

Quality & Accreditation Institute

Centre for Accreditation of Health & Social Care



Accreditation Standards for Headache Clinics

Final Draft, April 2026

Developed in Collaboration with



WORLD
HEADACHE
SOCIETY

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I. Introduction

To be written

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These standards are divided into 12 Chapters, 70 Standards and 281 Criteria. These standards can be used to accredit a Headache Clinic both as a standalone or part of a hospital.

On behalf of the Board of QAI's Centre for Accreditation of Health & Social Care (CAHSC), I would like to immensely thank the Chairman of the Technical Committee, Dr. Pravin Thomas and its members, Dr. W. Howell Jarrard, Dr. Trevor Gerson, Dr. Michael Vikelis, Dr. Meghan Piccinin, Dr. Noah Rosen, Ms. Angela Stockley and Mr. Arkaprabha Bhattacharya for drafting these standards.

I also wish to thank the stakeholders for providing inputs during stakeholder consultation process.

We are hopeful that Headache clinics as well as their patients would find these useful and we seek your feedback on continuous basis to improve them as part of our regular review and revision process which will generally takes place every three to four years.

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III. Abbreviations

The following abbreviations are used in these Standards:

- CAPA - Corrective and Preventive Action
- QPS - Continual Quality Improvement
- ED - Emergency Department
- HCP - Headache-Specific Clinical Care and Procedures
- ICHD - International Classification of Headache Disorders
- KPI - Key Performance Indicator
- L1/L2/L3 - Level 1 / Level 2 / Level 3 accreditation category
- MOH - Medication Overuse Headache
- ATDS - Picture Archiving and Communication System
- QI - Quality Improvement
- RUMBA - Relevant, Understandable, Measurable, Beneficial, Achievable
- WHS - World Headache Society

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IV. Glossary

Accreditation: A self-assessment and external peer review process used by health and social care organisations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve the health or social care system. (ISQuaEEA).

Accreditation category: The service tier applied for and assessed: L1, L2, or L3.

Adverse drug event:

Adverse event: Any untoward medical occurrence that may present during treatment with a pharmaceutical product, but which *does not necessarily have a causal relationship* with this treatment.

Adverse Drug Reaction: A response to a drug which is noxious and unintended and which occurs at doses normally used in man for prophylaxis, diagnosis, or therapy of disease or for the modification of physiologic function. Therefore ADR = Adverse Event with a causal link to a drug.

Adverse drug event: The FDA recognizes the term adverse drug event to be a synonym for adverse event. In the patient-safety literature, the terms adverse drug event and adverse event usually denote a causal association between the drug and the event, but there is a wide spectrum of definitions for these terms, including –

- harm caused by drug
- harm caused by drug use, and
- a medication error with or without harm drug

Institute of Medicine: “An injury resulting from medical intervention related to a drug”, which has been simplified to “an injury resulting from the use of a drug”. Adverse drug events extend beyond adverse drug reactions to include harm from overdoses and under-doses usually related to medication errors. A minority of adverse drug events is medication errors, and medication errors rarely result in adverse drug events.

Adverse event: Unintended injuries or complications that are caused by the management of a patient/service user’s care, rather than by the underlying disease. Such complications can lead to death, disability or a prolonged hospital stay.

Agreement: A contract, order, or understanding between two or more parties, such as between a facility and one of its customers. Agreements can be written or verbal, with verbal agreements documented (e.g., a written summary of the agreement should be available).

Assessment: All activities including history taking, physical examination, laboratory investigations that contribute towards determining the prevailing clinical status of the patient.

Care plan: A plan that identifies patient care needs, lists the strategy to meet those needs, documents treatment goals and objectives, outlines the criteria for ending interventions, and documents the individual’s progress in meeting specified goals and objectives. The format of the plan may be guided

by specific policies and procedures, protocols, practice guidelines or a combination of these. It includes preventive, promotive, curative and rehabilitative aspects of care.

Community: Individuals, families, groups and organisations that usually reside in the same locality.

Critical: Elements (such as materials, equipment, steps, or tasks) that can affect the safety of the donor or recipient and the identity, purity, potency, integrity, safety, or efficacy of the cellular therapy product or service.

Corrective Action: An activity performed to eliminate the cause of an existing nonconformance or other undesirable situation(s) in order to prevent recurrence.

Credentialing: The process of obtaining, verifying and assessing the qualification of a healthcare professional and subsequently permitting him/her to perform a set of procedures.

Data: Numbers, symbols, words, images, graphics that have yet to be organised or analysed.

Equipment: A durable item, instrument, or device used in a process or procedure. Examples of equipment include production equipment (e.g., cell separator, freezer, selection device, and centrifuge) or inspection, measurement, or test equipment (e.g., thermometer, cell counter, scales).

Family: The person(s) with a significant role in the patient's life. It mainly includes spouse, children and parents. It may also include a person not legally related to the patient but can make healthcare decisions for a patient if the patient loses decision-making ability.

Governance: The function of determining the organisation's direction, setting objectives and developing policy to guide the organisation in achieving its mission, and monitoring the achievement of those objectives and the implementation of policy.

Headache-trained physician: A physician with formal or documented advanced training and practice experience in headache medicine.

High-risk medications: High-risk medications can be defined as those drugs that have a heightened risk for adverse events or have heightened risk of catastrophic harm whenever there is an error. These drugs include generally have low therapeutic index.

Informed consent - Willingness of a party to undergo examination/procedure/ treatment by a healthcare provider. It may be implied (e.g. patient registering in OPD), expressed which may be written or verbal. Informed consent is a type of consent in which the healthcare provider has a duty to inform his/her patient about the procedure, its potential risk and benefits, alternative procedure with their risk and benefits so as to enable the patient to take an informed decision of his/her health care.

In law, it means active acquiescence or silent compliance by a person legally capable of consenting. In India legally age of consent is 18 years. It may be evidenced by words or acts or by silence when silence implies concurrence. Actual or implied consent is necessarily an element in every contract and every

agreement.

Maintain: To keep in the current state; to preserve or retain; to keep in a state of validity.

Materials: Goods or supply items used in a process or procedure to prepare the cellular therapy product or service. Reagents (whether purchased or prepared in-house) are a type of critical material.

Medication order: A written order by a physician, dentist, or other designated health professional for a medication to be dispensed by a pharmacy for administration to a patient.

Primary difference between *Prescription & Medication Order* is that the medication order is used after Prescription, to get medicines issued/ dispensed from Pharmacy. Medication Order is an active Record, while Prescription is a Document.

Observation capability: A documented ability to monitor and manage patients for a defined period after infusion, procedure, or severe attack.

Patient record/ medical record/ clinical record: A document which contains the chronological sequence of events that a patient undergoes during his stay in the healthcare organisation. It includes demographic data of the patient, assessment findings, diagnosis, consultations, procedures undergone, progress notes and discharge summary. (Death certificate, where applicable).

Policy: A written operational statement that formalises the approach to tasks that is consistent with the organisational objectives.

Prescription: A prescription is a document given by a physician or other healthcare practitioner in the form of instructions that govern the care plan for an individual patient.

Privileging: Formal authorization for a clinician to perform specified services or procedures within the organization.

Procedure: A description of how an activity is to be performed; i.e., a standard operating procedure. A specified way to carry out an activity or a process (ISO 9000).

Process: A set of related tasks and activities that accomplishes a work goal; i.e., that transforms input into output products and services. This transformation can be achieved by an activity or a series of interrelated activities.

A set of interrelated or interacting activities which transforms inputs into outputs (ISO 9000).

Processing: Any activity performed on a cellular therapy product, other than recovery, donor screening, donor testing, storage, labelling, ATDKaging, or distribution. Such processing activities include testing for microorganisms, preparation, sterilization, steps to inactivate or remove adventitious agents, preservation for storage, and removal from storage.

Programme: A sequence of activities designed to implement policies and accomplish objectives.

Potency: The therapeutic activity of a product as indicated by appropriate laboratory tests or adequately developed or controlled clinical data.

Quality improvement: plan that outlines quality improvement initiatives including the proposed actions, timelines and responsible individual(s).

Risk Management: A process that results in a report that analyses the potential for deviations or non-conformances to occur and the corrective and preventive actions to be taken to prevent or minimize risk.

Safety: Relative freedom from harmful effects to persons or products.

Scope of services: Range of clinical and supportive activities that are provided by a healthcare organisation.

Staff: All personnel working in the organization including employees, “fee-for-service” medical professionals, part-time workers, contractual personnel and volunteers.

Sterility: An aseptic condition, meaning an absence of living microorganisms.

Storage: The state of being kept in a place while not being used or transferred, shipped, or transported.

Tightly affiliated service: A formally documented, timely, and operationally reliable external service essential to patient care.

Vulnerable patient: Those patients who are prone to injury and disease by virtue of their age, sex, physical, mental and immunological status, e.g., infants, elderly, physically- and mentally-challenged, semiconscious/ unconscious, those on immunosuppressive and/or chemotherapeutic agents.

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V. Accreditation Categories

Public-facing terminology should be descriptive and understandable. Internal scoring and assessment administration may still use Level 1, Level 2, and Level 3 terminology for consistency.

Requirement area	L1	L2	L3
Headache-trained physicians	At least 1	At least 2	At least 2; one with senior leadership role
Core outpatient consultation service	Required	Required	Required
Headache procedures	Nerve blocks and onabotulinum toxin available	Required	Required
Infusion capability	Preferred through network or shared facility	Required capability	Required on site
After-hours advice / urgent access pathway	Documented referral plan	Required	Required
Hospital / emergency room linkage	Formal tie-up required	Formal tie-up required	Direct or tightly integrated access required
Multidisciplinary network	Referral network	Documented access to core disciplines	Core disciplines available or tightly affiliated
Advanced diagnostics	By referral	By referral with defined turnaround	Advanced headache-relevant imaging / CSF leak / neuro-ophthalmic pathways available
Observation or admission pathway	By referral	Preferred	Required
Research / clinical trials	Optional	Encouraged	Expected where feasible
Education / CME / training role	Encouraged	Expected	Required
International patient services	Optional	Optional	Available where claimed

V. Eligibility Rules

The following criteria are necessary, at a minimum, for the safe and successful performance of Headache Clinic for the Accreditation:

- The applying organization shall be a legally established clinic or hospital-based unit permitted to provide the services it advertises within its jurisdiction.
- The organization shall define its scope of services, operating hours, staffing model, and accreditation category sought (L1, L2, or L3).
- The organization shall have been operational long enough to generate records, data, and evidence of implementation. As a working benchmark for this draft, six months of routine service delivery is recommended for L1/L2 and twelve months for L3.
- The organization shall disclose all outsourced or affiliated services relevant to patient safety, including laboratory, imaging, emergency transfer, infusion, pharmacy, and sterilization arrangements.
- No accreditation category may be awarded solely on aspirational plans; only implemented services may be counted toward mandatory requirements.

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VI. Accreditation Standards Framework

This set of accreditation standards have a defined framework making them easy for facilities and assessors to use. These standards are categorised into Chapters as mentioned below. Each Chapter is divided into a number of Standards and each Standard is further divided into a number of criteria. Criterion is a measurable element to evaluate the compliance against that specific standard. All chapters together cover all components of care continuum in a Headache Clinic. The framework is as follows:

Sl. No.	Name of Chapter	No. of Standards	No. of Criteria
1	Governance, Leadership, Ethics, and Service Scope (GLE)	6	24
2	Human Resources, Credentialing, and Competency (HRC)	6	24
3	Facility, Equipment Safety, and Emergency Preparedness (FES)	6	24
4	Information Management, Documentation, and Digital Health (IMD)	5	20
5	Quality Improvement, Patient Safety, and Performance Measurement (QPS)	6	25
6	Access, Triage, Assessment, and Diagnostic Pathways (ATD)	7	28
7	Headache-Specific Clinical Care and Procedures (HCP)	8	32
8	Medication, Infusion, and Procedural Safety (MIP)	6	24
9	Multidisciplinary Networks and Referral Integration (MNR)	5	20
10	Patient Rights, Education, Experience, and Financial Transparency (PEF)	6	24
11	Infection Prevention, Occupational Safety, and Waste Management (IOW)	4	16
12	Research, Education, Teaching, and Outreach (RET)	5	20
	Total	70	281

Illustration of how the standard is structured:

Chapter is referred as acronym e.g.; Governance, Leadership, Ethics, and Service Scope is referred as GLE. Standards are numbered as GLE.1, GLE.2 etc. and criteria are numbered as GLE.1. a, GLE.1. b etc.

Standard framework can be depicted as follows:

Chapter

Standard

Criterion

Chapter 1. Governance, Leadership, Ethics, and Service Scope (GLE)

Standard GLE.1: Mission, vision, and defined scope of services

Criteria GLE.1. a: A documented mission, values statement, and scope of services exist.

Criteria GLE.1. b:

Scoring methodology:

Each criterion is scored at a scale of 10/5/0/NA based on the compliance as per below principle:

- Compliance to the requirement: 10 ($\geq 70\%$ samples complying)
- Partial compliance to the requirement: 5 (30 to 69% samples complying)
- Non-compliance to the requirement: 0 ($< 30\%$ samples complying)
- Not Applicable: NA (There may be a possibility that some of the standard/criterion is not relevant to a specific type of facility based on its services, in such case that standard/criterion shall be rated as NA)

Evaluation criteria for accreditation decision:

The facility must meet the following criteria for the award of accreditation.

- No zero is accepted in the regulatory/ legal requirements.
- The average score for individual standard must be ≥ 5 .
- The average score for individual chapter must be ≥ 7 .
- The overall average score for all chapters must be > 7 .

In addition to the above, all non-compliance (score of 0)/ partial compliance (score of 5) must be addressed satisfactorily in a defined time.

Chapter 1

Governance, Leadership, Ethics, and Service Scope (GLE)

Introduction

Leadership must establish the clinic's mission, legal accountability, service boundaries, and a culture of safe, ethical, and transparent care. In headache medicine, governance must also define what is managed locally versus referred onward without delay.

STANDARDS AND CRITERIA		
Standard	GLE.1:	Mission, vision, and defined scope of services <i>Applicability: L1/L2/L3</i>
Criterion	a.	A documented mission, values statement, and scope of services exist.
	b.	The accreditation category sought is clearly stated and consistent with actual services.
	c.	Operational hours, after-hours arrangements, and urgent-care escalation pathways are defined.
	d.	Services not provided on site are explicitly identified with referral arrangements.
Standard	GLE.2:	Governance accountability and organogram <i>Applicability: L1/L2/L3</i>
Criterion	a.	A dated organogram identifies reporting relationships and decision authority.
	b.	Leadership roles for clinical services, nursing / allied care, quality, and administration are assigned.
	c.	There is a mechanism for management review of performance, risks, incidents, and complaints.
	d.	Clinical and nonclinical outsourced services are subject to governance oversight.
Standard	GLE.3:	Legal and ethical compliance <i>Applicability: L1/L2/L3</i>
Criterion	a.	Required licenses, registrations, permits, and biomedical-waste authorizations are current.
	b.	Advertising and claimed about expertise, procedures, and outcomes are truthful and not misleading.
	c.	Patient confidentiality, informed consent, and financial transparency are supported by policy.
	d.	A mechanism exists to review legal notices, medico-legal events, and regulatory communications.
Standard	GLE.4:	Clinical governance in headache medicine

		Applicability: L1/L2/L3
Criterion	a.	The clinic uses recognized diagnostic terminology and maintains written clinical pathways for common headache presentations.
	b.	There is a list of procedures and services that clinicians are privileged to perform.
	c.	Criteria exist for emergency referral, hospitalization, specialist referral, and second opinion.
	d.	Complex conditions such as TACs, trigeminal neuralgia, CSF leak, IIH, or secondary headache red flags have escalation pathways.
Criterion	GLE.5:	Risk management and contracts <i>Applicability: L1/L2/L3</i>
	a.	Formal agreements exist for emergency transfer and critical external services on which patient safety depends.
	b.	Risks related to external imaging, laboratory, pharmacy, ambulance, sterilization, or hospital tie-up are reviewed periodically.
	c.	The organization maintains a risk register and records actions taken.
	d.	Patients are informed when part of their care depends on an affiliated service.
Criterion	GLE.6	Health promotion, education, and community responsibility <i>Applicability: L1 recommended / L2 expected / L3 required</i>
	a.	Patients receive advice on preventive care, trigger management, lifestyle, and medication safety.
	b.	The organization supports awareness activities related to headache disorders where feasible.
	c.	L3 centres should contribute to professional education, guideline dissemination, or CME.
	d.	Educational claims are aligned with evidence and organizational capability.

Chapter 2
Human Resources, Credentialing, and Competency (HRC)

Introduction

A headache program is only as safe as the people who deliver it. Staffing must be appropriate to the service category, and procedures may only be performed by clinicians who are appropriately trained, privileged, and periodically reassessed.

STANDARDS AND CRITERIA		
Standard	HRC.1:	Staffing plan and adequacy <i>Applicability: L1/L2/L3</i>
Criterion	a.	A written staffing plan maps personnel to clinic sessions, procedure sessions, infusion sessions, and urgent pathways.
	b.	L1 has at least one physician with additional training in headache medicine.
	c.	L2 and L3 have at least two headache-trained physicians or an equivalent documented model ensuring continuity and second review.
	d.	Nursing, administrative, and support staffing are adequate for patient volume and procedures performed.
Standard	HRC.2:	Credentialing and privileging. <i>Applicability: L1/L2/L3</i>
Criterion	a.	Primary source or equivalent verification of qualifications, registration, and relevant training is maintained.
	b.	Privileging is documented for procedures such as onabotulinum toxin administration, nerve blocks, infusions, and sedation when applicable.
	c.	Re-credentialing and privilege review occur periodically or when scope changes.
	d.	Independent practitioners and visiting faculty are also subject to credential review.
Standard	HRC.3:	Orientation and annual competency <i>Applicability: L1/L2/L3</i>
Criterion	a.	New staff receive induction covering patient identification, consent, emergencies, infection prevention, medication safety, and complaints handling.
	b.	Annual competency review includes at least role-relevant emergency, documentation, and safety elements.
	c.	Procedure and infusion staff have documented competency assessment and refreshers.
	d.	Front-desk staff are trained in confidentiality, patient communication, and urgent escalation.

Standard	HRC.4:	Continuous professional development <i>Applicability: L1/L2/L3</i>
Criterion	a.	Clinical staff participate in ongoing education relevant to their role.
	b.	Updates cover diagnostic pathways, new therapies, procedure safety, and adverse-event learning.
	c.	L2 and L3 centres should maintain a structured annual CPD calendar.
	d.	L3 centres should contribute as providers of training where feasible.
Standard	HRC.5:	Staff health, welfare, and occupational safety <i>Applicability: L1/L2/L3</i>
Criterion	a.	Occupational health risks, immunization needs, and exposure pathways are assessed.
	b.	Needlestick, blood / body fluid exposure, and hazardous-drug exposure pathways are documented.
	c.	Staff involved in direct patient care have fitness-to-work processes as required by local law and role.
	d.	Psychological well-being, fatigue, and burnout risks are recognized, especially in high-volume or procedure / infusion services.
Standard	HRC.6:	Performance review and grievance process <i>Applicability: L1/L2/L3</i>
Criterion	a.	Job descriptions are defined for all roles.
	b.	Appraisal or performance review occurs at planned intervals.
	c.	A confidential process exists for grievances, disciplinary concerns, and unsafe behavior reporting.
	d.	Staff can report safety concerns without fear of retaliation.

Chapter 3
Facility, Equipment, Safety, and Emergency Preparedness (FES)

Introduction

Headache clinics are ambulatory settings, but they still perform injections, monitor infusion therapy, manage vulnerable patients, and must be ready for deterioration, allergy, vasovagal events, and secondary headache emergencies.

STANDARDS AND CRITERIA		
Standard	FES.1:	Safe, accessible, and fit-for-purpose premises <i>Applicability: L1/L2/L3</i>
Criterion	a.	Reception, waiting, consultation, and procedure / infusion areas are appropriate to service volume.
	b.	Accessibility barriers are identified and mitigated for persons with disability, visual sensitivity, mobility limitation, or severe pain.
	c.	Privacy for history-taking and examination is maintained.
	d.	Lighting, noise, and waiting environment are appropriate for headache patients where feasible.
Standard	FES.2:	Emergency preparedness and transfer capability <i>Applicability: L1/L2/L3</i>
Criterion	a.	A documented response exists for anaphylaxis, syncope, seizure, hypertensive emergency, stroke-like presentations, suspected meningitis, and other urgent neurological presentations.
	b.	A formal tie-up with a nearby ED / hospital is mandatory for L1 and L2 unless embedded within a hospital; L3 requires direct or tightly integrated access.
	c.	Staff know how to activate emergency transfer, summon help, and communicate clinical information during handover.
	d.	Emergency phone numbers, transfer criteria, and ambulance arrangements are visibly available.
Standard	FES.3:	Resuscitation readiness <i>Applicability: L1 if medications/procedures are administered; L2/L3 required</i>
Criterion	a.	Emergency equipment and medicines appropriate to scope are available, checked, and accessible.
	b.	Cardiorespiratory monitoring, oxygen, suction, and resuscitation support are available where clinically indicated.
	c.	For L2 and L3 infusion services, cardiac monitoring and documented

		escalation criteria are defined when required by protocol.
	d.	A crash-cart or emergency kit checklist is maintained and reviewed.
Standard	FES.4:	Equipment management <i>Applicability: L1/L2/L3</i>
Criterion	a.	An equipment inventory exists for clinical and safety equipment.
	b.	Preventive maintenance and calibration are carried out as applicable.
	c.	Single-use versus reusable items are clearly managed.
	d.	Failed or expired equipment is removed from use and documented.
Standard	FES.5:	Procedure and infusion environment <i>Applicability: L1 if applicable / L2/L3 required for such services</i>
Criterion	a.	Procedure and infusion spaces support privacy, infection control, hand hygiene, and patient monitoring.
	b.	Written inclusion / exclusion criteria exist for outpatient procedures and infusions.
	c.	Observation requirements before discharge are defined.
	d.	L3 centres should have observation or short-stay capability for prolonged management when clinically required.
Standard	FES.6:	Utilities, fire, and security <i>Applicability: L1/L2/L3</i>
Criterion	a.	Potable water and electricity are available during operating hours; contingency arrangements exist for outage where necessary.
	b.	Fire and security plans are documented, understood, and periodically tested.
	c.	Restricted access exists for medication storage, records, and high-risk supplies.
	d.	Safety signages are present and understandable.

Chapter 4

Information Management, Documentation, and Digital Health (IMD)

Introduction

Reliable information systems are essential to continuity of care, audit, quality improvement, medico-legal defensibility, and cross-referral. In headache medicine, records should clearly capture symptom evolution, diagnosis, treatments tried, procedure details, and safety warnings.

STANDARDS AND CRITERIA		
Standard	IMD.1:	Patient registration and unique identification <i>Applicability: L1/L2/L3</i>
Criterion	a.	A unique patient identifier is used throughout the clinic.
	b.	Demographic data, contact data, and emergency contact information are captured appropriately.
	c.	Urgent cases can be flagged at registration and escalated immediately.
	d.	Duplicate or fragmented charts are prevented and corrected.
Standard	IMD.2:	Clinical documentation standard <i>Applicability: L1/L2/L3</i>
Criterion	a.	Initial assessment documents the presenting complaint, history, relevant red flags, examination, working diagnosis, and plan.
	b.	Follow-up notes record response, adverse events, medication changes, disability / impact where relevant, and next steps.
	c.	Procedure and infusion notes include indication, consent, checklist / time-out, agent used, dose, site, adverse events, and discharge status.
	d.	Referral or transfer notes communicate the reason, urgency, and receiving facility / clinician.
Standard	IMD.3:	Privacy, confidentiality, and security <i>Applicability: L1/L2/L3</i>
Criterion	a.	Policies address confidentiality, access control, backups, and authorized disclosure.
	b.	Paper and electronic records are protected from unauthorized access, loss, or alteration.
	c.	Staff are trained in privacy obligations.
	d.	Use of messaging platforms, teleconsultation platforms, and imaging exchange follows documented rules.
Standard	IMD.4:	Retention, retrieval, and destruction <i>Applicability: L1/L2/L3</i>
Criterion	a.	Retention periods comply with local requirements and patient safety

		needs.
	b.	Records are retrievable within a defined turnaround time.
	c.	Secure destruction is controlled and documented.
	d.	Archived data remain accessible for audit, complaints, legal review, and continuity of care.
Standard	IMD.5:	Digital health and telehealth governance <i>Applicability: If applicable to L1/L2/L3</i>
Criterion	a.	Telehealth eligibility, consent, documentation, prescribing, privacy, and escalation rules are defined.
	b.	Remote review of headache diaries, imaging, and patient-reported outcomes follows a documented process.
	c.	Electronic templates support standardized data capture and KPI reporting.
	d.	Digital systems downtime plans are available.

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Chapter 5

Quality Improvement, Patient Safety, and Performance Measurement (QPS)

Introduction

A mature headache program should measure what it does, learn from what goes wrong, and improve what matters most to patients. The purpose of this chapter is to transform accreditation from a checklist exercise into an operating system for safer and better care.

STANDARDS AND CRITERIA		
Standard	QPS.1:	Structured quality-improvement program <i>Applicability: L1/L2/L3</i>
Criterion	a.	An annual QI plan identifies priority projects, responsible persons, timelines, and measures.
	b.	QI topics include clinical, operational, and patient-experience priorities.
	c.	Progress is reviewed by management at planned intervals.
	d.	Improvements are translated into changed practice, not only reports.
Standard	QPS.2:	Patient safety program and incident learning <i>Applicability: L1/L2/L3</i>
Criterion	a.	Incident definitions and reporting routes are documented.
	b.	Medication, procedure, infusion, fall, delay, identification, privacy, and transfer incidents are included.
	c.	Root-cause or contributory-factor review is undertaken for significant events.
	d.	Corrective actions are tracked to closure and shared with relevant staff.
Standard	QPS.3:	WHS core safety goals <i>Applicability: L1/L2/L3</i>
Criterion	a.	Two-identifier patient verification is used.
	b.	Closed-loop communication is used for urgent results, referrals, and transfers.
	c.	Medication safety checks are built into prescribing, dispensing, and administration processes.
	d.	Procedure checklist / time-out and infection-prevention controls are used.
	e.	A deterioration and emergency activation pathway is operational.
Standard	QPS.4:	Clinical audit and outcome review <i>Applicability: L1/L2/L3</i>
Criterion	a.	A clinical audit calendar covers documentation, diagnosis, medication use, procedures, infusions, and referrals as relevant.

	b.	Audit results are analyzed and acted upon.
	c.	Repeat audits verify improvement.
	d.	L2 and L3 should hold periodic case review / morbidity meetings for complex or adverse events.
Standard	QPS.5:	Key performance indicators <i>Applicability: L1/L2/L3</i>
Criterion	a.	Indicator definitions, frequency, numerator / denominator, and ownership are documented.
	b.	At minimum, the organization tracks access, safety, documentation quality, patient experience, and staff training compliance.
	c.	Trends are reviewed and benchmarked internally over time.
	d.	Data are used to prioritize quality action.
Standard	QPS.6:	Complaints, compliments, and service-user voice <i>Applicability: L1/L2/L3</i>
	a.	Patients can submit feedback through accessible channels.
	b.	Complaints are logged, investigated, responded to, and closed within defined timelines.
	c.	Themes are escalated to management and linked to improvement activity.
	d.	L2 and L3 should periodically review patient education materials and service design with patient feedback input.

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Chapter 6

Access, Triage, Assessment, and Diagnostic Pathways (ATD)

Introduction

The clinic must not simply offer appointments; it must offer the right appointment to the right patient at the right time. This is especially important in headache medicine, where apparently benign symptoms may conceal secondary causes requiring urgent action.

STANDARDS AND CRITERIA		
Standard	ATD.1:	Defined access and triage process <i>Applicability: L1/L2/L3</i>
Criterion	a.	Appointment types and triage categories are defined.
	b.	Reception or triage staff can identify patients who require immediate clinical escalation.
	c.	The clinic accepts patients only when it can safely provide the needed service or arrange referral.
	d.	Waiting-time expectations and urgent access routes are communicated to patients.
Standard	ATD.2:	Red-flag and secondary-headache screening <i>Applicability: L1/L2/L3</i>
Criterion	a.	A structured red-flag checklist is used at initial assessment and updated when clinically necessary.
	b.	Escalation criteria are defined for thunderclap headache, new neurological deficit, fever / meningism, visual threat, pregnancy-related concern, cancer / immunosuppression risk, trauma, elevated ICP concern, and other relevant syndromes.
	c.	Urgent imaging / lumbar puncture / ophthalmic / ED referral pathways are documented.
	d.	Staff understand that red-flag screening complements rather than replaces clinical judgment.
Standard	ATD.3:	Comprehensive headache assessment <i>Applicability: L1/L2/L3</i>
Criterion	a.	Assessment covers symptom characteristics, chronology, disability / impact, medication history, prior treatments, comorbidities, and relevant examination findings.
	b.	The clinic defines a minimum data set for headache evaluation.
	c.	Where relevant, headache diaries or patient-reported tools are used.

	d.	Follow-up assessment records response, tolerability, adherence, and evolution of diagnosis.
Standard	ATD.4:	Diagnosis and clinical classification <i>Applicability: L1/L2/L3</i>
Criterion	a.	The working diagnosis or differential diagnosis is documented.
	b.	Diagnostic uncertainty is acknowledged when present and revisited during follow-up.
	c.	Patients with probable, mixed, or overlapping headache disorders are reassessed systematically.
	d.	Facial pain and cranial neuropathy pathways are distinguished from primary headache pathways when indicated.
Standard	ATD.5:	Diagnostic investigations and results management <i>Applicability: L1/L2/L3</i>
Criterion	a.	Indications for imaging and laboratory testing are guided by policy or pathway.
	b.	Results are tracked, reviewed, communicated, and acted upon in a timely manner.
	c.	Critical or unexpected findings trigger direct communication and escalation.
	d.	L3 centres should have access to advanced headache-relevant diagnostics either on site or through tightly affiliated services.
Standard	ATD.6:	Continuity of care and follow-up planning <i>Applicability: L1/L2/L3.</i>
Criterion	a.	The care plan, medication changes, warning signs, and follow-up timing are documented.
	b.	Mechanisms exist for continuity across in-person, telehealth, procedure, and infusion encounters.
	c.	Patients transferred to another provider or facility receive a documented referral summary.
	d.	The clinic has a process for patients lost to follow-up in high-risk situations where return is clinically important.
Standard	ATD.7:	Special populations and vulnerable patients <i>Applicability: If applicable to served populations</i>
Criterion	a.	Policies address children / adolescents where served, older adults, pregnancy, disability, cognitive vulnerability, and language barriers.
	b.	Patients undergoing moderate sedation, prolonged infusions, or minor procedures follow specific safety processes where applicable.
	c.	Consent and surrogate decision-making follow legal and ethical requirements.
	d.	Staff know how to escalate when vulnerability or safeguarding concerns are identified.

Chapter 7

Headache-Specific Clinical Care and Procedures (HCP)

Introduction

This chapter contains the heart of the WHS model. It translates generic clinic accreditation into requirements that are genuinely meaningful for headache medicine, interventional care, and facial pain practice.

STANDARDS AND CRITERIA		
Standard	HCP.1:	Evidence-informed pathways for common headache disorders <i>Applicability: L1/L2/L3</i>
Criterion	a.	Pathways exist for at least migraine, tension-type headache, cluster headache or TAC pathway where claimed, medication-overuse headache, and selected secondary headache presentations.
	b.	L2 and L3 should also maintain pathways for complex migraine, refractory headache, facial pain syndromes, and post-traumatic or cervicogenic overlap where relevant.
	c.	Pathways include diagnosis, acute treatment, preventive strategy, nonpharmacological care, and referral triggers.
	d.	Pathways are reviewed and updated periodically.
Standard	HCP.2:	Medication-overuse headache and detoxification pathway <i>Applicability: L1/L2/L3</i>
Criterion	a.	Medication overuse screening is part of assessment.
	b.	Patients receive a documented plan for withdrawal, bridge therapy, risk counseling, and follow-up.
	c.	L2 and L3 should have a formal detoxification pathway; L3 should have access to observation or admission when needed.
	d.	Relapse prevention education is documented.
Standard	HCP.3:	Procedure governance: nerve blocks, onabotulinum toxin, and related interventions <i>Applicability: L1 if procedures are offered / L2/L3 expected</i>
Criterion	a.	Indications, contraindications, consent, patient identification, time-out, documentation, and post-procedure advice are standardized.
	b.	Anatomical site, drug concentration, dose, lot number where applicable, and adverse events are documented.
	c.	Providers performing procedures are credentialed and privileged.
	d.	The clinic monitors outcomes and complications of procedures.

Standard	HCP.4:	Infusion services <i>Applicability: L2/L3 where offered</i>
Criterion	a.	Infusion indications, exclusion criteria, pre-infusion checks, monitoring intervals, and discharge criteria are documented.
	b.	Rescue medicines and emergency escalation procedures are available.
	c.	Infusion adverse events are logged and reviewed.
	d.	L2 requires the ability to perform infusion services; L3 requires on-site infusion capability.
Standard	HCP.5:	Facial pain, cranial neuralgia, and complex referral pathways <i>Applicability: As advertised; L3 advanced expectation</i>
Criterion	a.	Pathways exist for trigeminal neuralgia and selected facial pain syndromes where those services are advertised.
	b.	The organization differentiates primary headache disorders from dental, ENT, ophthalmic, TMJ, neuropathic, or structural facial pain causes.
	c.	L3 centres should have access to neurosurgery, pain medicine, oral and maxillofacial surgery, and neuro-ophthalmology through staff or tightly affiliated services.
	d.	Referral thresholds for invasive treatment are documented.
Standard	HCP.6:	Multimodal and nonpharmacologic care integration <i>Applicability: L1/L2/L3</i>
Criterion	a.	The care model addresses lifestyle, sleep, stress, behavior, and rehabilitation factors where relevant.
	b.	Access exists to psychology, physiotherapy, dietetics, or equivalent referral pathways based on category.
	c.	At least one validated nonpharmacologic / supportive intervention pathway is available directly or by referral.
	d.	Patient education reinforces self-management and prevention.
Standard	HCP.7:	Advanced diagnostics and complex headache expertise <i>Applicability: L3 required / L2 encouraged</i>
Criterion	a.	L3 centres have access to neuroradiology and headache-relevant advanced diagnostics through on-site or tightly affiliated services.
	b.	Pathways exist for CSF leak evaluation, IIH / visual-threat evaluation, complex inpatient rescue referral, and difficult diagnostic cases.
	c.	Access to specialists such as neuro-ophthalmology, neuroradiology, and neurosurgery is documented.
	d.	Complex-case discussion or MDT review occurs periodically.
Standard	HCP.8:	Observation, admission, and severe attack pathways <i>Applicability: L2 preferred / L3 required</i>
Criterion	a.	Criteria exist for observation, hospital transfer, inpatient rescue, and

		detoxification support.
	b.	L3 centres should have capacity for admission or a tightly integrated hospital pathway for severe attacks and detoxification.
	c.	Patients are not kept in the ambulatory setting beyond the clinic's monitored capability.
	d.	Discharge from observation or infusion follows clear criteria.

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Chapter 8
Medication, Infusion, and Procedural Safety (MIP)

Introduction

Medication safety in headache practice extends well beyond dispensing. It includes prescribing, reconciliation, allergies, infusions, controlled substances, rescue drugs, and management of predictable adverse events.

STANDARDS AND CRITERIA		
Standard	MIP.1:	Medication management policy and formulary control <i>Applicability: L1/L2/L3</i>
Criterion	a.	A medication policy defines procurement, storage, prescribing, preparation, administration, monitoring, and disposal as applicable.
	b.	A list of high-risk medications and emergency medicines is maintained.
	c.	Look-alike / sound-alike and expiry-risk controls are in place where relevant.
	d.	The formulary or medication list reflects actual use and service category.
Standard	MIP.2:	Safe prescribing and reconciliation <i>Applicability: L1/L2/L3</i>
Criterion	a.	Prescriptions are attributable, legible, dated, and complete.
	b.	Allergies and relevant contraindications are documented before prescribing or administration.
	c.	Medication reconciliation or meaningful medication review occurs at clinically relevant points.
	d.	Prescription audit is performed periodically.
Standard	MIP.3:	Storage, preparation, dispensing, and administration <i>Applicability: L1/L2/L3 where medications are stocked/administered</i>
	a.	Storage conditions, temperature control, and security are maintained.
	b.	Prepared medications are labelled appropriately when preparation is required.
	c.	Administration is performed only by trained personnel within role and privilege.
	d.	Right patient, right drug, right dose, right route, right time, and expiry checks are performed.
Standard	MIP.4:	Monitoring for adverse drug and infusion events <i>Applicability: L1/L2/L3</i>
Criterion	a.	Definitions and documentation of adverse drug events, infusion reactions,

		extravasation, and allergic reactions are in place.
	b.	Response protocols and rescue medicines are immediately available where relevant.
	c.	Events are reported and reviewed as part of the safety program.
	d.	Patients receive discharge advice on delayed adverse effects and when to seek help.
Standard	MIP.5:	Sedation and monitoring where applicable <i>Applicability: If applicable</i>
Criterion	a.	Inclusion criteria, fasting / medication review where applicable, monitoring requirements, recovery criteria, and staff competency are defined.
	b.	Sedation is only performed within legal scope, training, and equipment capability.
	c.	Patients are not discharged before defined recovery criteria are met.
	d.	Organizations not offering sedation must state that clearly and have referral arrangements when needed.
Standard	MIP.6:	Controlled drugs and audit trail <i>Applicability: If applicable</i>
Criterion	a.	Stock receipt, issue, administration, wastage, and balance are recorded as legally required.
	b.	Access is restricted to authorized persons.
	c.	Periodic audit reconciles stock and use.
	d.	Discrepancies are escalated immediately.

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Chapter 9

Multidisciplinary Networks and Referral Integration (MNR)

Introduction

No headache centre is truly excellent in isolation. The quality of care depends not only on what happens inside the clinic, but also on whether the clinic can access the right partner disciplines at the right time.

STANDARDS AND CRITERIA		
Standard	MNR.1:	Referral network design <i>Applicability: L1/L2/L3</i>
Criterion	a.	A directory of referral partners is maintained and reviewed.
	b.	Core disciplines relevant to the category level are identified.
	c.	Referral expectations, contact routes, and urgency categories are defined.
	d.	Patient handover information requirements are standardized.
Standard	MNR.2:	Emergency, hospital, and diagnostic tie-ups <i>Applicability: L1/L2/L3</i>
Criterion	a.	L1 and L2 have a formal tie-up with an ED / hospital unless embedded in one.
	b.	Arrangements exist for urgent imaging, laboratory support, and ambulance or transport where relevant.
	c.	Turnaround expectations and escalation routes are understood.
	d.	Failures in external service response are reviewed under governance.
Standard	MNR.3:	Multidisciplinary access for headache care <i>Applicability: Category-specific</i>
Criterion	a.	L1 demonstrates referral access to at least relevant supporting disciplines.
	b.	L2 demonstrates operational access to pain medicine, emergency support, psychology, physiotherapy, dietetics, ENT / ophthalmology / dentistry as clinically relevant.
	c.	L3 demonstrates staff or tightly affiliated access to neuroradiology, neuro-ophthalmology, neurosurgery, oral and maxillofacial expertise, pharmacy, and rehabilitation / psychology as relevant.
	d.	Referral completion and feedback loops are monitored.
Standard	MNR.4:	Shared care and communication <i>Applicability: L1/L2/L3</i>
Criterion	a.	Referring and receiving providers exchange sufficient clinical information.
	b.	High-risk or complex patients have a clearly documented lead clinician or

		team.
	c.	MDT discussion is available for selected complex cases, especially in L2 / L3.
	d.	Patients are informed about who is responsible for what.
Standard	MNR.5:	International services and external stakeholder communication <i>Applicability: If claimed</i>
Criterion	a.	Claims regarding interpreter support, coordination, records sharing, and travel-related arrangements are verifiable.
	b.	Continuity and follow-up after return to home country or city are addressed.
	c.	Clinical responsibility is not obscured by concierge or marketing arrangements.
	d.	L3 centres advertising international services should audit the quality of such coordination.

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Chapter 10
Patient Rights, Education, Experience, and Financial Transparency (PEF)

Introduction

Headache care is longitudinal and trust-dependent. Patients need rights protection, understandable explanations, realistic expectations, and clear cost information to remain engaged in care.

STANDARDS AND CRITERIA		
Standard	PEF.1:	Patient rights and responsibilities <i>Applicability: L1/L2/L3</i>
Criterion	a.	Rights include dignity, privacy, confidentiality, informed decision-making, refusal of treatment, access to records, safety, complaint rights, and information on expected costs.
	b.	Responsibilities are communicated respectfully.
	c.	Staff understand and can explain these rights.
	d.	Rights information is available in understandable language / format.
Standard	PEF.2:	Informed consent and shared decision-making <i>Applicability: L1/L2/L3</i>
Criterion	a.	Consent processes exist for procedures, infusions, telehealth, data sharing where required, and other specified interventions.
	b.	Benefits, risks, alternatives, and likely follow-up requirements are explained.
	c.	Decision-making is adapted for vulnerable patients and legal representatives when needed.
	d.	Documentation supports shared decision-making, not merely signature collection.
Standard	PEF.3:	Patient and family education <i>Applicability: L1/L2/L3</i>
Criterion	a.	Patients receive information on diagnosis, warning signs, medication use, side effects, lifestyle and trigger management, and follow-up expectations.
	b.	Where relevant, education addresses headache diary use, medication-overuse prevention, pregnancy or lactation considerations, and procedure aftercare.
	c.	Educational materials are reviewed periodically for clarity and accuracy.
	d.	Communication is documented in language / form the patient can understand.
Standard	PEF.4:	Patient experience and communication quality <i>Applicability: L1/L2/L3</i>
Criterion	a.	Patients are informed about delays, changes, and results communication pathways.

	b.	Language-access or interpreter arrangements are available when needed.
	c.	Staff are trained in respectful communication, including with patients in pain or sensory distress.
	d.	The physical and communication environment should reduce avoidable distress for headache patients where feasible.
Standard	PEF.5:	Cost transparency and billing integrity <i>Applicability: L1/L2/L3</i>
Criterion	a.	A tariff list or fee schedule is available.
	b.	Patients are informed when referrals, investigations, procedures, or infusions may generate additional costs.
	c.	Bills and estimates are understandable.
	d.	No misleading package claims are made.
Standard	PEF.6:	Complaints, compliments, and grievance redressal <i>Applicability: L1/L2/L3</i>
Criterion	a.	A documented complaint process exists and is accessible.
	b.	Complaints are investigated impartially and responded to within defined timelines.
	c.	Patterns are reviewed by leadership.
	d.	Learning from complaints is visible in-service improvements.

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Chapter 11

Infection Prevention, Occupational Safety, and Waste Management (IOW)

Introduction

Even highly specialized neurological clinics are not exempt from the fundamentals of hygiene, sharps safety, injection safety, and waste segregation. Procedure-heavy headache practice can create avoidable infection and occupational risks if basics are neglected.

Standard	IOW.1:	Infection prevention and hand hygiene program <i>Applicability: L1/L2/L3</i>
Criterion	a.	Policies cover hand hygiene, environmental cleaning, injection safety, and cleaning / disinfection of equipment and surfaces.
	b.	Hand-hygiene facilities and supplies are available at point of care.
	c.	Staff are trained and monitored.
	d.	High-touch areas and procedure areas are included in cleaning schedules.
Standard	IOW.2:	Aseptic practice for procedures and injections <i>Applicability: L1 if procedures occur / L2/L3 expected</i>
Criterion	a.	Single-use items are not reused.
	b.	Skin preparation, tray preparation, sharps handling, and post-procedure cleaning are standardized.
	c.	Storage of procedure supplies protects sterility and integrity.
	d.	Breaks in asepsis are recognized and managed.
Standard	IOW.3:	Biomedical waste and sharps management <i>Applicability: L1/L2/L3</i>
Criterion	a.	Color-coded or legally compliant waste segregation is implemented.
	b.	Sharps containers are available at point of use and not overfilled.
	c.	Waste collection and final disposal arrangements are documented.
	d.	Staff know the pathway for accidental exposure or waste incidents.
Standard	IOW.4:	Occupational exposure and environmental safety <i>Applicability: L1/L2/L3</i>
Criterion	a.	Pathways exist for needlestick injury, spills, hazardous-drug exposure, and environmental hazards.
	b.	Relevant staff vaccination and health precautions are addressed.
	c.	Incident review includes occupational events, not only patient harm.
	d.	Environmental safety hazards are logged and corrected.

Chapter 12

Research, Education, Teaching, and Outreach (RET)

Introduction

Advanced headache centres often function not only as clinics but as knowledge-generating and capacity-building institutions. This chapter recognizes that role while keeping the expectations proportional to category level.

STANDARDS AND CRITERIA		
Standard	RET.1:	Research governance <i>Applicability: If research is conducted</i>
Criterion	a.	Research activity is permitted only within applicable legal and ethical approval frameworks.
	b.	Roles, accountability, consent, confidentiality, and data integrity are defined.
	c.	The distinction between routine care and research participation is clear to patients.
	d.	Adverse events related to research are governed and reported appropriately.
Standard	RET.2:	Clinical trials and good clinical practice <i>Applicability: If trials are conducted; L3 encouraged</i>
Criterion	a.	Investigators and study staff have documented training appropriate to role.
	b.	Study storage, accountability, documentation, and participant protection are governed.
	c.	Trial-related urgent care and referral pathways are defined.
	d.	The clinic does not claim clinical-trial capacity unless operationally implemented.
Standard	RET.3:	Education and CME role <i>Applicability: L1 encouraged / L2 expected / L3 required</i>
Criterion	a.	L2 and L3 maintain a documented plan for internal and external education.
	b.	Teaching content is aligned with evidence and clearly distinguished from promotional activity.
	c.	Educational sessions are evaluated and improved.
	d.	L3 centres are expected to contribute to CME, fellowships, workshops, or specialist training where feasible.
Standard	RET.4:	Trainee supervision and academic integrity

		Applicability: If trainees are present
Criterion	a.	The role and supervision level of trainees are defined.
	b.	Patients are informed when learners are involved, consistent with local policy.
	c.	Supervision is appropriate to task complexity and patient risk.
	d.	Trainee documentation and procedure participation follow policy.
Standard	RET.5:	Public outreach and advocacy <i>Applicability: L1 encouraged / L2/L3 expected where claimed</i>
Criterion	a.	Public education activity is accurate and evidence-aligned.
	b.	Campaigns do not trivialize or overmedicalize headache disorders.
	c.	Where community or international outreach is claimed, governance and quality oversight are evident.
	d.	Partnerships with societies or public bodies are documented where relevant.

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