing great emphasis on the HHC staff's responsibility towards the clients, proper prescription, attention to drug side effects, prevention of client falls, use of safety equipment (14) and client protection against infections (15), some studies have highlighted the necessity to report errors not only in serious events but also in cases prone to error (16). On the other hand, they have also taken into consideration the regulations of HHC centers for the proper removal of infectious waste for environment protection and infection risk reduction (15,18).

HHC Services Quality Improvement was another dimension. The participants stated that HHC quality analysis, through obtaining client satisfaction, all staff involvement in improved quality of service, and attention to staff's capability knowledge, are influential factors in improving the quality of services. Previous studies support the improved HHC service quality and consider client satisfaction evaluation as one of the HHC quality indicators (14). They emphasize staff support and participation in continuous quality improvement programs (15). They also maintain that staff training and increased competency are prerequisites for offering high-quality care services (16).

Concerning communication and information management, the participants, along with their emphasis on establishing therapeutic communication with the client and the families, introduced this kind of interaction as effective regarding HHC quality. Some studies have regarded effective interaction as vital in offering effective care (15). Aase et al (16) emphasized effective interprofessional communication and stated that HHC clients tend to tolerate clinical errors more than communication defects. Participants accentuated the observance of the compliance plan, believing that lack of compliance could hinder effective communication. According to our religious, cultural, and Islamic beliefs, nurses need to consider this critical point, particularly in non-emergency situations, since receiving care from people of the same sex is among the rights that lead to client peace and comfort (19).

Management and leadership were another dimension wherein the participants considered guiding staff and aligning them with the HHC center's vision as the manager's duties. They also underlined the description of the staff duties and monitoring of their performance by the manager. In some studies, management and leadership amount to staff performance planning and monitoring (15), while in others included, the manager's attention

to manpower and increased staff motivation was seen as a factor in building a sense of belonging and eventually improving the quality of care (16). As to HHC center facilities, the participants highlighted the presence of office equipment such as office furniture and files and medical equipment such as telephones and sphygmomanometers. Equipment was divided into two general and specialized sections, and the center's equipment with healthy and suitable tools to provide home care was of utmost importance (14).

Limitaions of the study

The interview framework was created following a review of standards from a select group of countries, specifically the United States, Australia, Canada, and the American Nurses Association. It is important to note that standards from other countries or international organizations may encompass additional dimensions and components that are not addressed in this study.

Conclusion and Future Recommendations

In this study, the main dimensions and components of accreditation standards were extracted based on international experiences and opinions of experts and stakeholders, which can be used as a framework for developing accreditation standards for home healthcare facilities.

Other researchers can help promote the development and revision of standards by evaluating the standards' content and examining stakeholders' views and opinions.

Authors' Contribution

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Conflict of Interests

The authors declare no conflict of interest.

Ethical Issues

The Research Ethics Committee of Iran University of Medical Sciences approved the study using the code of ethics IR.IUMS.REC.1399.117.

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