# ASF HOME CARE STANDARDS

## Complete Reference — Base Standard + 1 Endorsement

*Version 3.0 · 2026*

Accréditation Sans Frontières · Paris, France · Geneva, Switzerland · Tbilisi, Georgia

# Document Control

| | |
|---|---|
| **Document Title** | ASF Home Care Standards |
| **Document Reference** | ASF-HC-STD3-v3.0 |
| **Version / Edition** | Version 3.0 |
| **Status** | Published |
| **Date of Publication** | 12 September 2026 |
| **Place of Publication** | Paris, France |
| **Issuing Authority** | ASF International Standards Council, Accréditation Sans Frontières |
| **Language of Origin** | English |
| **Effective Date** | 12 September 2026 |
| **Next Scheduled Review** | 12 September 2029 |
| **Supersedes** | Version 2.0 and earlier editions |

# Foreword

This standard originates from a deliberate policy choice made in Georgia in 2014: to advocate for international healthcare accreditation rather than attempt to replace it. Working through the Public Health Institute of Georgia (PHIG, established 2011), its founders organized the country's first structured accreditation initiative — including expert missions by Joint Commission International — and carried this advocacy directly to Georgia's Ministry of Health over the following years.

That advocacy produced, in 2018, the first draft of a Georgian-adapted accreditation standard, and in 2020, the formal establishment of Accréditation Sans Frontières (ASF) as an international legal entity in Paris, alongside the ASF International Standards Council — the standing body responsible for developing and revising ASF's standards. The Council's methodology is directly informed by the World Health Organization's guideline development process, including WHO's use of the GRADE framework for weighing evidence certainty, adapted to the practical work of accreditation. ASF's founder has served since 2016 as a founding member of the UN Secretary-General's Independent Accountability Panel for Every Woman, Every Child, Every Adolescent, and ASF has been a member of the International Society for Quality in Health Care (ISQua) since 2023.

This advocacy also found regulatory validation in Georgian government policy requiring independent international accreditation of hospitals, formally implemented through Order №4/б (26 January 2023).

Consistent with the structure recognized across major international standards bodies, ASF's work spans four pillars: accreditation of organizations against its published standards, accreditation of the standards themselves through the International Standards Council's ongoing review, accreditation of the surveyors who conduct ASF's own assessments, and accreditation of the training that equips facilities and professionals to meet them, delivered through GMJ Academy. This standard has been developed and refined through consultation with practitioners across multiple continents, and every edition includes a Health & Migration endorsement grounded in WHO's Global Competency Standards for health workers serving refugees and migrants — a commitment ASF treats as non-negotiable. Consistent with ASF's founding principle of accreditation without borders, this standard is published in full and made freely available to any organization seeking to build accreditation capacity in its own country.

This, the third edition, is published in 2026. The ASF International Standards Council reviews and revises each standard on a three-year cycle.

# About This Document

This is the ASF Home Care complete standard — seven mandatory base standards covering the full client journey through any in-home care arrangement, from a single independent caregiver to a multi-caregiver home care agency, plus one built endorsement layering onto that base: Health & Migration. No endorsement is ever issued alone — it is only assessed after the base standard is genuinely met in full.

Every criterion follows the same two-page structure established across ASF's standards: an assessment page (a facility self-assessment table, and exactly what an ASF assessor will independently check) and a guidance page (why the standard exists, what good and failure look like, how to implement from zero).

Every criterion carries at least one reference. Numbered references are formal, individually verified Vancouver-style citations; where a criterion instead reflects genuine professional consensus without one attributable paper, that is stated honestly rather than assigned an invented citation.

**Immediately after this page is the Facility Classification chapter — the same four-type model already established for ASF's Hospital standard, adapted for home care providers specifically: Crisis, Transitional, Small, or Standard.**

## Alignment With ISO 9001:2015

This standard's governance structure — Standard 7 — is deliberately built to reflect the core management principles of ISO 9001:2015, the international quality management system standard [7]. This is a statement of structural alignment, not a claim of certification: ISO 9001:2015 compliance is a formal status determined only through accredited external audit, which this document does not confer. The table below shows the mapping honestly, clause by clause.

| ISO 9001:2015 CLAUSE | WHERE THIS STANDARD REFLECTS IT |
|---|---|
| Clause 4 — Context of the Organization | Not directly covered — outside this standard's client-safety scope. |
| Clause 5 — Leadership | 7.1 — Leadership Is Real and Accountable |
| Clause 6 — Planning | 3.4 (Risk Register) and 7.8 (Quality Objectives Are Set, Specific, and Tracked) |
| Clause 7 — Support | 4.2 (Credentials), 7.4 (Records), 7.6 (Scope of Practice) |
| Clause 8 — Operation | Standard 4 (Care & Treatment) in full |
| Clause 9 — Performance Evaluation | 7.7 — Leadership Reviews Overall Performance at Planned Intervals |
| Clause 10 — Improvement | 7.5 (Incident Reporting) and 7.9 (Continual Improvement Process) |

# Facility Classification — Which Type of Home Care Provider Are You?

## Four Facility Types, Not One

The same four-category model built for ASF's Hospital standard applies here, with one deliberate change: Small is anchored to a genuine, real-world unit for home care — a single, independent caregiver. Home care, unlike a hospital or a facility-based residential setting, can be and very often is delivered by exactly one caregiver working directly for a client or family.

### Standard (ST)

A fully resourced, functioning home care agency — a full multi-caregiver team, administrative and supervisory structure, no adaptation needed.

### Small (SM) — where staffing depth, not crisis or poverty, is the defining constraint

Exactly one independent caregiver is the confirmed anchor. This is not a research threshold requiring external verification — it is the plain, real unit of home care itself: a solo caregiver, otherwise stable, genuinely limited only by being one person doing what a larger agency would otherwise share.

### Transitional (TR)

Real national resource or infrastructure limitation, no active conflict — the same World Bank-anchored logic used throughout ASF's standards.

### Crisis (CR)

Active conflict or humanitarian emergency — overrides every other consideration, exactly as in the Hospital standard.

## The Universal Floor

A small number of criteria apply in full, in every one of the four types, with no exceptions: genuine background verification for anyone entering a client's home unsupervised, real informed consent, dignity and non-discrimination, freedom from abuse and neglect, and a caregiver who is genuinely reachable if something goes wrong — a real, specific requirement given a home caregiver, unlike facility staff, often works entirely alone.

## Which Type of Home Care Provider Are You?

**Answer these questions in order, top to bottom. The moment you answer YES, stop — that is your answer. If you reach the end still answering NO, you are Standard.**

| WORK DOWN THIS LIST. STOP AT YOUR FIRST YES. | | | |
|---|---|---|---|
| **1** | **Is your country in an active war, armed conflict, or a declared humanitarian emergency right now?**<br>*This means fighting, displacement, or a declared emergency is actually happening now — not that things are generally difficult.* | ☐ **YES → CR CRISIS** | ☐ NO → next question |
| **2** | **Does your national government struggle badly to fund healthcare, or is national power or medicine supply unreliable — even though there is no war or crisis?**<br>*This is about your country as a whole, not just your own facility.* | ☐ **YES → TR TRANSITIONAL** | ☐ NO → next question |
| **3** | **Are you a single, independent caregiver working directly for a client or family, not employed by a larger agency, and is that the main reason you cannot offer certain services — for example, coverage during your own illness or a second caregiver for overnight care?**<br>*This applies even in a stable, well-funded country. A genuine solo caregiver, not a small agency team — the limit here is being one person, nothing else.* | ☐ **YES → SM SMALL** | ☐ NO → next question |
| **If you answered NO to all three questions above:**<br>You are **STANDARD (ST)** — no crisis, no national constraint, and staffing depth is not holding you back. | | | |

| THIS IS ME |
|---|
| **My type:** ☐ **CR** ☐ **TR** ☐ **SM** ☐ **ST** |

*Example: A solo, independent caregiver working in rural Moldova — no active conflict, so NO to question 1. National healthcare funding is genuinely unreliable, so YES to question 2. Stop there. This caregiver is TR.*

*Verified, not just accepted, on the assessor's visit. If reality is different from what you ticked, the classification is corrected on the spot.*

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# STANDARD 1

## Client Rights & Dignity in the Home Setting

**MANDATORY**

*5 criteria*

| | Standard 1.1 **NON-NEGOTIABLE** · *Standard 1: Client Rights & Dignity in the Home Setting*<br>**The Client's Home Remains Genuinely Theirs to Control** | **ASSESSMENT** ASF-HC-STD1-v3.0 |
|---|---|---|

| **CR** FULL | **TR** FULL | **SM** FULL | **ST** FULL |
|---|---|---|---|

**1.1**
**NON-NEGOTIABLE**
L1

THE STANDARD

## The Client's Home Remains Genuinely Theirs to Control

Care is delivered in genuine recognition that this is the client's own home, not the provider's space — the client's own household routines, possessions, and living arrangements are genuinely respected, not overridden or rearranged for the caregiver's own convenience.

| **PROVIDER SELF-ASSESSMENT** Tick YES, PARTIAL, or NO for each question. | | | | |
|---|---|---|---|---|
| **1** | **Does the caregiver genuinely respect the client's own household routines and living arrangements?**<br>*Real, active respect, not the caregiver rearranging things for their own convenience.*<br>Doc: N/A — tested directly | YES | PARTIAL | NO |
| **2** | **Is the client's personal property genuinely treated with care, not handled carelessly or without permission?**<br>*Real, careful, respectful handling, not an assumption that access to the home implies access to everything in it.*<br>Doc: N/A — tested directly | YES | PARTIAL | NO |
| **3** | **Does the client genuinely retain control over decisions about their own household, not deferred to the caregiver's preferences?**<br>*Real, retained client control, not decisions quietly shifting to the caregiver over time.*<br>Doc: N/A — tested directly | YES | PARTIAL | NO |

**ALL YES** Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

| **WHAT THE ASSESSOR DOES ON SITE** no surprises, no hidden checks | |
|---|---|
| **ASK**<br>*Client household control interview* | Asks the client directly whether they feel genuine control over their own household has been maintained. |
| **OBSERVE**<br>*Property handling observation* | Observes whether the caregiver genuinely handles the client's property with care and permission. |
| **ASK**<br>*Caregiver respect interview* | Asks the caregiver how they specifically respect the client's household routines and preferences. |

REFERENCES

*[1] Home care clients' bill of rights establishes the right to be treated with courtesy, dignity, and respect, and to control one's own household and lifestyle, with personal property treated with respect, as a foundational right distinct from facility-based care settings.*

Standard 1.1 · *Standard 1: Client Rights & Dignity in the Home Setting*

## Guidance & Learning

**GUIDANCE** ASF-HC-STD1-v3.0

## WHY THIS STANDARD EXISTS

Unlike a facility, where the provider controls the physical environment, home care happens entirely within the client's own domain — a right this specific and this genuinely distinct doesn't appear in facility-based accreditation for the simple reason that facilities don't face this question, and getting it wrong here means genuinely violating someone's control over their own home, not simply a facility policy lapse.

**The evidence: [1] Home care clients' bill of rights establishes the right to be treated with courtesy, dignity, and respect, and to control one's own household and lifestyle, with personal property treated with respect, as a foundational right distinct from facility-based care settings.**

| WHAT GOOD LOOKS LIKE | WHAT FAILURE LOOKS LIKE |
|---|---|
| ✓ The caregiver genuinely respects the client's own household routines. | ✗ The caregiver rearranges the household for their own convenience. |
| ✓ Personal property is genuinely treated with care and permission. | ✗ Personal property is handled carelessly or without permission. |
| ✓ The client genuinely retains control over their own household decisions. | ✗ Household decisions have quietly shifted to the caregiver over time. |

## MOST COMMON REASONS PROVIDERS SCORE PARTIAL

1 **Respect is generally strong but the caregiver occasionally makes small household changes without asking first.**
*Even small changes deserve the same genuine respect for the client's own authority over their space.*

2 **Property is handled carefully but the client hasn't been specifically asked about boundaries around personal items.**
*Genuine respect benefits from an explicit conversation, not an assumption of shared understanding.*

3 **Control is generally respected but decisions during high-stress moments sometimes default to the caregiver's judgment.**
*Genuine client control matters most, not least, during exactly these moments.*

## HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

**Week 1** Review current practice for genuine respect of client household control and property.

**Week 2** Establish a clear conversation with each client about household preferences and boundaries.

**Week 3** Train caregivers on genuinely deferring to client authority over their own space.

**Ongoing** Check in with clients periodically about their experience of household control.

## FOR SURVEYORS — WHAT IS NOT OBVIOUS

**Ask the client directly whether they feel this is still genuinely their own home during care visits.**
*A direct, honest answer reveals genuine respect, not an assumption based on general politeness.*

**Observe how the caregiver handles a household item or space during an actual visit.**
*Direct observation reveals genuine practice, not stated intention.*

**E-LEARNING** academy.gmj.ge/hc-std1-1-household-control — 30 min · complete before self-assessment

| | Standard 1.2 **NON-NEGOTIABLE** · *Standard 1: Client Rights & Dignity in the Home Setting*<br>**A Written Statement of Rights Is Provided and Genuinely Understood** | **ASSESSMENT** ASF-HC-STD1-v3.0 |
|---|---|---|
| **CR** FULL | **TR** FULL | **SM** FULL | **ST** FULL |

**1.2**
**NON-NEGOTIABLE**
L1

THE STANDARD

## A Written Statement of Rights Is Provided and Genuinely Understood

Every client receives a written statement of their rights before care begins, read aloud to them in a language they genuinely understand if they cannot read it themselves — not care beginning before this genuine understanding is confirmed.

**PROVIDER SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.**

| | | | | |
|---|---|---|---|---|
| **1** | **Does every client genuinely receive a written statement of rights before care begins?**<br>*Real, prior provision, not a document given after care has already started.*<br>Doc: Client rights statement documentation | YES | PARTIAL | NO |
| **2** | **Is this statement genuinely read aloud, in a language the client understands, when they cannot read it themselves?**<br>*Real, accessible communication, not a document left unread if literacy or language is a barrier.*<br>Doc: N/A — tested directly | YES | PARTIAL | NO |
| **3** | **Can the client genuinely explain back at least some of their own rights, not just confirm receiving a document?**<br>*Real, demonstrated understanding, not confirmation of receipt alone.*<br>Doc: N/A — tested directly | YES | PARTIAL | NO |

**ALL YES** Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

| **WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks** | |
|---|---|
| **DOCUMENT**<br>*Rights statement provision review* | Reviews records confirming the written statement was genuinely provided before care began. |
| **OBSERVE**<br>*Accessibility observation* | Observes or confirms whether the statement is genuinely read aloud in an understandable language when needed. |
| **ASK**<br>*Client understanding check* | Asks a client to explain back some of their own rights, not just confirm receiving a document. |

REFERENCES

*[2] Home care providers are required by statute to provide each client with a written copy of their rights in advance of or during the initial evaluation visit and before care begins, with the statement read to the client in a language they understand if they cannot read it themselves.*

Standard 1.2 · *Standard 1: Client Rights & Dignity in the Home Setting*

# Guidance & Learning

**GUIDANCE** ASF-HC-STD1-v3.0

## WHY THIS STANDARD EXISTS

A client's real ability to exercise their rights depends on genuinely knowing what those rights are before care starts, not discovering them only if a problem later arises, and the specific requirement to have this read aloud when a client can't read it themselves is what makes this genuinely accessible, not just a document technically provided.

**The evidence: [2] Home care providers are required by statute to provide each client with a written copy of their rights in advance of or during the initial evaluation visit and before care begins, with the statement read to the client in a language they understand if they cannot read it themselves.**

| WHAT GOOD LOOKS LIKE | WHAT FAILURE LOOKS LIKE |
|---|---|
| ✓ Every client genuinely receives the written statement before care begins. | ✗ The statement is provided after care has already started, or not at all. |
| ✓ The statement is genuinely read aloud in an understandable language when needed. | ✗ No accommodation exists for a client who cannot read the statement themselves. |
| ✓ Clients can genuinely explain back some of their own rights. | ✗ Clients cannot describe any of their own rights beyond having received a document. |

## MOST COMMON REASONS PROVIDERS SCORE PARTIAL

1 **The statement is provided in advance but the read-aloud accommodation isn't consistently offered to clients who need it.**
*Genuine accessibility requires this accommodation to be consistently available, not offered only when specifically requested.*

2 **Understanding is generally confirmed but not specifically documented in a genuinely verifiable way.**
*Documented confirmation provides more reliable evidence of genuine understanding than an informal impression.*

3 **The statement is provided to the client but a legal representative, where one exists, isn't consistently also informed.**
*A legal representative's genuine understanding matters as much as the client's own, particularly for decisions requiring their involvement.*

## HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

**Week 1** Review current practice for genuine, prior provision of the written rights statement.

**Week 2** Establish a consistent read-aloud accommodation for clients unable to read the statement themselves.

**Week 3** Build a process for confirming and documenting genuine client understanding.

**Ongoing** Extend this practice consistently to any legal representative involved.

## FOR SURVEYORS — WHAT IS NOT OBVIOUS

**Ask a client to describe one or two of their own rights, not just confirm they received a document.**
*This tests genuine understanding, not just documented delivery.*

**Ask how the statement was handled for a client with limited literacy or a different primary language.**
*A specific, real example reveals genuine accessibility practice, not an assumption of adequacy.*

**E-LEARNING** academy.gmj.ge/hc-std1-2-rights-statement — 30 min · complete before self-assessment

Standard 1.3 **CORE** · *Standard 1: Client Rights & Dignity in the Home Setting*

## The Client Can Genuinely Request a Caregiver Replacement

**ASSESSMENT** ASF-HC-STD1-v3.0

| CR N/A | TR FULL | SM ADAPTED | ST FULL |
|---|---|---|---|

**1.3**
**CORE**
L1

THE STANDARD

## The Client Can Genuinely Request a Caregiver Replacement

A client can genuinely request a different caregiver when the current relationship isn't working well for them, with a real, respectful process for making this request — not locked into a single caregiver relationship they're uncomfortable with, and not made to feel this request will trigger conflict or reduced care quality.

**PROVIDER SELF-ASSESSMENT** Tick YES, PARTIAL, or NO for each question.

| | | | | |
|---|---|---|---|---|
| **1** | **Can a client genuinely request a different caregiver, with a real, known process for doing so?**<br>*A real, known, accessible process, not an unstated or discouraged option.*<br>Doc: Caregiver replacement request process | YES | PARTIAL | NO |
| **2** | **Is this request handled respectfully, without the client fearing conflict or reduced care quality as a result?**<br>*Real, respectful handling, not a request that creates tension or retaliation.*<br>Doc: N/A — tested directly | YES | PARTIAL | NO |
| **3** | **Is a replacement genuinely, practically arranged within a reasonable timeframe, not left unresolved indefinitely?**<br>*Real, timely resolution, not a request acknowledged but never actually fulfilled.*<br>Doc: Replacement resolution record | YES | PARTIAL | NO |

**ALL YES** Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

**WHAT THE ASSESSOR DOES ON SITE** no surprises, no hidden checks

| | |
|---|---|
| **ASK**<br>*Client awareness interview* | Asks a client whether they know they can request a caregiver replacement and how to do so. |
| **DOCUMENT**<br>*Request handling review* | Reviews records for evidence that replacement requests are handled respectfully and without retaliation. |
| **DOCUMENT**<br>*Resolution timeliness review* | Reviews whether replacement requests are genuinely resolved within a reasonable timeframe. |

REFERENCES

*[3] Home care clients' bill of rights specifically establishes the right to request caregiver replacement when necessary, reflecting the genuinely singular nature of the home care caregiver relationship compared with facility-based care.*

Standard 1.3 · *Standard 1: Client Rights & Dignity in the Home Setting*

## Guidance & Learning

**GUIDANCE** ASF-HC-STD1-v3.0

## WHY THIS STANDARD EXISTS

The caregiver relationship in home care is often singular and personal in a way facility-based care rarely is, and a client who feels genuinely unable to request a change — whether from personality mismatch, discomfort, or a more serious concern — has no real recourse within a single, unchangeable relationship; a real, respected replacement process is what preserves the client's genuine choice.

**The evidence: [3] Home care clients' bill of rights specifically establishes the right to request caregiver replacement when necessary, reflecting the genuinely singular nature of the home care caregiver relationship compared with facility-based care.**

| WHAT GOOD LOOKS LIKE | WHAT FAILURE LOOKS LIKE |
|---|---|
| ✓ Clients genuinely know they can request a caregiver replacement and how. | ✗ Clients don't know this option exists or feel discouraged from raising it. |
| ✓ Requests are handled respectfully, without conflict or reduced care quality. | ✗ Requests create tension or a perceived risk of reduced care quality. |
| ✓ Replacements are genuinely, practically arranged within a reasonable timeframe. | ✗ Requests are acknowledged but never actually fulfilled. |

## MOST COMMON REASONS PROVIDERS SCORE PARTIAL

1 **The option is known but clients report feeling uncomfortable actually using it.**
*Genuine comfort using a right matters as much as formal awareness that it exists.*

2 **Requests are handled respectfully but resolution timing varies significantly without explanation.**
*Consistent, timely resolution is what makes this right genuinely reliable, not dependent on circumstance.*

3 **The process works well for straightforward mismatches but isn't clearly defined for a more serious concern about the caregiver.**
*A serious concern deserves the same clear, defined process as a straightforward personality mismatch, not left ambiguous.*

## HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

**Week 1** Review current caregiver replacement practice for genuine client awareness and comfort.

**Week 2** Establish a clear, respectful, known process for requesting replacement.

**Week 3** Build a defined timeframe for resolving replacement requests.

**Ongoing** Confirm clients feel genuinely comfortable using this option when needed.

## FOR SURVEYORS — WHAT IS NOT OBVIOUS

**Ask a client directly whether they know they could request a different caregiver, and how they'd feel doing so.**
*A specific, honest answer reveals genuine awareness and comfort, not just formal policy existence.*

**Ask for a real, recent example of a replacement request and how it was actually handled.**
*A real, traceable example reveals whether this right functions in practice, not just in policy.*

**E-LEARNING** academy.gmj.ge/hc-std1-3-caregiver-replacement — 30 min · complete before self-assessment

| | Standard 1.4 **NON-NEGOTIABLE** · *Standard 1: Client Rights & Dignity in the Home Setting*<br>**A Reachable Alternate Contact Exists Beyond the Caregiver Themselves** | **ASSESSMENT** ASF-HC-STD1-v3.0 |
|---|---|---|
| **CR** FULL | **TR** FULL | **SM** FULL | **ST** FULL |

**1.4**
**NON-NEGOTIABLE**
L1

THE STANDARD

## A Reachable Alternate Contact Exists Beyond the Caregiver Themselves

The client has a genuine, known way to reach the agency or a supervisor directly, separate from the caregiver — reachable at any time care might occur, not limited to standard business hours — given a caregiver working alone in a client's home is, by definition, not available to receive a concern about their own conduct.

| PROVIDER SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question. | | | | |
|---|---|---|---|---|
| **1** | **Does the client have a genuine, known way to reach the agency or a supervisor, separate from the caregiver?**<br>*A real, distinct contact, not the caregiver themselves as the only point of contact.*<br>Doc: Alternate contact documentation | YES | PARTIAL | NO |
| **2** | **Is this contact genuinely reachable at any time care might occur, not limited to standard business hours?**<br>*Real, extended or 24/7 availability matching when care actually happens, not a narrow business-hours window.*<br>Doc: N/A — tested directly | YES | PARTIAL | NO |
| **3** | **Does the client genuinely know this contact exists and how to use it, not merely told once at intake?**<br>*Real, retained, practical awareness, not information given once and forgotten.*<br>Doc: N/A — tested directly | YES | PARTIAL | NO |

**ALL YES** Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

| WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks | |
|---|---|
| **DOCUMENT**<br>*Alternate contact review* | Reviews documentation confirming a genuine, distinct contact separate from the caregiver. |
| **DOCUMENT**<br>*Availability review* | Reviews whether this contact is genuinely reachable across the actual hours care occurs. |
| **ASK**<br>*Client awareness interview* | Asks a client whether they currently know how to reach this alternate contact. |

REFERENCES

*[4] Home care clients' bill of rights specifically establishes the right to contact the agency directly, separate from the caregiver, at any time care might occur, reflecting the necessary safeguard this represents given the isolated nature of one-on-one home caregiving.*

Standard 1.4 · *Standard 1: Client Rights & Dignity in the Home Setting*

## Guidance & Learning

GUIDANCE ASF-HC-STD1-v3.0

### WHY THIS STANDARD EXISTS

A concern about a caregiver's own conduct or performance can't genuinely be raised to that same caregiver, and a client who has no other real, known way to reach the agency has no real recourse for exactly the kind of concern this contact exists to address — this isn't a general customer service nicety, it's a specific, necessary safeguard given the caregiver relationship's genuine isolation.

**The evidence: [4] Home care clients' bill of rights specifically establishes the right to contact the agency directly, separate from the caregiver, at any time care might occur, reflecting the necessary safeguard this represents given the isolated nature of one-on-one home caregiving.**

| WHAT GOOD LOOKS LIKE | WHAT FAILURE LOOKS LIKE |
|---|---|
| ✓ A genuine, distinct contact exists, separate from the caregiver. | ✗ The caregiver is effectively the only point of contact for any concern. |
| ✓ This contact is genuinely reachable across the actual hours care occurs. | ✗ The alternate contact is only reachable during limited business hours. |
| ✓ Clients genuinely, currently know how to use this contact. | ✗ Clients were told once at intake but no longer recall how to reach this contact. |

### MOST COMMON REASONS PROVIDERS SCORE PARTIAL

1 **A contact exists and is reachable but isn't proactively reintroduced to clients periodically.**
*Genuine, retained awareness benefits from periodic reinforcement, not information given only once.*

2 **Availability covers daytime hours well but overnight or weekend care isn't matched by equivalent contact availability.**
*The contact's real value depends on matching the actual hours care occurs, not just typical hours.*

3 **The contact exists for general concerns but clients aren't specifically told this is where a concern about the caregiver's own conduct should go.**
*Clients need to specifically know this contact is the right place for exactly this kind of concern, not left to infer it.*

### HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

**Week 1** Review current alternate contact availability against the actual hours care occurs.

**Week 2** Establish or extend contact availability to match actual care hours.

**Week 3** Build periodic reinforcement of this contact information for clients.

**Ongoing** Confirm clients retain genuine, practical awareness of this contact.

### FOR SURVEYORS — WHAT IS NOT OBVIOUS

**Ask a client directly, without prompting, how they would reach someone other than their caregiver with a concern.**
*An unprompted, confident answer reveals genuine, retained awareness, not information given once and forgotten.*

**Test contact availability during an off-hours period specifically.**
*This is where alternate contact availability is most likely to fall short of matching actual care hours.*

**E-LEARNING** academy.gmj.ge/hc-std1-4-alternate-contact — 30 min · complete before self-assessment

| | Standard 1.5 **NON-NEGOTIABLE** · *Standard 1: Client Rights & Dignity in the Home Setting*<br>**Freedom From Abuse and Neglect Is Actively Verified** | **ASSESSMENT** ASF-HC-STD1-v3.0 |
|---|---|---|

| **CR** FULL | **TR** FULL | **SM** ADAPTED | **ST** FULL |
|---|---|---|---|

**1.5**
**NON-NEGOTIABLE**
L1

THE STANDARD

## Freedom From Abuse and Neglect Is Actively Verified

Freedom from physical, verbal, emotional, and sexual abuse, and from neglect, is genuinely, actively verified through real, periodic check-ins independent of the caregiver — not simply stated as a right on a document and otherwise assumed absent good reason to suspect a problem.

| **PROVIDER SELF-ASSESSMENT** Tick YES, PARTIAL, or NO for each question. | | | | |
|---|---|---|---|---|
| **1** | **Is freedom from abuse and neglect genuinely, actively verified through real, periodic independent check-ins?**<br>*Real, active verification, not an assumption of safety absent a specific complaint.*<br>Doc: Independent check-in record | YES | PARTIAL | NO |
| **2** | **Are these check-ins genuinely conducted separate from the caregiver, not observed or overheard by them?**<br>*Real, genuine independence, not a check-in that occurs in the caregiver's presence.*<br>Doc: N/A — tested directly | YES | PARTIAL | NO |
| **3** | **Is there a specific, defined response process if a check-in reveals a genuine concern?**<br>*A real, defined response, not a concern noted without resulting action.*<br>Doc: Concern response protocol | YES | PARTIAL | NO |

**ALL YES** Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

| **WHAT THE ASSESSOR DOES ON SITE** no surprises, no hidden checks | |
|---|---|
| **DOCUMENT**<br>*Check-in record review* | Reviews records of genuine, periodic, independent check-ins with clients. |
| **OBSERVE**<br>*Independence verification* | Confirms check-ins are genuinely conducted separate from the caregiver's presence. |
| **DOCUMENT**<br>*Response protocol review* | Reviews the specific, defined response process for a concern identified during a check-in. |

REFERENCES

*[5] Home care clients' bill of rights establishes freedom from physical, verbal, emotional, and sexual abuse and from neglect as a foundational right, requiring active protective measures given the isolated, largely unsupervised nature of one-on-one home caregiving.*

Standard 1.5 · *Standard 1: Client Rights & Dignity in the Home Setting*

# Guidance & Learning

**GUIDANCE** ASF-HC-STD1-v3.0

## WHY THIS STANDARD EXISTS

A client experiencing abuse or neglect from an isolated, unsupervised caregiver has no facility staff, no colleague, and no witness who might otherwise notice — genuine, independent verification through periodic contact separate from the caregiver relationship itself is what actually protects this right, not the mere statement of it in a rights document the client received once.

**The evidence: [5] Home care clients' bill of rights establishes freedom from physical, verbal, emotional, and sexual abuse and from neglect as a foundational right, requiring active protective measures given the isolated, largely unsupervised nature of one-on-one home caregiving.**

| WHAT GOOD LOOKS LIKE | WHAT FAILURE LOOKS LIKE |
|---|---|
| ✓ Freedom from abuse and neglect is genuinely, actively verified through periodic independent check-ins. | ✗ Safety is assumed absent a specific complaint, with no active verification. |
| ✓ Check-ins are genuinely conducted separate from the caregiver's presence. | ✗ Check-ins, if any, occur in the caregiver's presence, undermining genuine independence. |
| ✓ A specific, defined response process exists for any identified concern. | ✗ No defined response exists if a concern is identified. |

## MOST COMMON REASONS PROVIDERS SCORE PARTIAL

1 **Check-ins happen but not on a genuinely regular, defined schedule.**
*A regular, defined schedule is what makes this verification reliably protective, not occasional or reactive contact.*

2 **Check-ins are independent but don't specifically ask about the caregiver relationship, focusing only on general wellbeing.**
*Genuine verification benefits from specific attention to the caregiver relationship itself, not general wellbeing alone.*

3 **A response process exists but hasn't been specifically tested against a real identified concern.**
*An untested response process may not function reliably when a genuine concern actually arises.*

## HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

**Week 1** Review current practice for genuine, independent, periodic client check-ins.

**Week 2** Establish a regular, defined check-in schedule conducted separate from the caregiver.

**Week 3** Build check-ins to specifically address the caregiver relationship, not general wellbeing alone.

**Ongoing** Confirm the response process functions when a genuine concern is identified.

## FOR SURVEYORS — WHAT IS NOT OBVIOUS

**Ask how a check-in would genuinely occur without the caregiver present or aware of its specific content.**
*A specific, confident answer reveals genuine independence, not a check-in that's effectively supervised.*

**Ask for a real example of a concern identified through a check-in and what happened next.**
*A real, traceable example reveals whether this process genuinely functions, not just exists in policy.*

**E-LEARNING** academy.gmj.ge/hc-std1-5-abuse-neglect-verification — 30 min · complete before self-assessment

# STANDARD 2

## Caregiver Screening & Background Verification

**MANDATORY**

*5 criteria*

| | Standard 2.1 **NON-NEGOTIABLE** · *Standard 2: Caregiver Screening & Background Verification*<br>**Background Screening Uses Verified Identity, Not Name-Based Matching Alone** | **ASSESSMENT** ASF-HC-STD2-v3.0 |
|---|---|---|
| **CR** FULL | **TR** FULL | **SM** FULL | **ST** FULL |

**2.1**
**NON-NEGOTIABLE**
L1

THE STANDARD

## Background Screening Uses Verified Identity, Not Name-Based Matching Alone

Every caregiver undergoes a genuine criminal record check verified against a unique identifier — fingerprint, national identity number, or another reliable biometric or official record — not a name-based search alone, which can miss real, disqualifying history recorded under a different or misspelled name, or fail to distinguish between people who genuinely share a common name.

| **PROVIDER SELF-ASSESSMENT** Tick YES, PARTIAL, or NO for each question. | | | | |
|---|---|---|---|---|
| **1** | **Does every caregiver undergo a criminal record check verified against a unique identifier, not a name-based search alone?**<br>*Real, identity-verified screening, not a less reliable name-based alternative.*<br>Doc: Identity-verified screening record | YES | PARTIAL | NO |
| **2** | **Is this screening genuinely completed before the caregiver has any unsupervised access to a client?**<br>*Real, prior completion, not access granted while screening is still pending.*<br>Doc: Screening completion timing record | YES | PARTIAL | NO |
| **3** | **Does the check draw on the most complete official record genuinely available in this jurisdiction, not a partial or limited search?**<br>*Real, comprehensive use of whatever official record system genuinely exists here, not the narrowest possible search.*<br>Doc: N/A — tested directly | YES | PARTIAL | NO |

**ALL YES** Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

| **WHAT THE ASSESSOR DOES ON SITE** no surprises, no hidden checks | |
|---|---|
| **DOCUMENT**<br>*Identity-verified screening review* | Reviews records confirming genuine, identity-verified screening for every caregiver. |
| **DOCUMENT**<br>*Timing review* | Reviews whether screening genuinely completed before any unsupervised client access. |
| **DOCUMENT**<br>*Record completeness review* | Reviews whether the check genuinely draws on the most complete official record system available in this jurisdiction. |

REFERENCES

*[6] Established vetting practice across multiple countries' care-sector screening systems requires criminal record checks verified against a fingerprint or other unique official identifier, distinct from and more reliable than a name-based search alone, particularly in regions where common names or limited civil registration make name-matching unreliable.*

Standard 2.1 · *Standard 2: Caregiver Screening & Background Verification*

## Guidance & Learning

**GUIDANCE** ASF-HC-STD2-v3.0

### WHY THIS STANDARD EXISTS

A caregiver will often work entirely alone with a vulnerable person in their own home, and a name-based check — genuinely less reliable than verification against a unique, official identifier — can miss real, disqualifying criminal history or wrongly implicate an innocent person sharing a common name; this isn't a minor technical distinction, it's the difference between a screening process that actually works and one that only appears to.

**The evidence: [6] Established vetting practice across multiple countries' care-sector screening systems requires criminal record checks verified against a fingerprint or other unique official identifier, distinct from and more reliable than a name-based search alone, particularly in regions where common names or limited civil registration make name-matching unreliable.**

| WHAT GOOD LOOKS LIKE | WHAT FAILURE LOOKS LIKE |
|---|---|
| ✓ Every caregiver genuinely undergoes identity-verified criminal record screening. | ✗ Screening relies on a name-based check alone, without identity verification. |
| ✓ Screening is genuinely completed before any unsupervised client access. | ✗ Caregivers have unsupervised access while screening is still pending. |
| ✓ The check genuinely uses the most complete official record system available here. | ✗ The check uses only a minimal or partial search when a more complete official record system is genuinely available. |

### MOST COMMON REASONS PROVIDERS SCORE PARTIAL

1 **Identity-verified screening is used for direct hires but not consistently for contracted or agency-placed caregivers.**
*Every caregiver entering a client's home carries the same real risk, regardless of employment arrangement.*

2 **Screening is completed before hire but a gap sometimes exists before results are actually reviewed.**
*Genuine protection depends on results being reviewed, not merely initiated, before unsupervised access begins.*

3 **A genuinely more complete record system exists in this jurisdiction but the service defaults to a narrower, easier search instead.**
*Choosing the narrower search when a more complete one is genuinely available defeats the real purpose of this criterion.*

### HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

**Week 1** Review current screening practice for genuine identity-verified checking across all caregiver types.

**Week 2** Establish a firm requirement that unsupervised access never begins before results are reviewed.

**Week 3** Confirm the most complete official record system genuinely available here is actually being used.

**Ongoing** Audit screening completeness for contracted and agency-placed caregivers specifically.

### FOR SURVEYORS — WHAT IS NOT OBVIOUS

**Ask to see the actual, identity-verified screening record for a specific, real caregiver.**
*A specific, real record reveals genuine practice, not an assumption of adequate screening.*

**Ask how a contracted or agency-placed caregiver's screening differs from a direct hire's.**
*This reveals whether genuine screening rigor extends beyond the most straightforward hiring arrangement.*

**E-LEARNING** academy.gmj.ge/hc-std2-1-identity-verified-screening — 30 min · complete before self-assessment

Standard 2.2 **NON-NEGOTIABLE** · *Standard 2: Caregiver Screening & Background Verification*

**Abuse Registries Are Checked in Every Jurisdiction the Caregiver Has Worked**

**ASSESSMENT** ASF-HC-STD2-v3.0

| CR FULL | TR FULL | SM ADAPTED | ST FULL |
|---|---|---|---|

**2.2**
**NON-NEGOTIABLE**
L1

THE STANDARD

## Abuse Registries Are Checked in Every Jurisdiction the Caregiver Has Worked

Where a national, regional, or local abuse and neglect registry exists, it is genuinely checked for every jurisdiction where the caregiver has previously worked, not only their current place of residence — given a real, disqualifying finding in a prior location doesn't disappear simply because the caregiver has since relocated.

| PROVIDER SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question. | | | | |
|---|---|---|---|---|
| **1** | **Are relevant abuse registries genuinely checked for every jurisdiction the caregiver has worked?**<br>*Real, comprehensive checking, not limited to current location.*<br>Doc: Multi-jurisdiction registry check record | YES | PARTIAL | NO |
| **2** | **Is prior work history genuinely, specifically obtained to identify which jurisdictions require checking?**<br>*Real, specific inquiry, not an assumption of only local work history.*<br>Doc: Work history disclosure record | YES | PARTIAL | NO |
| **3** | **Is there a process for verifying the caregiver's stated work history, not accepted on self-report alone?**<br>*Real, independent verification, not self-report taken at face value.*<br>Doc: Work history verification process | YES | PARTIAL | NO |

**ALL YES** Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

| WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks | |
|---|---|
| **DOCUMENT**<br>*Multi-jurisdiction check review* | Reviews records confirming registry checks genuinely cover every jurisdiction the caregiver has worked, where such registries exist. |
| **DOCUMENT**<br>*Work history disclosure review* | Reviews whether work history is genuinely, specifically obtained to identify relevant jurisdictions. |
| **DOCUMENT**<br>*Verification process review* | Reviews the process for independently verifying self-reported work history. |

REFERENCES

*[7] Comprehensive caregiver background screening requires searching abuse and neglect registries, where they exist, in the caregiver's current location as well as other jurisdictions where they have previously worked, given that a substantiated finding in a prior location remains genuinely relevant regardless of subsequent relocation.*

Standard 2.2 · *Standard 2: Caregiver Screening & Background Verification*

## Guidance & Learning

**GUIDANCE** ASF-HC-STD2-v3.0

### WHY THIS STANDARD EXISTS

A caregiver with a genuine, substantiated abuse or neglect finding in one place could otherwise relocate — across a region, or across a border — and pass a screening that only checks their current location's registry, and this isn't a hypothetical concern — it's specifically why comprehensive screening practice explicitly extends this check to every jurisdiction a caregiver has actually worked, not just where they currently live.

**The evidence: [7] Comprehensive caregiver background screening requires searching abuse and neglect registries, where they exist, in the caregiver's current location as well as other jurisdictions where they have previously worked, given that a substantiated finding in a prior location remains genuinely relevant regardless of subsequent relocation.**

| WHAT GOOD LOOKS LIKE | WHAT FAILURE LOOKS LIKE |
|---|---|
| ✓ Registry checks genuinely cover every jurisdiction the caregiver has previously worked, where a registry exists. | ✗ Registry checks are limited to the caregiver's current location. |
| ✓ Work history is genuinely, specifically obtained to identify relevant jurisdictions. | ✗ Work history isn't specifically obtained; only current location is checked. |
| ✓ Self-reported work history is independently, genuinely verified. | ✗ Self-reported work history is accepted without any independent verification. |

### MOST COMMON REASONS PROVIDERS SCORE PARTIAL

1 **Multi-jurisdiction checking happens for recent work history but not for employment further in the past.**
*A substantiated finding remains genuinely relevant regardless of how long ago it occurred.*

2 **Work history is obtained but isn't cross-checked against other available records for accuracy.**
*Genuine verification protects against an incomplete or inaccurate self-reported history.*

3 **The process is thorough for caregivers with a clearly documented history but less rigorous for those with gaps in their reported history.**
*A gap in reported history is exactly where a genuine, undisclosed prior finding is most likely to be hiding.*

### HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

**Week 1** Review current registry checking practice for genuine multi-jurisdiction coverage.

**Week 2** Establish specific, thorough work history collection covering the caregiver's full relevant history.

**Week 3** Build independent verification of self-reported work history.

**Ongoing** Give specific attention to caregivers with gaps or ambiguity in their reported history.

### FOR SURVEYORS — WHAT IS NOT OBVIOUS

**Ask how the service would identify which jurisdictions to check for a caregiver with a long, varied work history.**
*A specific, confident answer reveals genuine, thorough practice, not a check limited to current residence.*

**Ask what happens when a caregiver's reported work history has a genuine gap or inconsistency.**
*A specific, thoughtful answer reveals whether verification genuinely addresses this real risk.*

**E-LEARNING** academy.gmj.ge/hc-std2-2-multi-jurisdiction-registry-check — 30 min · complete before self-assessment

Standard 2.3 **NON-NEGOTIABLE** · *Standard 2: Caregiver Screening & Background Verification*

# Any National Care-Worker Exclusion Registry Is Specifically Checked

**ASSESSMENT** ASF-HC-STD2-v3.0

| CR FULL | TR FULL | SM FULL | ST FULL |
|---|---|---|---|

**2.3**
**NON-NEGOTIABLE**
L1

THE STANDARD

## Any National Care-Worker Exclusion Registry Is Specifically Checked

Where a national or regional registry exists that specifically bars individuals from care-related work due to substantiated misconduct — distinct from a general criminal record — every caregiver is specifically checked against it, not assumed covered by a general criminal background check alone; where no such registry exists in this jurisdiction, the service verifies this history through the most reliable alternative genuinely available, such as direct verification with prior care-sector employers.

| PROVIDER SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question. | | | | |
|---|---|---|---|---|
| **1** | **Where a national care-worker exclusion registry exists, is every caregiver specifically checked against it?**<br>*Real, distinct verification, not conflated with general criminal checking.*<br>Doc: Exclusion registry check record | YES | PARTIAL | NO |
| **2** | **Where no such registry exists, is a genuine alternative verification effort made?**<br>*A real, active alternative, not a gap treated as an excuse to skip verification.*<br>Doc: Alternative verification documentation | YES | PARTIAL | NO |
| **3** | **Is this check genuinely repeated periodically, not limited to a one-time check at hire?**<br>*Real, periodic reconfirmation, not a check assumed valid indefinitely.*<br>Doc: Periodic recheck schedule | YES | PARTIAL | NO |

**ALL YES** Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

| WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks | |
|---|---|
| **DOCUMENT**<br>*Exclusion registry check review* | Reviews records confirming specific, distinct verification against any relevant national exclusion registry. |
| **DOCUMENT**<br>*Alternative verification review* | Where no such registry exists, reviews evidence of a genuine alternative verification effort. |
| **DOCUMENT**<br>*Periodic recheck review* | Reviews whether this check is genuinely repeated periodically. |

REFERENCES

*[8] Comprehensive caregiver background screening in jurisdictions that maintain a dedicated care-worker exclusion or barred-persons registry requires this to be specifically checked, distinct from and not covered by a general criminal history search alone, given such registries can capture substantiated misconduct that a criminal record search would not.*

Standard 2.3 · *Standard 2: Caregiver Screening & Background Verification*

## Guidance & Learning

**GUIDANCE** ASF-HC-STD2-v3.0

## WHY THIS STANDARD EXISTS

A registry specifically barring individuals from care work can identify people excluded for reasons a standard criminal check may not capture — a substantiated finding that fell short of criminal prosecution, for instance — and a service that doesn't specifically check this distinct source, where one exists, or make a genuine equivalent effort where one doesn't, has a real, distinct gap in its screening process.

**The evidence: [8] Comprehensive caregiver background screening in jurisdictions that maintain a dedicated care-worker exclusion or barred-persons registry requires this to be specifically checked, distinct from and not covered by a general criminal history search alone, given such registries can capture substantiated misconduct that a criminal record search would not.**

| WHAT GOOD LOOKS LIKE | WHAT FAILURE LOOKS LIKE |
|---|---|
| ✓ Every caregiver is specifically, distinctly checked against any relevant national exclusion registry. | ✗ An existing exclusion registry is assumed covered by general criminal background checking alone. |
| ✓ Where no registry exists, a genuine alternative verification effort is made. | ✗ Absence of a national registry is treated as reason to skip this verification entirely. |
| ✓ This check is genuinely repeated periodically, not a one-time verification. | ✗ The check happens once at hire and is never repeated. |

## MOST COMMON REASONS PROVIDERS SCORE PARTIAL

1 **The check happens at hire but isn't genuinely repeated on a defined, regular schedule.**
*A caregiver's exclusion status can change after hire, and periodic rechecking reflects this genuine possibility.*

2 **Where no registry exists, alternative verification happens inconsistently rather than as a genuine, standard practice.**
*The absence of a formal registry shouldn't mean this verification effort becomes optional or informal.*

3 **Rechecking happens but isn't consistently documented in a way that's genuinely verifiable.**
*Documented rechecking is what makes genuine, ongoing compliance verifiable, not simply assumed.*

## HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

**Week 1** Review current screening for specific, distinct verification against any relevant exclusion registry.

**Week 2** Establish a periodic, defined recheck schedule for this verification.

**Week 3** Where no registry exists, build a genuine, standard alternative verification process.

**Ongoing** Document each periodic recheck for genuine verifiability.

## FOR SURVEYORS — WHAT IS NOT OBVIOUS

**Ask whether a national care-worker exclusion registry exists here, and how the service checks it.**
*A specific, confident answer reveals genuine awareness and practice, not an assumption of adequacy.*

**Where no such registry exists, ask what genuine alternative verification the service actually performs.**
*A specific, real answer reveals whether the absence of a registry is treated as a real gap to fill, not an excuse to skip verification.*

**E-LEARNING** academy.gmj.ge/hc-std2-3-care-worker-exclusion-check — 30 min · complete before self-assessment

| | Standard 2.4 **NON-NEGOTIABLE** · *Standard 2: Caregiver Screening & Background Verification* **Screening Is Genuinely Repeated Periodically** | **ASSESSMENT** ASF-HC-STD2-v3.0 |
|---|---|---|

| **CR** ADAPTED | **TR** FULL | **SM** FULL | **ST** FULL |
|---|---|---|---|

**2.4**
**NON-NEGOTIABLE**
L1

THE STANDARD

## Screening Is Genuinely Repeated Periodically

Background screening is genuinely repeated on a periodic, defined schedule for every active caregiver — not treated as a one-time check completed at initial hire and never revisited, given a caregiver's record can genuinely change after they've already begun working with clients.

| **PROVIDER SELF-ASSESSMENT** Tick YES, PARTIAL, or NO for each question. | | | | |
|---|---|---|---|---|
| **1** | **Is background screening genuinely repeated on a periodic, defined schedule for every active caregiver?** *Real, periodic rescreening, not a one-time check assumed to remain valid indefinitely.* Doc: Periodic rescreening schedule documentation | YES | PARTIAL | NO |
| **2** | **Does rescreening genuinely cover the same comprehensive scope as initial screening, not an abbreviated check?** *Real, complete rescreening, not a narrower or less thorough repeat check.* Doc: N/A — tested directly | YES | PARTIAL | NO |
| **3** | **Is there a specific, defined response if rescreening reveals a genuine, new disqualifying finding?** *A real, defined response, not continued employment despite a genuinely new finding.* Doc: Rescreening finding response process | YES | PARTIAL | NO |

**ALL YES** Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

| **WHAT THE ASSESSOR DOES ON SITE** no surprises, no hidden checks | |
|---|---|
| **DOCUMENT** *Rescreening schedule review* | Reviews the defined schedule for periodic rescreening of active caregivers. |
| **DOCUMENT** *Scope completeness review* | Reviews whether rescreening genuinely matches the comprehensive scope of initial screening. |
| **DOCUMENT** *Finding response review* | Reviews the defined response process for a new disqualifying finding identified through rescreening. |

REFERENCES

*[9] Established care-sector screening practice increasingly recommends periodic rescreening for caregivers, distinct from a one-time check completed only at initial hire, reflecting that a caregiver's record can genuinely change during active employment.*

Standard 2.4 · *Standard 2: Caregiver Screening & Background Verification*

## Guidance & Learning

**GUIDANCE** ASF-HC-STD2-v3.0

### WHY THIS STANDARD EXISTS

A caregiver who passed screening at hire could genuinely accumulate a disqualifying finding afterward, and a service relying solely on the initial screening has no real way of knowing whether a currently active caregiver's record has since changed — periodic rescreening is what actually keeps this protection current, not just historically accurate.

**The evidence: [9] Established care-sector screening practice increasingly recommends periodic rescreening for caregivers, distinct from a one-time check completed only at initial hire, reflecting that a caregiver's record can genuinely change during active employment.**

| WHAT GOOD LOOKS LIKE | WHAT FAILURE LOOKS LIKE |
|---|---|
| ✓ Screening is genuinely repeated on a periodic, defined schedule. | ✗ Screening happens once at hire and is never genuinely repeated. |
| ✓ Rescreening genuinely matches the comprehensive scope of initial screening. | ✗ Rescreening, if any, is abbreviated compared with initial screening. |
| ✓ A real, defined response addresses any new disqualifying finding. | ✗ No defined response exists for a new finding identified through rescreening. |

### MOST COMMON REASONS PROVIDERS SCORE PARTIAL

1 **Rescreening happens but the interval between checks is long enough that a genuine change could go uncaught for an extended period.**
*A genuinely protective interval catches a change before it's had an extended period to matter.*

2 **Rescreening covers criminal history but doesn't consistently repeat the abuse registry or exclusion registry checks.**
*Every component of the original comprehensive screening carries the same real, ongoing relevance.*

3 **A response process exists but hasn't been applied to a real, identified rescreening finding to date.**
*An untested response process may not function reliably when a genuine rescreening finding actually occurs.*

### HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

**Week 1** Review current screening practice for genuine, periodic rescreening versus a one-time check.

**Week 2** Establish a defined rescreening schedule matching the full scope of initial screening.

**Week 3** Build a specific, defined response process for a new rescreening finding.

**Ongoing** Confirm rescreening occurs consistently across the full active caregiver roster.

### FOR SURVEYORS — WHAT IS NOT OBVIOUS

**Ask when a specific, currently active caregiver was last rescreened.**
*A specific, real answer reveals genuine, ongoing practice, not a one-time historical check.*

**Ask whether rescreening covers the same components as initial screening, not just criminal history.**
*This reveals whether rescreening is genuinely comprehensive, not an abbreviated repeat.*

**E-LEARNING** academy.gmj.ge/hc-std2-4-periodic-rescreening — 30 min · complete before self-assessment

| | | |
|---|---|---|
| | Standard 2.5 **CORE** · *Standard 2: Caregiver Screening & Background Verification*<br>**A Disqualifying Finding Triggers Individualized Assessment** | **ASSESSMENT** ASF-HC-STD2-v3.0 |

| CR N/A | TR FULL | SM ADAPTED | ST FULL |
|---|---|---|---|

**2.5**
**CORE**
L1

THE STANDARD

## A Disqualifying Finding Triggers Individualized Assessment

A criminal history finding triggers a genuine, individualized assessment of its actual relevance to caregiving work — not an automatic, blanket rejection applied regardless of the finding's nature, age, or relevance to the specific role.

**PROVIDER SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.**

| | | | | |
|---|---|---|---|---|
| **1** | **Does a criminal history finding trigger a genuine, individualized assessment, not an automatic blanket rejection?**<br>*Real, case-specific evaluation, not a policy that disqualifies regardless of context.*<br>Doc: Individualized assessment documentation | YES | PARTIAL | NO |
| **2** | **Does this assessment genuinely consider the nature, age, and relevance of the finding to caregiving specifically?**<br>*Real, specific consideration of these factors, not a superficial review.*<br>Doc: N/A — tested directly | YES | PARTIAL | NO |
| **3** | **Is the assessment process itself consistently applied, not varying arbitrarily between different candidates?**<br>*Genuine, consistent application, not inconsistent treatment of similar findings across different candidates.*<br>Doc: N/A — tested directly | YES | PARTIAL | NO |

**ALL YES** Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

**WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks**

| | |
|---|---|
| **DOCUMENT**<br>*Assessment documentation review* | Reviews evidence of genuine, individualized assessment for criminal history findings. |
| **DOCUMENT**<br>*Factor consideration review* | Reviews whether assessments genuinely consider nature, age, and relevance to caregiving. |
| **DOCUMENT**<br>*Consistency review* | Reviews whether the assessment process is consistently applied across different candidates. |

REFERENCES

*[10] Established good practice in employment vetting recognizes individualized assessment of criminal history findings as more accurate and fairer than blanket disqualification policies, distinct from automatic rejection applied without regard to the finding's actual nature, age, or relevance.*

Standard 2.5 · *Standard 2: Caregiver Screening & Background Verification*

## Guidance & Learning

**GUIDANCE** ASF-HC-STD2-v3.0

### WHY THIS STANDARD EXISTS

A genuinely individualized assessment — considering the nature of the offense, how long ago it occurred, and its actual relevance to caregiving — is what balances real client safety against fair treatment of a candidate, rather than either extreme of ignoring a genuine concern or automatically excluding someone regardless of context; this is recognized good practice in vetting and employment decisions broadly, not a narrow technical requirement.

**The evidence: [10] Established good practice in employment vetting recognizes individualized assessment of criminal history findings as more accurate and fairer than blanket disqualification policies, distinct from automatic rejection applied without regard to the finding's actual nature, age, or relevance.**

| WHAT GOOD LOOKS LIKE | WHAT FAILURE LOOKS LIKE |
|---|---|
| ✓ A genuine, individualized assessment occurs for every criminal history finding. | ✗ Blanket disqualification is applied automatically, regardless of the finding's context. |
| ✓ The assessment genuinely considers nature, age, and relevance to caregiving. | ✗ Assessment, if any, doesn't genuinely consider relevant factors. |
| ✓ The process is applied consistently across different candidates. | ✗ The process varies arbitrarily between different candidates with similar findings. |

### MOST COMMON REASONS PROVIDERS SCORE PARTIAL

1 **Individualized assessment is applied for common, minor findings but less consistently for more serious ones.**
*Every finding deserves the same genuine, individualized consideration, particularly serious ones where the stakes of the decision are highest.*

2 **Assessment considers the nature of the offense but doesn't specifically document how age and relevance were actually weighed.**
*Documented, specific reasoning provides more genuine assurance the assessment was substantive, not a formality.*

3 **The process is generally consistent but hasn't been specifically reviewed for potential disparate impact across candidates.**
*A review for disparate impact is what confirms the process is genuinely fair, not just procedurally consistent.*

### HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

**Week 1** Review current practice for genuine individualized assessment versus blanket disqualification.

**Week 2** Establish a structured assessment process specifically documenting nature, age, and relevance factors.

**Week 3** Train staff conducting assessments on consistent, fair application.

**Ongoing** Review assessment decisions periodically for genuine consistency across candidates.

### FOR SURVEYORS — WHAT IS NOT OBVIOUS

**Ask for a real, specific example of an individualized assessment and how the decision was actually reached.**
*A real, traceable example reveals genuine, substantive assessment, not a formality.*

**Ask how the service ensures consistent treatment of similar findings across different candidates.**
*A specific, thoughtful answer reveals genuine attention to fairness, not an assumption of consistency.*

**E-LEARNING** academy.gmj.ge/hc-std2-5-individualized-assessment — 30 min · complete before self-assessment

# STANDARD 3

## Home Environment Safety Assessment

**MANDATORY**

*5 criteria*

| | Standard 3.1 **NON-NEGOTIABLE** · *Standard 3: Home Environment Safety Assessment*<br>**A Genuine, Structured Home Safety Assessment Occurs Before Care Begins** | **ASSESSMENT** ASF-HC-STD3-v3.0 |
|---|---|---|
| **CR** FULL | **TR** FULL | **SM** FULL | **ST** FULL |

**3.1**
**NON-NEGOTIABLE**
L1

THE STANDARD

## A Genuine, Structured Home Safety Assessment Occurs Before Care Begins

A genuine, structured home safety assessment — covering flooring, lighting, stairs, bathroom hazards, and clear pathways — is conducted before care begins, not assumed adequate from a general first impression of the home.

| PROVIDER SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question. | | | | |
|---|---|---|---|---|
| **1** | **Does a genuine, structured home safety assessment occur before care begins, not a general impression alone?**<br>*Real, structured assessment using a defined checklist, not an informal, general impression.*<br>Doc: Home safety assessment documentation | YES | PARTIAL | NO |
| **2** | **Does this assessment genuinely cover flooring, lighting, stairs, bathroom hazards, and clear pathways specifically?**<br>*Complete, specific coverage of these real hazard categories, not a partial or generic check.*<br>Doc: N/A — tested directly | YES | PARTIAL | NO |
| **3** | **Is the assessment genuinely completed by someone trained to recognise these specific hazards, not left to informal observation?**<br>*Real, trained assessment, not an untrained caregiver's informal impression.*<br>Doc: Assessor training record | YES | PARTIAL | NO |

**ALL YES** Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

| WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks | |
|---|---|
| **DOCUMENT**<br>*Assessment documentation review* | Reviews the actual, structured home safety assessment record for a sample of clients. |
| **DOCUMENT**<br>*Coverage completeness review* | Reviews whether the assessment genuinely covers all specific, defined hazard categories. |
| **DOCUMENT**<br>*Assessor training review* | Reviews training records confirming the assessor is genuinely trained to recognise these hazards. |

REFERENCES

*[11] A meta-analysis of home safety intervention found it could reduce falls by 39 percent among at-risk seniors, with structured home fall-hazard checklists established as an effective, evidence-based fall prevention strategy distinct from a general, unstructured impression of the home.*

Standard 3.1 · *Standard 3: Home Environment Safety Assessment*

## Guidance & Learning

**GUIDANCE** ASF-HC-STD3-v3.0

### WHY THIS STANDARD EXISTS

Home fall-hazard checklists are established as an effective fall prevention strategy, with home safety intervention shown to reduce falls by nearly 39 percent among at-risk seniors, and a service that skips this genuine, structured assessment in favor of a general impression misses the specific, real hazards a structured checklist is actually designed to catch.

**The evidence: [11] A meta-analysis of home safety intervention found it could reduce falls by 39 percent among at-risk seniors, with structured home fall-hazard checklists established as an effective, evidence-based fall prevention strategy distinct from a general, unstructured impression of the home.**

| WHAT GOOD LOOKS LIKE | WHAT FAILURE LOOKS LIKE |
|---|---|
| ✓ A genuine, structured assessment occurs before care begins for every client. | ✗ Assessment relies on a general impression, not a structured checklist. |
| ✓ The assessment genuinely covers all specific, defined hazard categories. | ✗ The assessment covers some hazard categories but misses others. |
| ✓ The assessment is genuinely completed by someone trained to recognise these hazards. | ✗ The assessment is completed by someone without genuine, specific training. |

### MOST COMMON REASONS PROVIDERS SCORE PARTIAL

1 **The assessment is thorough for common areas but doesn't specifically address less obvious spaces like a basement or garage the client actually uses.**
*Every space the client genuinely uses carries real hazard potential, not only the most visible rooms.*

2 **The assessment happens before care begins but documentation doesn't clearly capture what was specifically checked.**
*Specific documentation is what makes the assessment genuinely verifiable and actionable later.*

3 **Assessor training covers general hazard awareness but not the specific, structured checklist categories used.**
*Structured, checklist-specific training is what actually equips an assessor to catch hazards general awareness alone would miss.*

### HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

**Week 1** Review current pre-care assessment practice for genuine, structured coverage.

**Week 2** Adopt or strengthen a structured home safety checklist covering all key hazard categories.

**Week 3** Train assessors specifically on the structured checklist and hazard recognition.

**Ongoing** Extend assessment to all spaces the client genuinely uses, not only common areas.

### FOR SURVEYORS — WHAT IS NOT OBVIOUS

**Ask to see the actual, structured home safety assessment for a specific, real client.**
*A real, specific record reveals genuine, structured practice, not an assumption of general adequacy.*

**Ask an assessor to describe the specific hazard categories the checklist covers.**
*A specific, confident answer reveals genuine, structured training, not general hazard awareness.*

**E-LEARNING** academy.gmj.ge/hc-std3-1-structured-home-assessment — 30 min · complete before self-assessment

| | Standard 3.2 **NON-NEGOTIABLE** · *Standard 3: Home Environment Safety Assessment* **Identified Hazards Lead to Genuine, Tracked Remediation** | **ASSESSMENT** ASF-HC-STD3-v3.0 |
|---|---|---|

| **CR** FULL | **TR** FULL | **SM** ADAPTED | **ST** FULL |
|---|---|---|---|

**3.2**
**NON-NEGOTIABLE**
L1

THE STANDARD

## Identified Hazards Lead to Genuine, Tracked Remediation

A hazard identified during home safety assessment leads to genuine, tracked remediation — a specific action taken, a specific person responsible, a specific timeframe — not a hazard noted on a checklist and then left unaddressed.

| **PROVIDER SELF-ASSESSMENT** Tick YES, PARTIAL, or NO for each question. | | | | |
|---|---|---|---|---|
| **1** | **Does an identified hazard lead to genuine, tracked remediation, not a checklist item left unaddressed?** *Real, tracked, resulting action, not documentation without follow-through.* Doc: Hazard remediation tracking record | YES | PARTIAL | NO |
| **2** | **Is a specific person and timeframe genuinely assigned to each identified hazard, not left informally open-ended?** *Real, specific accountability and timing, not a vague intention to address it eventually.* Doc: N/A — tested directly | YES | PARTIAL | NO |
| **3** | **Is remediation genuinely verified as completed, not assumed done without confirmation?** *Real, confirmed completion, not an assumption the hazard was actually addressed.* Doc: Remediation completion verification | YES | PARTIAL | NO |

**ALL YES** Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

| **WHAT THE ASSESSOR DOES ON SITE** no surprises, no hidden checks | |
|---|---|
| **DOCUMENT** *Remediation tracking review* | Reviews records for genuine, tracked remediation of identified hazards. |
| **DOCUMENT** *Accountability review* | Reviews whether specific responsibility and timeframes are genuinely assigned to each hazard. |
| **DOCUMENT** *Completion verification review* | Reviews whether remediation completion is genuinely, specifically verified. |

REFERENCES

*[12] Home fall-hazard checklists are established as effective specifically when paired with genuine remediation of identified hazards, with the underlying evidence for fall reduction depending on hazards actually being addressed, not merely documented.*

Standard 3.2 · *Standard 3: Home Environment Safety Assessment*

# Guidance & Learning

**GUIDANCE** ASF-HC-STD3-v3.0

## WHY THIS STANDARD EXISTS

A documented hazard that never actually gets fixed provides no more real protection than a hazard never identified at all, and the whole protective value of a structured assessment depends on genuine follow-through — identifying a loose rug or a poorly lit stairwell only matters if something actually, verifiably changes afterward.

**The evidence: [12] Home fall-hazard checklists are established as effective specifically when paired with genuine remediation of identified hazards, with the underlying evidence for fall reduction depending on hazards actually being addressed, not merely documented.**

| WHAT GOOD LOOKS LIKE | WHAT FAILURE LOOKS LIKE |
|---|---|
| ✓ Identified hazards genuinely lead to tracked, resulting remediation. | ✗ Hazards are documented on a checklist but never actually addressed. |
| ✓ Specific accountability and timeframes are genuinely assigned to each hazard. | ✗ No specific person or timeframe is assigned; remediation remains open-ended. |
| ✓ Remediation completion is genuinely, specifically verified. | ✗ Remediation is assumed complete without genuine verification. |

## MOST COMMON REASONS PROVIDERS SCORE PARTIAL

**1 Remediation happens reliably for hazards the caregiver can fix directly but stalls for those requiring the family's action.**
*A hazard requiring family involvement carries the same real risk and deserves the same genuine tracking through to completion.*

**2 Timeframes are assigned but aren't consistently followed up on when the deadline passes.**
*A timeframe without genuine follow-up doesn't provide reliable assurance the hazard was actually addressed.*

**3 Verification happens through caregiver report but isn't independently confirmed for higher-risk hazards.**
*Independent confirmation matters most exactly where a hazard carries the greatest real consequence if remediation didn't actually happen.*

## HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

**Week 1** Review current hazard remediation practice for genuine tracking through to completion.

**Week 2** Establish specific accountability and timeframes for every identified hazard.

**Week 3** Build a follow-up process for hazards requiring family or third-party action.

**Ongoing** Independently verify remediation completion for higher-risk hazards.

## FOR SURVEYORS — WHAT IS NOT OBVIOUS

**Ask for a real, recent example of an identified hazard and trace it through to confirmed remediation.**
*A real, traceable example reveals genuine follow-through, not documentation without resulting action.*

**Ask what happens when a hazard requires the family's action rather than the caregiver's own.**
*A specific, confident answer reveals whether tracking genuinely extends beyond what the caregiver alone controls.*

**E-LEARNING** academy.gmj.ge/hc-std3-2-hazard-remediation — 30 min · complete before self-assessment

Standard 3.3 **NON-NEGOTIABLE** · *Standard 3: Home Environment Safety Assessment*

## A Fall Genuinely Triggers Reassessment

**ASSESSMENT** ASF-HC-STD3-v3.0

| CR FULL | TR FULL | SM FULL | ST FULL |
|---|---|---|---|

**3.3**
**NON-NEGOTIABLE**
L1

THE STANDARD

### A Fall Genuinely Triggers Reassessment

When a client experiences a fall, this genuinely triggers a specific, structured reassessment of the home environment and the client's own risk factors — not treated as an isolated event requiring only immediate first aid, given a documented fall is a strong, real predictor of another one.

| PROVIDER SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question. | | | | |
|---|---|---|---|---|
| **1** | **Does a client fall genuinely trigger a structured reassessment, not treated as an isolated event?**<br>*Real, structured reassessment, not routine continuation after first aid.*<br>Doc: Post-fall reassessment record | YES | PARTIAL | NO |
| **2** | **Does reassessment genuinely cover both the home environment and the client's own risk factors?**<br>*Complete reassessment of both, not one dimension alone.*<br>Doc: N/A — tested directly | YES | PARTIAL | NO |
| **3** | **Does reassessment happen promptly after the fall, not delayed to a routine review?**<br>*Real, prompt reassessment specifically triggered by the fall.*<br>Doc: Reassessment timing record | YES | PARTIAL | NO |

**ALL YES** Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

| WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks | |
|---|---|
| **DOCUMENT**<br>*Post-fall reassessment review* | Reviews records for genuine, structured reassessment following a documented fall. |
| **DOCUMENT**<br>*Reassessment scope review* | Reviews whether reassessment genuinely covers both home environment and client risk factors. |
| **DOCUMENT**<br>*Timing review* | Reviews whether reassessment genuinely occurs promptly after the fall, not delayed. |

REFERENCES

*[13] Research found nearly 57 percent of seniors experienced a second fall within one year of an initial fall, establishing a documented fall as a strong, genuine predictor requiring structured reassessment, distinct from treatment as an isolated, resolved event.*

Standard 3.3 · *Standard 3: Home Environment Safety Assessment*

## Guidance & Learning

**GUIDANCE** ASF-HC-STD3-v3.0

### WHY THIS STANDARD EXISTS

Research specifically found that nearly 57 percent of seniors who fall once experience a second fall within a year, meaning a first fall isn't simply a past event to document — it's a genuine, strong signal that both the home environment and the client's own risk factors deserve immediate, structured re-examination, not routine continuation of the existing care plan.

**The evidence: [13] Research found nearly 57 percent of seniors experienced a second fall within one year of an initial fall, establishing a documented fall as a strong, genuine predictor requiring structured reassessment, distinct from treatment as an isolated, resolved event.**

| WHAT GOOD LOOKS LIKE | WHAT FAILURE LOOKS LIKE |
|---|---|
| ✓ A fall genuinely triggers a specific, structured reassessment. | ✗ A fall is treated as an isolated event, with no triggered reassessment. |
| ✓ Reassessment genuinely covers both home environment and client risk factors. | ✗ Reassessment, if any, covers only one dimension, not both home and client factors. |
| ✓ Reassessment genuinely happens promptly, not delayed to a routine review. | ✗ Reassessment is delayed until a routine, already-scheduled review. |

### MOST COMMON REASONS PROVIDERS SCORE PARTIAL

1 **Reassessment happens for falls resulting in injury but not consistently for falls without apparent immediate harm.**
*A fall without apparent injury still carries the same genuine, statistical risk of recurrence.*

2 **Home environment reassessment happens but client-specific risk factors like medication or balance aren't consistently re-examined.**
*Both dimensions genuinely contribute to fall risk, and reassessment should address each.*

3 **Reassessment happens within a reasonable time but isn't specifically documented as fall-triggered, making the pattern harder to track over time.**
*Documenting the fall-triggered link is what makes a genuine recurrence pattern visible over time, not just each reassessment in isolation.*

### HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

**Week 1** Review current post-fall response for genuine, structured reassessment versus routine continuation.

**Week 2** Establish a defined reassessment process specifically covering home and client risk factors.

**Week 3** Confirm reassessment occurs promptly for every fall, including those without apparent injury.

**Ongoing** Document reassessments as specifically fall-triggered for pattern tracking.

### FOR SURVEYORS — WHAT IS NOT OBVIOUS

**Ask for a real, recent example of a client fall and trace what reassessment actually followed.**
*A real, traceable example reveals whether this process genuinely functions, not just exists in policy.*

**Ask whether a fall without apparent injury still triggers the same reassessment as one that does.**
*This tests whether the response genuinely reflects the real, statistical recurrence risk, not just visible severity.*

**E-LEARNING** academy.gmj.ge/hc-std3-3-post-fall-reassessment — 30 min · complete before self-assessment

Standard 3.4 **CORE** · *Standard 3: Home Environment Safety Assessment*

# The Home Environment Is Reassessed Periodically

**ASSESSMENT** ASF-HC-STD3-v3.0

| CR N/A | TR FULL | SM ADAPTED | ST FULL |
|---|---|---|---|

**3.4**
**CORE**
L1

THE STANDARD

## The Home Environment Is Reassessed Periodically

The home environment is genuinely reassessed on a periodic, defined schedule, not limited to the initial assessment at the start of care, given a home's physical condition and hazard profile can genuinely change over the course of an ongoing care relationship.

**PROVIDER SELF-ASSESSMENT** Tick YES, PARTIAL, or NO for each question.

| | | | | |
|---|---|---|---|---|
| **1** | **Is the home genuinely reassessed on a periodic schedule, not limited to initial assessment?**<br>*Real, periodic reassessment, not a one-time check treated as permanent.*<br>Doc: Periodic reassessment schedule documentation | YES | PARTIAL | NO |
| **2** | **Does the caregiver's regular presence genuinely inform this reassessment?**<br>*Real use of the caregiver's actual presence, not an infrequent separate visit alone.*<br>Doc: N/A — tested directly | YES | PARTIAL | NO |
| **3** | **Is a genuine change in the home's condition captured between scheduled reassessments?**<br>*Real, ongoing attentiveness, not hazard recognition limited to formal points.*<br>Doc: N/A — tested directly | YES | PARTIAL | NO |

**ALL YES** Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

**WHAT THE ASSESSOR DOES ON SITE** no surprises, no hidden checks

| | |
|---|---|
| **DOCUMENT**<br>*Periodic schedule review* | Reviews the defined schedule for periodic home environment reassessment. |
| **ASK**<br>*Ongoing presence interview* | Asks a caregiver how their regular presence genuinely informs ongoing hazard awareness between formal reassessments. |
| **DOCUMENT**<br>*Between-assessment capture review* | Reviews evidence that changes are genuinely captured between scheduled reassessment points. |

REFERENCES

*[14] Therapist home visits to identify and remediate hazards are considered the gold-standard method for fall prevention but are rarely feasible for most patients, establishing the genuine, structural value of a home caregiver's regular, ongoing presence for periodic reassessment that a typical clinical model cannot otherwise provide.*

Standard 3.4 · *Standard 3: Home Environment Safety Assessment*

## Guidance & Learning

**GUIDANCE** ASF-HC-STD3-v3.0

### WHY THIS STANDARD EXISTS

Home care's genuine, structural advantage over a clinic-based fall prevention program is that the caregiver is already, regularly present in the home — periodic reassessment is what actually uses this advantage, rather than treating the initial assessment as a permanent, one-time snapshot of a home whose real condition continues to change.

**The evidence: [14] Therapist home visits to identify and remediate hazards are considered the gold-standard method for fall prevention but are rarely feasible for most patients, establishing the genuine, structural value of a home caregiver's regular, ongoing presence for periodic reassessment that a typical clinical model cannot otherwise provide.**

| WHAT GOOD LOOKS LIKE | WHAT FAILURE LOOKS LIKE |
|---|---|
| ✓ The home environment is genuinely reassessed on a periodic, defined schedule. | ✗ Reassessment is limited to the initial visit, never genuinely repeated. |
| ✓ The caregiver's regular presence genuinely informs ongoing reassessment. | ✗ Periodic reassessment happens but doesn't draw on the caregiver's actual regular presence. |
| ✓ Genuine changes are captured between scheduled reassessment points, not missed until the next formal check. | ✗ Changes between scheduled reassessments go unnoticed until the next formal check. |

### MOST COMMON REASONS PROVIDERS SCORE PARTIAL

1 **Periodic reassessment happens but the interval is long enough that a genuine, meaningful change could go uncaught.**
*A genuinely protective interval reflects how quickly a home's real condition can meaningfully change.*

2 **Caregivers are present regularly but aren't specifically prompted to note hazard-relevant changes as part of routine visits.**
*This genuine structural advantage only provides real value if caregivers are specifically prompted to use it.*

3 **Reassessment documentation exists but isn't compared against the initial assessment to identify what's genuinely changed.**
*A direct comparison is what actually reveals genuine change, not just that reassessment technically occurred again.*

### HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

**Week 1** Review current reassessment practice for genuine, periodic repetition beyond the initial visit.

**Week 2** Establish a defined reassessment schedule with a genuinely protective interval.

**Week 3** Train caregivers to specifically note hazard-relevant changes during routine visits.

**Ongoing** Compare reassessment documentation against prior assessments to identify genuine changes.

### FOR SURVEYORS — WHAT IS NOT OBVIOUS

**Ask a caregiver whether they've ever noticed and reported a new hazard between scheduled reassessments.**
*A real, specific example reveals whether this genuine structural advantage is actually being used.*

**Ask to compare a client's initial assessment against their most recent reassessment.**
*A real, direct comparison reveals whether reassessment genuinely tracks meaningful change over time.*

**E-LEARNING** academy.gmj.ge/hc-std3-4-periodic-reassessment — 30 min · complete before self-assessment

Standard 3.5 **NON-NEGOTIABLE** · *Standard 3: Home Environment Safety Assessment*

# Emergency Access to the Home Is Genuinely Confirmed

**ASSESSMENT** ASF-HC-STD3-v3.0

| CR FULL | TR FULL | SM FULL | ST FULL |
|---|---|---|---|

**3.5**
**NON-NEGOTIABLE**
L1

THE STANDARD

## Emergency Access to the Home Is Genuinely Confirmed

A genuine, verified plan exists for how emergency responders would actually access the home if the client is unable to reach the door — a lockbox code, a designated key holder, a specific access arrangement — not assumed that responders will simply find a way in when the moment arrives.

**PROVIDER SELF-ASSESSMENT** Tick YES, PARTIAL, or NO for each question.

| | | | | |
|---|---|---|---|---|
| **1** | **Does a genuine, verified emergency access plan exist for this home?**<br>*A real, confirmed arrangement, not an assumption responders will find a way in.*<br>Doc: Emergency access plan documentation | YES | PARTIAL | NO |
| **2** | **Is this plan genuinely known to the client, family, and caregiver?**<br>*Real, confirmed awareness, not a plan that exists only on paper.*<br>Doc: N/A — tested directly | YES | PARTIAL | NO |
| **3** | **Is the access arrangement genuinely verified as functional?**<br>*Real, verified functionality, not an assumption it would work when needed.*<br>Doc: Access arrangement verification | YES | PARTIAL | NO |

**ALL YES** Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

**WHAT THE ASSESSOR DOES ON SITE** no surprises, no hidden checks

| | |
|---|---|
| **DOCUMENT**<br>*Access plan documentation review* | Reviews the specific, documented emergency access plan for each client's home. |
| **ASK**<br>*Awareness confirmation interview* | Asks the client, family, and caregiver whether they're genuinely aware of the current access plan. |
| **DOCUMENT**<br>*Functional verification review* | Reviews evidence the access arrangement has been genuinely verified as functional. |

REFERENCES

*[15] Verified emergency access arrangements for a client unable to reach the door, distinct from an assumption that responders will resolve access in the moment, are established as necessary home safety planning, reflecting a risk specific to care delivered in a private residence.*

Standard 3.5 · *Standard 3: Home Environment Safety Assessment*

## Guidance & Learning

**GUIDANCE** ASF-HC-STD3-v3.0

### WHY THIS STANDARD EXISTS

A client who falls, or experiences another genuine emergency, may be physically unable to reach the door, and an emergency response that's delayed or obstructed by an access problem loses exactly the time that matters most in a genuine emergency — this is a real, foreseeable problem specific to home care that a facility, with staff already inside, doesn't face in the same way.

**The evidence: [15] Verified emergency access arrangements for a client unable to reach the door, distinct from an assumption that responders will resolve access in the moment, are established as necessary home safety planning, reflecting a risk specific to care delivered in a private residence.**

| WHAT GOOD LOOKS LIKE | WHAT FAILURE LOOKS LIKE |
|---|---|
| ✓ A genuine, specific emergency access plan exists for the home. | ✗ No specific access plan exists beyond an assumption responders will manage. |
| ✓ The plan is genuinely known and confirmed with client, family, and caregiver. | ✗ The plan exists on paper but relevant parties aren't genuinely aware of it. |
| ✓ The arrangement is genuinely verified as functional, not assumed to work. | ✗ The arrangement's functionality has never been verified. |

### MOST COMMON REASONS PROVIDERS SCORE PARTIAL

1 **An access plan exists and is known to the caregiver but hasn't been specifically confirmed with the client's family.**
*Every party who might need to act on this plan deserves the same genuine, confirmed awareness.*

2 **The plan was verified as functional at setup but hasn't been reconfirmed since, and circumstances may have changed.**
*An access arrangement's real functionality should be periodically reconfirmed, not assumed to remain valid indefinitely.*

3 **A plan exists for the primary caregiver's shifts but isn't consistently communicated to a covering or substitute caregiver.**
*A covering caregiver facing a real emergency needs the same genuine, current awareness as the primary one.*

### HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

**Week 1** Review current emergency access planning for genuine, specific, verified arrangements.

**Week 2** Confirm access plan awareness with client, family, and all caregivers, including covering staff.

**Week 3** Verify the access arrangement's genuine functionality directly.

**Ongoing** Periodically reconfirm the access plan remains current and functional.

### FOR SURVEYORS — WHAT IS NOT OBVIOUS

**Ask the caregiver directly what the specific emergency access plan is for this client's home.**
*A specific, confident answer reveals genuine awareness, not an assumption a plan exists somewhere.*

**Ask when the access arrangement was last actually verified as functional.**
*A specific, real answer reveals genuine verification, not an assumption it would work when needed.*

**E-LEARNING** academy.gmj.ge/hc-std3-5-emergency-access — 30 min · complete before self-assessment

# STANDARD 4

## Medication Management & Family Coordination

**MANDATORY**

*5 criteria*

| | Standard 4.1 **NON-NEGOTIABLE** · *Standard 4: Medication Management & Family Coordination* **Medication Reminders and Administration Are Genuinely Distinguished** | **ASSESSMENT** ASF-HC-STD4-v3.0 |
|---|---|---|

| **CR** FULL | **TR** FULL | **SM** FULL | **ST** FULL |
|---|---|---|---|

**4.1**
**NON-NEGOTIABLE**
L1

THE STANDARD

## Medication Reminders and Administration Are Genuinely Distinguished

The service genuinely distinguishes between medication reminders, which a non-clinical caregiver can appropriately provide, and actual medication administration, which requires clinical training and appropriate supervision — not conflating the two, or allowing a non-clinical caregiver to perform tasks genuinely beyond their actual scope.

| **PROVIDER SELF-ASSESSMENT** Tick YES, PARTIAL, or NO for each question. | | | | |
|---|---|---|---|---|
| **1** | **Does the service genuinely distinguish reminders from administration, matching the caregiver's actual scope?** *Real, specific role clarity, not conflation of these different tasks.* Doc: Scope of practice policy documentation | YES | PARTIAL | NO |
| **2** | **Are non-clinical caregivers specifically trained on this real medication boundary?** *Real, specific training, not general awareness assumed sufficient.* Doc: Caregiver scope training record | YES | PARTIAL | NO |
| **3** | **Is there a process for identifying when a client's needs exceed a non-clinical caregiver's scope?** *A real, active recognition process, not continuing regardless of a task outside scope.* Doc: Scope escalation process | YES | PARTIAL | NO |

**ALL YES** Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

| **WHAT THE ASSESSOR DOES ON SITE** no surprises, no hidden checks | |
|---|---|
| **DOCUMENT** *Scope policy review* | Reviews the specific, documented distinction between reminders and administration. |
| **DOCUMENT** *Caregiver training review* | Reviews training records confirming caregivers understand this specific boundary. |
| **OBSERVE** *Task observation* | Observes an actual medication-related interaction to confirm the caregiver's role genuinely matches their actual scope. |

REFERENCES

*[16] The distinction between medication reminders, appropriately provided by non-clinical caregivers, and medication administration, requiring clinical training and supervision, is established as a foundational scope-of-practice boundary in home care, with role confusion identified as a genuine contributing factor in caregiver-related medication errors.*

Standard 4.1 · *Standard 4: Medication Management & Family Coordination*

# Guidance & Learning

**GUIDANCE** ASF-HC-STD4-v3.0

## WHY THIS STANDARD EXISTS

A personal care aide providing a reminder and a trained clinical professional administering medication are performing genuinely different tasks with genuinely different real risk, and a service that blurs this distinction — whether from convenience, staffing pressure, or simple confusion about roles — risks a caregiver performing clinical tasks they were never actually trained or authorized to perform.

**The evidence: [16] The distinction between medication reminders, appropriately provided by non-clinical caregivers, and medication administration, requiring clinical training and supervision, is established as a foundational scope-of-practice boundary in home care, with role confusion identified as a genuine contributing factor in caregiver-related medication errors.**

| WHAT GOOD LOOKS LIKE | WHAT FAILURE LOOKS LIKE |
|---|---|
| ✓ The service genuinely, clearly distinguishes reminders from administration. | ✗ Reminders and administration are conflated, with no genuine distinction in practice. |
| ✓ Non-clinical caregivers are specifically trained on this real boundary. | ✗ Caregivers aren't specifically trained on this boundary, relying on general awareness. |
| ✓ A real process identifies when needs exceed a non-clinical caregiver's scope. | ✗ Caregivers continue performing tasks genuinely beyond their scope without escalation. |

## MOST COMMON REASONS PROVIDERS SCORE PARTIAL

1 **The distinction is clear in policy but caregivers report genuine uncertainty about specific medication tasks in practice.**
*Policy clarity needs to translate into genuine, practical confidence for the caregivers actually performing the work.*

2 **Training addresses the general principle but not specific, real examples of where the boundary actually falls.**
*Concrete examples make an abstract scope boundary genuinely actionable in daily practice.*

3 **Escalation happens for entirely new medication needs but not consistently when an existing arrangement quietly becomes more complex.**
*Gradual complexity creep is exactly where a scope boundary is most likely to be crossed without anyone deciding it should be.*

## HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

**Week 1** Review current practice for genuine distinction between reminders and administration.

**Week 2** Train all non-clinical caregivers specifically on this boundary with concrete examples.

**Week 3** Establish a clear escalation process for medication needs exceeding scope.

**Ongoing** Monitor for medication arrangements that have quietly grown more complex over time.

## FOR SURVEYORS — WHAT IS NOT OBVIOUS

**Ask a non-clinical caregiver to describe specifically what they can and cannot do with a client's medications.**
*A specific, confident answer reveals genuine understanding, not general awareness of the concept.*

**Ask for a real example of a medication need that was identified as exceeding a caregiver's scope.**
*A real, traceable example reveals whether escalation genuinely functions, not just exists in policy.*

**E-LEARNING** academy.gmj.ge/hc-std4-1-reminder-vs-administration — 30 min · complete before self-assessment

Standard 4.2 **NON-NEGOTIABLE** · *Standard 4: Medication Management & Family Coordination*

## A Single, Current Medication List Is Shared Across Everyone Involved

**ASSESSMENT** ASF-HC-STD4-v3.0

| CR FULL | TR FULL | SM ADAPTED | ST FULL |
|---|---|---|---|

**4.2**
**NON-NEGOTIABLE**
L1

THE STANDARD

### A Single, Current Medication List Is Shared Across Everyone Involved

A single, genuinely current medication list is actively shared across everyone involved in the client's care — the caregiver, family members, and any other provider — not maintained separately by each party in a way that allows the same medication task to be missed by everyone, or duplicated by more than one.

**PROVIDER SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.**

| | | | | |
|---|---|---|---|---|
| **1** | **Does a single, genuinely current medication list exist and get actively shared across everyone involved in care?**<br>*Real, shared, current information, not separate lists maintained independently by each party.*<br>Doc: Shared medication list documentation | YES | PARTIAL | NO |
| **2** | **Is this list genuinely updated immediately when a medication changes, not left outdated until a routine review?**<br>*Real, prompt updating, not a stale list corrected only periodically.*<br>Doc: N/A — tested directly | YES | PARTIAL | NO |
| **3** | **Do all parties — caregiver, family, other providers — genuinely know this shared list exists and where to find it?**<br>*Real, confirmed awareness across every party, not a list only one person actually knows about.*<br>Doc: N/A — tested directly | YES | PARTIAL | NO |

**ALL YES** Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

**WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks**

| | |
|---|---|
| **DOCUMENT**<br>*Shared list review* | Reviews evidence of a single, genuinely current medication list shared across all involved parties. |
| **DOCUMENT**<br>*Update timing review* | Reviews whether the list is genuinely updated promptly when a medication changes. |
| **ASK**<br>*Party awareness interview* | Asks a family member and caregiver separately whether they know the shared list exists and how to access it. |

REFERENCES

*[17] A documented case found an automated dose dispensing package missing a medication while home care separately omitted to administer it, illustrating a genuine coordination failure between multiple parties each managing medication without a single, shared, current source.*

Standard 4.2 · *Standard 4: Medication Management & Family Coordination*

## Guidance & Learning

**GUIDANCE** ASF-HC-STD4-v3.0

## WHY THIS STANDARD EXISTS

A real, documented case shows exactly this failure: an automated dose dispensing system missed a medication while a separate home care service also failed to administer it, precisely because no single, shared, current list connected what each party believed was happening — genuine coordination through one shared source is what actually closes this real gap between multiple well-intentioned parties each assuming someone else has it covered.

**The evidence: [17] A documented case found an automated dose dispensing package missing a medication while home care separately omitted to administer it, illustrating a genuine coordination failure between multiple parties each managing medication without a single, shared, current source.**

| WHAT GOOD LOOKS LIKE | WHAT FAILURE LOOKS LIKE |
|---|---|
| ✓ A single, genuinely current medication list is actively shared across everyone involved. | ✗ Multiple parties maintain separate lists, with no single shared, current source. |
| ✓ The list is genuinely updated promptly when a medication changes. | ✗ The list becomes outdated, updated only periodically rather than promptly. |
| ✓ All parties genuinely know this list exists and how to access it. | ✗ Some parties don't know a shared list exists or how to find it. |

## MOST COMMON REASONS PROVIDERS SCORE PARTIAL

1 **A shared list exists between the caregiver and agency but isn't consistently shared with family members.**
*Family members administering or overseeing medication carry the same real need for current, shared information.*

2 **The list is updated promptly for new prescriptions but discontinued medications aren't consistently removed.**
*An outdated entry for a discontinued medication carries real, genuine risk of unintended continued administration.*

3 **Awareness of the shared list is strong among regular caregivers but weaker among occasional or covering staff.**
*Occasional and covering staff need the same genuine awareness, since they may be the one relying on the list when it matters most.*

## HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

**Week 1** Review current medication list practice for genuine, single-source sharing across all parties.

**Week 2** Establish a shared list format accessible to caregiver, family, and other providers.

**Week 3** Build a process ensuring prompt updates, including removal of discontinued medications.

**Ongoing** Confirm awareness of the shared list extends to occasional and covering staff.

## FOR SURVEYORS — WHAT IS NOT OBVIOUS

**Ask a family member and the caregiver separately to show you the current medication list they each use.**
*A real, direct comparison reveals whether a genuine, single shared source actually exists.*

**Ask how a recent medication change was communicated to everyone involved in the client's care.**
*A specific, real example reveals whether sharing genuinely happens promptly, not just in principle.*

**E-LEARNING** academy.gmj.ge/hc-std4-2-shared-medication-list — 30 min · complete before self-assessment

Standard 4.3 **NON-NEGOTIABLE** · *Standard 4: Medication Management & Family Coordination*

**A Medication Change or Care Transition Triggers Structured Review**

**ASSESSMENT** ASF-HC-STD4-v3.0

| CR ADAPTED | TR FULL | SM FULL | ST FULL |
|---|---|---|---|

**4.3**
**NON-NEGOTIABLE**
L1

THE STANDARD

## A Medication Change or Care Transition Triggers Structured Review

A medication change or a care transition — hospital discharge, a new prescriber, a change in caregiver — genuinely triggers a structured review of the client's complete medication regimen, not treated as a routine update folded into ordinary care without specific, dedicated attention.

**PROVIDER SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.**

| | | | | |
|---|---|---|---|---|
| **1** | **Does a medication change or care transition genuinely trigger a structured review, not folded into routine care?** *Real, specific, structured review triggered by the event itself, not routine, undifferentiated continuation.* Doc: Structured review trigger documentation | YES | PARTIAL | NO |
| **2** | **Does this review genuinely confirm the current medication list and check for confusing instructions?** *Real, specific confirmation of these elements, not a general check.* Doc: N/A — tested directly | YES | PARTIAL | NO |
| **3** | **Is the caregiver's actual understanding of the new or changed regimen genuinely verified, not assumed?** *Real, verified caregiver understanding, not an assumption of comprehension.* Doc: Caregiver understanding verification | YES | PARTIAL | NO |

**ALL YES** Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

**WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks**

| | |
|---|---|
| **DOCUMENT** *Trigger review* | Reviews evidence that medication changes and care transitions genuinely trigger structured review. |
| **DOCUMENT** *Review content review* | Reviews whether the structured review genuinely confirms the medication list and checks for confusing instructions. |
| **ASK** *Caregiver understanding check* | Asks a caregiver to explain a recently changed medication regimen to confirm genuine understanding. |

REFERENCES

*[18] Treatment complexity is identified as the leading contributing factor in caregiver-related medication errors, with structured review of the complete medication regimen specifically recommended after treatment changes or transitions of care, distinct from routine, unstructured continuation of the existing arrangement.*

Standard 4.3 · *Standard 4: Medication Management & Family Coordination*

# Guidance & Learning

**GUIDANCE** ASF-HC-STD4-v3.0

## WHY THIS STANDARD EXISTS

Treatment complexity and care transitions are specifically identified as leading contributors to caregiver-related medication errors, and a genuine, structured review at exactly these moments — confirming the current medication list, checking for confusing instructions, and verifying the caregiver's actual understanding — is what catches problems before they become errors, rather than after.

**The evidence: [18] Treatment complexity is identified as the leading contributing factor in caregiver-related medication errors, with structured review of the complete medication regimen specifically recommended after treatment changes or transitions of care, distinct from routine, unstructured continuation of the existing arrangement.**

| WHAT GOOD LOOKS LIKE | WHAT FAILURE LOOKS LIKE |
|---|---|
| ✓ A medication change or care transition genuinely triggers structured review. | ✗ Changes are folded into routine care without any dedicated, structured review. |
| ✓ The review genuinely confirms the current list and checks for confusing instructions. | ✗ The review, if any, doesn't specifically confirm the list or check for confusion. |
| ✓ Caregiver understanding of the new regimen is genuinely verified. | ✗ Caregiver understanding is assumed, never actually verified. |

## MOST COMMON REASONS PROVIDERS SCORE PARTIAL

1 **Structured review happens for hospital discharge but not consistently for a change in prescriber alone.**
*Every genuine transition point carries the same real risk of medication regimen confusion.*

2 **The review confirms the list but doesn't specifically check whether instructions are genuinely clear to the caregiver.**
*A confirmed list doesn't guarantee the instructions attached to it are genuinely understood.*

3 **Verification happens through a brief check-in but isn't specific enough to confirm genuine, detailed understanding.**
*A brief check-in doesn't reliably distinguish genuine understanding from polite agreement that understanding is present.*

## HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

**Week 1** Review current practice for genuine, structured review at medication changes and transitions.

**Week 2** Establish a structured review process specifically confirming list accuracy and instruction clarity.

**Week 3** Build a genuine method for verifying caregiver understanding, not assuming it.

**Ongoing** Extend structured review consistently to every type of transition, not hospital discharge alone.

## FOR SURVEYORS — WHAT IS NOT OBVIOUS

**Ask for a real, recent example of a medication change and trace what structured review actually followed.**
*A real, traceable example reveals genuine practice, not policy language alone.*

**Ask a caregiver to explain a recently changed regimen in their own words.**
*This tests genuine understanding, not just that a review technically occurred.*

**E-LEARNING** academy.gmj.ge/hc-std4-3-transition-triggered-review — 30 min · complete before self-assessment

Standard 4.4 **NON-NEGOTIABLE** · *Standard 4: Medication Management & Family Coordination*

# Medications Belonging to Different Household Members Are Distinguished and Secured

**ASSESSMENT** ASF-HC-STD4-v3.0

| CR FULL | TR FULL | SM FULL | ST FULL |
|---|---|---|---|

**4.4**
**NON-NEGOTIABLE**
L1

THE STANDARD

## Medications Belonging to Different Household Members Are Distinguished and Secured

Medications belonging to different people in the household are genuinely, physically distinguished and securely stored separately — not left commingled in a way that risks a client taking another person's medication, a real, documented error type in home medication management.

**PROVIDER SELF-ASSESSMENT** Tick YES, PARTIAL, or NO for each question.

| | | | | |
|---|---|---|---|---|
| **1** | **Are medications belonging to different household members genuinely, physically distinguished and stored separately?** *Real, physical separation, not commingled storage relying on memory to distinguish.* Doc: Medication storage arrangement documentation | YES | PARTIAL | NO |
| **2** | **Is secure storage genuinely used, not just physical separation without any restricted access?** *Real, secure storage — locked or restricted — not separation alone without genuine access control.* Doc: N/A — tested directly | YES | PARTIAL | NO |
| **3** | **Has the household genuinely been assessed for this specific risk, not assumed low-risk without checking?** *Real, specific assessment of this risk in this particular household, not a generic assumption.* Doc: Household medication risk assessment | YES | PARTIAL | NO |

**ALL YES** Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

**WHAT THE ASSESSOR DOES ON SITE** no surprises, no hidden checks

| | |
|---|---|
| **OBSERVE** *Storage arrangement observation* | Physically observes medication storage for genuine separation between household members. |
| **OBSERVE** *Security verification* | Confirms storage is genuinely secure, not merely physically separated without restricted access. |
| **DOCUMENT** *Household risk assessment review* | Reviews whether this specific risk was genuinely assessed for this household. |

REFERENCES

*[19] Research on medication safety in family caregiving of older adults specifically identifies taking another person's medication as a documented error type, alongside restricted, secure storage as an established, more powerful safeguard against medication errors generally.*

Standard 4.4 · *Standard 4: Medication Management & Family Coordination*

## Guidance & Learning

**GUIDANCE** ASF-HC-STD4-v3.0

### WHY THIS STANDARD EXISTS

Real research on medication errors in home caregiving specifically identifies taking another person's medication as a documented, real error type, and this risk is genuinely elevated in a shared household where more than one person's medications are present — physical separation and secure, distinct storage is what actually prevents this specific, real mistake.

**The evidence: [19] Research on medication safety in family caregiving of older adults specifically identifies taking another person's medication as a documented error type, alongside restricted, secure storage as an established, more powerful safeguard against medication errors generally.**

| WHAT GOOD LOOKS LIKE | WHAT FAILURE LOOKS LIKE |
|---|---|
| ✓ Medications for different household members are genuinely, physically separated. | ✗ Medications for different people are commingled without genuine separation. |
| ✓ Storage is genuinely secure, with real restricted access. | ✗ Storage is separated but not genuinely secure or access-restricted. |
| ✓ The household's specific risk for this error type has been genuinely assessed. | ✗ This specific risk was never assessed for this particular household. |

### MOST COMMON REASONS PROVIDERS SCORE PARTIAL

1 **Separation is maintained for the client's own medications but a family member's medications aren't consistently kept apart.**
*Every person's medications present in the household carry the same real risk of confusion.*

2 **Storage is generally separated but a specific area, like a shared kitchen counter, sometimes sees temporary commingling.**
*Genuine separation needs to hold consistently, not only in the primary storage location.*

3 **Assessment happened at initial care setup but hasn't been reconfirmed as household composition or medications have changed.**
*A household's real medication situation can change meaningfully, and the assessment should reflect current, not historical, circumstances.*

### HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

**Week 1** Physically assess current medication storage for genuine separation and security.

**Week 2** Establish secure, distinct storage for each household member's medications.

**Week 3** Conduct a specific risk assessment for this household's actual medication situation.

**Ongoing** Reassess storage arrangements as household composition or medications change.

### FOR SURVEYORS — WHAT IS NOT OBVIOUS

**Physically inspect medication storage directly, checking for genuine separation between household members.**
*Direct observation reveals genuine practice, not an assumption of adequate separation.*

**Ask specifically about storage in shared spaces, like a kitchen counter or bathroom.**
*This is where genuine separation is most likely to lapse in daily practice.*

**E-LEARNING** academy.gmj.ge/hc-std4-4-household-medication-separation — 30 min · complete before self-assessment

Standard 4.5 **CORE** · *Standard 4: Medication Management & Family Coordination*

**A Missed or Uncertain Dose Is Actively Followed Up**

**ASSESSMENT** ASF-HC-STD4-v3.0

| CR N/A | TR FULL | SM ADAPTED | ST FULL |
|---|---|---|---|

**4.5**
**CORE**
L1

THE STANDARD

## A Missed or Uncertain Dose Is Actively Followed Up

When a dose is genuinely missed, or it's genuinely uncertain whether it was taken, this is actively, specifically followed up — not left unresolved on the assumption that a single missed or uncertain dose doesn't warrant real attention.

| PROVIDER SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question. | | | | |
|---|---|---|---|---|
| **1** | **Does a genuinely missed or uncertain dose receive active, specific follow-up, not left unresolved?**<br>*Real, active follow-up, not a missed dose noted without genuine resulting action.*<br>Doc: Missed dose follow-up record | YES | PARTIAL | NO |
| **2** | **Is there a specific process for determining what to actually do when a dose was genuinely missed?**<br>*A real, defined process, not improvised or inconsistent handling case by case.*<br>Doc: Missed dose response protocol | YES | PARTIAL | NO |
| **3** | **Are recurring missed or uncertain doses genuinely reviewed for a broader pattern, not treated as isolated incidents each time?**<br>*Real, pattern-level review, not each occurrence handled in isolation without noticing a recurring issue.*<br>Doc: N/A — tested directly | YES | PARTIAL | NO |

**ALL YES** Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

| WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks | |
|---|---|
| **DOCUMENT**<br>*Follow-up record review* | Reviews evidence of genuine, active follow-up on missed or uncertain doses. |
| **DOCUMENT**<br>*Response protocol review* | Reviews the specific, defined process for handling a missed dose. |
| **DOCUMENT**<br>*Pattern review* | Reviews whether recurring missed doses are genuinely examined for a broader pattern. |

REFERENCES

*[20] Forgetting to take medicine is identified among the most common medication errors in family caregiving of older adults, establishing active follow-up on a missed or uncertain dose as necessary practice, distinct from noting the occurrence without genuine resulting action.*

Standard 4.5 · *Standard 4: Medication Management & Family Coordination*

# Guidance & Learning

GUIDANCE ASF-HC-STD4-v3.0

## WHY THIS STANDARD EXISTS

Forgetting to take medicine and uncertainty about whether a dose was taken are both documented, real, common error types, and a service that doesn't actively follow up on these specific situations — rather than noting them and moving on — misses the chance to catch a genuine pattern before it becomes a more serious, cumulative problem.

**The evidence: [20] Forgetting to take medicine is identified among the most common medication errors in family caregiving of older adults, establishing active follow-up on a missed or uncertain dose as necessary practice, distinct from noting the occurrence without genuine resulting action.**

| WHAT GOOD LOOKS LIKE | WHAT FAILURE LOOKS LIKE |
|---|---|
| ✓ A missed or uncertain dose genuinely receives active, specific follow-up. | ✗ A missed dose is noted but receives no genuine, resulting follow-up. |
| ✓ A real, defined process guides what to do when a dose is missed. | ✗ Handling varies inconsistently, without a defined process. |
| ✓ Recurring missed doses are genuinely reviewed for a broader pattern. | ✗ Recurring missed doses are treated as isolated incidents each time, missing the pattern. |

## MOST COMMON REASONS PROVIDERS SCORE PARTIAL

1 **Follow-up happens for doses the caregiver directly witnesses being missed but not for genuine uncertainty about whether a dose was taken.**
*Genuine uncertainty deserves the same active follow-up as a confirmed miss, since the real risk is similar.*

2 **A response protocol exists but doesn't specify when a missed dose should trigger contacting the prescriber.**
*Some missed doses carry genuine clinical significance warranting prescriber awareness, not just internal follow-up.*

3 **Individual incidents are followed up but aren't reviewed collectively to identify a genuine, recurring pattern.**
*A recurring pattern only becomes visible when individual incidents are actually reviewed together, not each in isolation.*

## HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

**Week 1** Review current practice for genuine, active follow-up on missed or uncertain doses.

**Week 2** Establish a specific, defined response protocol, including prescriber contact criteria.

**Week 3** Build a process for reviewing missed dose incidents collectively for patterns.

**Ongoing** Track missed dose patterns over time for a specific client.

## FOR SURVEYORS — WHAT IS NOT OBVIOUS

**Ask for a real, recent example of a missed dose and what specifically happened afterward.**
*A real, traceable example reveals genuine follow-up, not a policy that exists without practical application.*

**Ask whether a recurring pattern of missed doses for one client has ever been specifically identified and addressed.**
*A real, thoughtful answer reveals whether pattern-level review genuinely happens, not just individual incident handling.*

**E-LEARNING** academy.gmj.ge/hc-std4-5-missed-dose-followup — 30 min · complete before self-assessment

# STANDARD 5

## Caregiver Safety in an Uncontrolled Environment

**MANDATORY**

*5 criteria*

Standard 5.1 **NON-NEGOTIABLE** · *Standard 5: Caregiver Safety in an Uncontrolled Environment*

**A Genuine Risk Assessment of the Home Occurs Before the First Visit**

**ASSESSMENT** ASF-HC-STD5-v3.0

| CR FULL | TR FULL | SM ADAPTED | ST FULL |
|---|---|---|---|

**5.1**
**NON-NEGOTIABLE**
L1

THE STANDARD

## A Genuine Risk Assessment of the Home Occurs Before the First Visit

A genuine risk assessment of the client's home and household — including household members, pets, and known environmental hazards — occurs before a caregiver's first visit, not left for the caregiver to discover in real time upon arrival.

| PROVIDER SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question. | | | | |
|---|---|---|---|---|
| **1** | **Does a genuine risk assessment of the home and household occur before the caregiver's first visit?**<br>*Real, advance assessment, not the caregiver discovering hazards upon arrival.*<br>Doc: Pre-visit home risk assessment documentation | YES | PARTIAL | NO |
| **2** | **Does this assessment specifically address household members, pets, and known environmental hazards?**<br>*Complete, specific coverage of these real risk categories, not a generic or partial check.*<br>Doc: N/A — tested directly | YES | PARTIAL | NO |
| **3** | **Is the caregiver genuinely briefed on identified risks before their first visit, not left to encounter them unprepared?**<br>*Real, prior briefing, not information gathered but never actually communicated to the caregiver.*<br>Doc: Caregiver briefing record | YES | PARTIAL | NO |

**ALL YES** Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

| WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks | |
|---|---|
| **DOCUMENT**<br>*Pre-visit assessment review* | Reviews the actual, documented risk assessment conducted before a caregiver's first visit. |
| **DOCUMENT**<br>*Coverage completeness review* | Reviews whether the assessment genuinely covers household members, pets, and environmental hazards. |
| **ASK**<br>*Caregiver briefing interview* | Asks a caregiver whether they were genuinely briefed on identified risks before their first visit. |

REFERENCES

*[21] Documented occupational hazard research for home-based care work identifies hostile animals, violence, and unpredictable household conditions among the genuine risks caregivers face, establishing genuine advance risk assessment of the home and household as necessary practice, distinct from the caregiver discovering hazards upon arrival.*

Standard 5.1 · *Standard 5: Caregiver Safety in an Uncontrolled Environment*

## Guidance & Learning

**GUIDANCE** ASF-HC-STD5-v3.0

### WHY THIS STANDARD EXISTS

A caregiver walking into an unfamiliar home for the first time faces a genuinely unpredictable environment the agency hasn't controlled, and a real risk assessment conducted in advance is what actually prepares the caregiver for what they're walking into, rather than leaving them to encounter a genuine hazard — a hostile animal, an unstable household member, a known safety concern — with no advance warning at all.

**The evidence: [21] Documented occupational hazard research for home-based care work identifies hostile animals, violence, and unpredictable household conditions among the genuine risks caregivers face, establishing genuine advance risk assessment of the home and household as necessary practice, distinct from the caregiver discovering hazards upon arrival.**

| WHAT GOOD LOOKS LIKE | WHAT FAILURE LOOKS LIKE |
|---|---|
| ✓ A genuine risk assessment occurs before every caregiver's first visit. | ✗ No advance assessment occurs; caregivers discover risks upon arrival. |
| ✓ The assessment specifically covers household members, pets, and environmental hazards. | ✗ The assessment misses key categories like household members or pets. |
| ✓ Caregivers are genuinely briefed on identified risks before arriving. | ✗ Risks are identified but never actually communicated to the caregiver. |

### MOST COMMON REASONS PROVIDERS SCORE PARTIAL

**1 Assessment happens for new clients but isn't repeated when a new caregiver is assigned to an existing client.**
*Every caregiver entering a home for the first time faces the same genuine, real unfamiliarity, regardless of how long the client has received care.*

**2 The assessment identifies obvious hazards but doesn't specifically ask about household members with a history of volatility.**
*This specific, real risk category deserves the same direct inquiry as more visible environmental hazards.*

**3 Briefing happens verbally but isn't documented in a way that's genuinely verifiable later.**
*Documented briefing is what makes this practice genuinely verifiable later, not just assumed from stated intention.*

### HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

**Week 1** Review current pre-visit assessment practice for genuine, comprehensive coverage.

**Week 2** Establish a structured assessment specifically addressing household members, pets, and hazards.

**Week 3** Build a documented briefing process for every new caregiver assignment.

**Ongoing** Extend assessment to every new caregiver-client pairing, not only new clients.

### FOR SURVEYORS — WHAT IS NOT OBVIOUS

**Ask a caregiver whether they were briefed on any specific risks before their first visit to a client's home.**
*A specific, real answer reveals genuine practice, not an assumption of adequate preparation.*

**Ask how the assessment specifically addresses a household member with a history of volatility, not only physical hazards.**
*This reveals whether the assessment genuinely extends beyond visible, physical risk categories.*

**E-LEARNING** academy.gmj.ge/hc-std5-1-pre-visit-risk-assessment — 30 min · complete before self-assessment

Standard 5.2 **NON-NEGOTIABLE** · *Standard 5: Caregiver Safety in an Uncontrolled Environment*

**A Workplace Violence Prevention Program Exists, Adapted for the Home Setting**

**ASSESSMENT** ASF-HC-STD5-v3.0

| CR FULL | TR FULL | SM ADAPTED | ST FULL |
|---|---|---|---|

**5.2**
**NON-NEGOTIABLE**
L1

THE STANDARD

## A Workplace Violence Prevention Program Exists, Adapted for the Home Setting

A genuine workplace violence prevention program exists, specifically adapted for the reality of a caregiver working alone in a private home — not a generic facility-based program applied without adaptation, and not assumed unnecessary because violence seems unlikely in this specific client relationship.

**PROVIDER SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.**

| | | | | |
|---|---|---|---|---|
| **1** | **Does a genuine workplace violence prevention program exist, specifically adapted for the home care setting?**<br>*Real, home-care-specific adaptation, not a generic facility-based program applied without change.*<br>Doc: Workplace violence prevention program documentation | YES | PARTIAL | NO |
| **2** | **Does this program genuinely address the specific reality of a caregiver working alone, without on-site colleagues?**<br>*Real, specific attention to this genuine, distinct condition, not a program built assuming colleague proximity.*<br>Doc: N/A — tested directly | YES | PARTIAL | NO |
| **3** | **Are caregivers genuinely trained on this program, not assuming general awareness of workplace safety is sufficient?**<br>*Real, specific training on this program, not general safety awareness.*<br>Doc: Caregiver violence prevention training record | YES | PARTIAL | NO |

**ALL YES** Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

**WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks**

| | |
|---|---|
| **DOCUMENT**<br>*Program documentation review* | Reviews the actual workplace violence prevention program for genuine home-care-specific adaptation. |
| **DOCUMENT**<br>*Lone-worker adaptation review* | Reviews whether the program genuinely addresses the reality of a caregiver working alone. |
| **DOCUMENT**<br>*Caregiver training review* | Reviews training records confirming caregivers are specifically trained on this program. |

REFERENCES

*[22] Enforcement and inspection findings from multiple jurisdictions have specifically penalized home care providers for failing to protect staff from workplace violence, establishing genuine, adapted violence prevention programming as a real compliance and safety necessity in home care specifically, distinct from a generic facility-based program applied without adaptation.*

Standard 5.2 · *Standard 5: Caregiver Safety in an Uncontrolled Environment*

## Guidance & Learning

**GUIDANCE** ASF-HC-STD5-v3.0

### WHY THIS STANDARD EXISTS

Real enforcement action has specifically penalized a home healthcare provider for failing to protect staff from workplace violence, and existing workplace violence programs built for hospital settings genuinely don't address the specific, real conditions of a caregiver working alone in someone else's home — a program that hasn't been actually adapted for this reality provides far less real protection than it appears to on paper.

**The evidence: [22] Enforcement and inspection findings from multiple jurisdictions have specifically penalized home care providers for failing to protect staff from workplace violence, establishing genuine, adapted violence prevention programming as a real compliance and safety necessity in home care specifically, distinct from a generic facility-based program applied without adaptation.**

| WHAT GOOD LOOKS LIKE | WHAT FAILURE LOOKS LIKE |
|---|---|
| ✓ A genuine, home-care-adapted workplace violence prevention program exists. | ✗ No violence prevention program exists, or a generic facility-based one is applied unadapted. |
| ✓ The program genuinely addresses the caregiver's real, lone-worker condition. | ✗ The program doesn't genuinely address the caregiver's lone-worker reality. |
| ✓ Caregivers are specifically trained on this program, not general safety awareness alone. | ✗ Caregivers rely on general safety awareness, without specific program training. |

### MOST COMMON REASONS PROVIDERS SCORE PARTIAL

1 **The program addresses violence from the client but not from other household members or visitors present during care.**
*Every person genuinely present in the home during care carries real, potential risk, not the client alone.*

2 **Training covers the program's existence but not specific, practical steps a caregiver would actually take in a real incident.**
*Genuine preparedness requires concrete, actionable steps, not general awareness that a program exists.*

3 **The program exists but hasn't been reviewed since first developed, potentially missing changes in known risk patterns.**
*A program that hasn't kept pace with evolving risk patterns may no longer genuinely address the real conditions caregivers actually face.*

### HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

**Week 1** Review current violence prevention programming for genuine home-care-specific adaptation.

**Week 2** Build specific, practical guidance addressing the caregiver's real, lone-worker condition.

**Week 3** Train all caregivers on concrete, actionable steps for a real incident.

**Ongoing** Review and update the program as known risk patterns evolve.

### FOR SURVEYORS — WHAT IS NOT OBVIOUS

**Ask a caregiver to describe specific, practical steps they'd take if they felt unsafe during a visit.**
*A specific, confident answer reveals genuine, practical training, not general safety awareness.*

**Ask whether the program addresses risk from someone other than the client present in the home.**
*This reveals whether the program genuinely reflects the real, full range of home-based risk, not the client alone.*

**E-LEARNING** academy.gmj.ge/hc-std5-2-violence-prevention-program — 30 min · complete before self-assessment

| | | |
|---|---|---|
| | Standard 5.3 **NON-NEGOTIABLE** · *Standard 5: Caregiver Safety in an Uncontrolled Environment*<br>**The Caregiver Has a Genuine Way to Signal Distress Discreetly** | **ASSESSMENT** ASF-HC-STD5-v3.0 |

| CR FULL | TR FULL | SM ADAPTED | ST FULL |
|---|---|---|---|

**5.3**
**NON-NEGOTIABLE**
L1

THE STANDARD

## The Caregiver Has a Genuine Way to Signal Distress Discreetly

The caregiver has a genuine, practical way to signal distress or request help during a visit — without alerting anyone present in the home that they've done so — not left with no real option beyond openly announcing they feel unsafe in the moment they most need discretion.

| PROVIDER SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question. | | | | |
|---|---|---|---|---|
| **1** | **Does the caregiver have a genuine, practical way to discreetly signal distress or request help?**<br>*A real, discreet mechanism, not the caregiver's only option being to openly announce feeling unsafe.*<br>Doc: Discreet signaling mechanism documentation | YES | PARTIAL | NO |
| **2** | **Is this mechanism genuinely known and practiced by the caregiver, not merely described in a policy document?**<br>*Real, practiced familiarity, not theoretical awareness of a mechanism never actually used or tested.*<br>Doc: Caregiver mechanism familiarity record | YES | PARTIAL | NO |
| **3** | **Is there a genuine, defined response when this signal is triggered, not a signal that goes unanswered?**<br>*A real, defined response process, not a discreet signal with no actual, resulting action.*<br>Doc: Signal response protocol | YES | PARTIAL | NO |

**ALL YES** Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

| WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks | |
|---|---|
| **DOCUMENT**<br>*Signaling mechanism review* | Reviews the actual, documented discreet signaling mechanism available to caregivers. |
| **ASK**<br>*Caregiver familiarity interview* | Asks a caregiver to describe how they would use this mechanism in a real situation. |
| **DOCUMENT**<br>*Response protocol review* | Reviews the defined response process for when this signal is triggered. |

REFERENCES

*[23] Adaptations proposed for home healthcare violence prevention specifically include logging systems and discreet safety mechanisms distinct from openly announced distress, reflecting the genuine, practical need for a caregiver to signal for help without alerting anyone present in the home.*

Standard 5.3 · *Standard 5: Caregiver Safety in an Uncontrolled Environment*

# Guidance & Learning

**GUIDANCE** ASF-HC-STD5-v3.0

## WHY THIS STANDARD EXISTS

A caregiver who feels genuinely unsafe during a visit may not be able to safely announce this openly if the source of that unsafety is present in the room, and a real, discreet signaling method — a code word, a silent alert, a check-in system that would flag a missed response — is what actually provides a way to get help without escalating the immediate situation.

**The evidence: [23] Adaptations proposed for home healthcare violence prevention specifically include logging systems and discreet safety mechanisms distinct from openly announced distress, reflecting the genuine, practical need for a caregiver to signal for help without alerting anyone present in the home.**

| WHAT GOOD LOOKS LIKE | WHAT FAILURE LOOKS LIKE |
|---|---|
| ✓ A genuine, discreet signaling mechanism exists and is practical to use. | ✗ No discreet option exists beyond openly announcing distress. |
| ✓ Caregivers are genuinely familiar with and have practiced using it. | ✗ Caregivers know a mechanism exists in policy but haven't genuinely practiced using it. |
| ✓ A real, defined response follows when the signal is triggered. | ✗ A triggered signal has no defined, resulting response. |

## MOST COMMON REASONS PROVIDERS SCORE PARTIAL

1 **A mechanism exists and caregivers know about it but haven't specifically practiced using it in a realistic scenario.**
*Genuine familiarity under real pressure depends on practiced use, not knowledge of the mechanism's existence alone.*

2 **The mechanism works well during scheduled check-in times but isn't available between them if an urgent need arises.**
*A caregiver's genuine need for this mechanism can arise at any point during a visit, not only at scheduled intervals.*

3 **A response protocol exists but hasn't been specifically tested to confirm it actually triggers a timely, real response.**
*An untested protocol may not function reliably when a genuine distress signal is actually triggered.*

## HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

**Week 1** Review current caregiver distress signaling options for genuine discretion and practicality.

**Week 2** Establish a specific, practical, discreet mechanism available at any point during a visit.

**Week 3** Train and practice this mechanism with every caregiver in a realistic scenario.

**Ongoing** Test the response protocol periodically to confirm genuine, timely response.

## FOR SURVEYORS — WHAT IS NOT OBVIOUS

**Ask a caregiver to demonstrate or describe exactly how they would use this mechanism in a real situation.**
*A specific, confident demonstration reveals genuine, practiced familiarity, not theoretical policy knowledge.*

**Ask what happens on the receiving end when this signal is actually triggered.**
*A specific, confident answer reveals a genuine, defined response, not a signal that might go unanswered.*

**E-LEARNING** academy.gmj.ge/hc-std5-3-discreet-distress-signal — 30 min · complete before self-assessment

Standard 5.4 **CORE** · *Standard 5: Caregiver Safety in an Uncontrolled Environment*

**Hostile Animals and Environmental Hazards Are Specifically Assessed**

**ASSESSMENT** ASF-HC-STD5-v3.0

| CR N/A | TR FULL | SM ADAPTED | ST FULL |
|---|---|---|---|

**5.4**
**CORE**
L1

THE STANDARD

## Hostile Animals and Environmental Hazards Are Specifically Assessed

Hostile or unpredictable animals, along with other genuine environmental hazards specific to home-based work — poor lighting, unsafe walking conditions, extreme temperature — are specifically assessed for each home, not overlooked as a lesser concern compared with interpersonal risk.

**PROVIDER SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.**

| | | | | |
|---|---|---|---|---|
| **1** | **Are hostile or unpredictable animals specifically assessed for each home, not overlooked?**<br>*Real, specific assessment of this genuine risk category, not treated as a minor or secondary concern.*<br>Doc: Animal risk assessment documentation | YES | PARTIAL | NO |
| **2** | **Are other environmental hazards — lighting, walking conditions, temperature — specifically, genuinely assessed?**<br>*Complete, specific coverage of these real hazard categories, not a generic or partial check.*<br>Doc: N/A — tested directly | YES | PARTIAL | NO |
| **3** | **Does an identified hazard genuinely lead to a specific accommodation or precaution, not simply noted without resulting action?**<br>*Real, resulting action, not a documented hazard without any genuine, practical response.*<br>Doc: Hazard accommodation record | YES | PARTIAL | NO |

**ALL YES** Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

**WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks**

| | |
|---|---|
| **DOCUMENT**<br>*Animal risk assessment review* | Reviews whether hostile animal risk is specifically, genuinely assessed for each home. |
| **DOCUMENT**<br>*Environmental hazard review* | Reviews whether other environmental hazards are specifically, comprehensively assessed. |
| **DOCUMENT**<br>*Accommodation review* | Reviews whether an identified hazard genuinely leads to a specific, resulting accommodation. |

REFERENCES

*[24] Documented occupational hazard research for home-based care work identifies hostile animals, dangerous walking conditions, and temperature extremes among the genuine risks caregivers face, establishing these as genuine risk categories requiring specific assessment alongside interpersonal safety concerns.*

Standard 5.4 · *Standard 5: Caregiver Safety in an Uncontrolled Environment*

# Guidance & Learning

GUIDANCE ASF-HC-STD5-v3.0

## WHY THIS STANDARD EXISTS

These hazards are specifically, formally documented among the real occupational risks home healthcare workers face, and they can be just as genuinely disabling as an interpersonal safety concern — a caregiver bitten by a hostile dog or injured navigating unsafe conditions to reach the door has experienced a real, preventable workplace injury the same as any other.

**The evidence: [24] Documented occupational hazard research for home-based care work identifies hostile animals, dangerous walking conditions, and temperature extremes among the genuine risks caregivers face, establishing these as genuine risk categories requiring specific assessment alongside interpersonal safety concerns.**

| WHAT GOOD LOOKS LIKE | WHAT FAILURE LOOKS LIKE |
|---|---|
| ✓ Hostile animal risk is genuinely, specifically assessed for each home. | ✗ Animal risk is overlooked or treated as a lesser concern. |
| ✓ Other environmental hazards are genuinely, comprehensively assessed. | ✗ Environmental hazard assessment is generic or incomplete. |
| ✓ An identified hazard genuinely leads to a specific, resulting accommodation. | ✗ An identified hazard is documented but leads to no genuine, resulting action. |

## MOST COMMON REASONS PROVIDERS SCORE PARTIAL

1 **Assessment covers dogs specifically but not other animals that could genuinely pose a risk.**
*Any animal genuinely capable of causing harm deserves the same specific assessment attention.*

2 **Lighting and walking condition hazards are assessed but seasonal temperature extremes aren't specifically reconsidered as seasons change.**
*A genuine, seasonal hazard deserves reassessment reflecting the actual, current conditions, not a static, one-time check.*

3 **Hazards are identified but the resulting accommodation is informal, not consistently documented as a specific response.**
*A specific, documented accommodation is what confirms genuine follow-through, not an informal response that may not actually persist.*

## HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

**Week 1** Review current environmental hazard assessment for genuine, comprehensive coverage.

**Week 2** Establish specific assessment of animal risk and other environmental hazard categories.

**Week 3** Build a process ensuring identified hazards lead to specific, documented accommodations.

**Ongoing** Reassess seasonal or changing environmental hazards periodically.

## FOR SURVEYORS — WHAT IS NOT OBVIOUS

**Ask how the service specifically assesses animal risk for a real, current client's home.**
*A specific, real example reveals genuine assessment practice, not an assumption it's covered generally.*

**Ask for a real example of an environmental hazard identified and the specific accommodation that resulted.**
*A real, traceable example reveals genuine, resulting action, not documentation alone.*

**E-LEARNING** academy.gmj.ge/hc-std5-4-environmental-hazard-assessment — 30 min · complete before self-assessment

| | Standard 5.5 **CORE** · *Standard 5: Caregiver Safety in an Uncontrolled Environment*<br>**Near-Misses Are Actively Reported and Used to Update Risk Assessments** | **ASSESSMENT** ASF-HC-STD5-v3.0 |
|---|---|---|

| CR N/A | TR FULL | SM ADAPTED | ST FULL |
|---|---|---|---|

**5.5**
**CORE**
L1

THE STANDARD

## Near-Misses Are Actively Reported and Used to Update Risk Assessments

A near-miss — a situation that could have resulted in harm but didn't — is actively reported by caregivers and genuinely used to update risk assessments and safety procedures, not dismissed as a non-event simply because no actual harm occurred this time.

| PROVIDER SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question. | | | | |
|---|---|---|---|---|
| **1** | **Are caregivers genuinely encouraged and supported to report a near-miss, not discouraged from doing so?**<br>*Real, active encouragement, not a culture where near-misses go unreported for fear of consequence.*<br>Doc: Near-miss reporting process documentation | YES | PARTIAL | NO |
| **2** | **Does a reported near-miss genuinely lead to an updated risk assessment, not filed without resulting action?**<br>*Real, resulting update to the actual risk assessment, not a report that changes nothing.*<br>Doc: Risk assessment update record | YES | PARTIAL | NO |
| **3** | **Are near-miss reports genuinely reviewed for a broader pattern, not treated only as isolated, individual incidents?**<br>*Real, pattern-level review, not each report considered only in isolation.*<br>Doc: N/A — tested directly | YES | PARTIAL | NO |

**ALL YES** Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

| WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks | |
|---|---|
| **DOCUMENT**<br>*Reporting process review* | Reviews the specific, active process encouraging caregivers to report near-misses. |
| **DOCUMENT**<br>*Risk assessment update review* | Reviews evidence that near-miss reports genuinely lead to updated risk assessments. |
| **DOCUMENT**<br>*Pattern review* | Reviews whether near-miss reports are genuinely examined collectively for broader patterns. |

REFERENCES

*[25] Near-misses are established as genuine warning signs of potential hazards, with caregiver reporting enabling agencies to update risk assessments, improve safety procedures, and prevent future injuries before actual harm occurs.*

Standard 5.5 · *Standard 5: Caregiver Safety in an Uncontrolled Environment*

**Guidance & Learning**

**GUIDANCE** ASF-HC-STD5-v3.0

## WHY THIS STANDARD EXISTS

Near-misses are specifically identified as genuine warning signs of potential hazards, and a service that only responds after actual harm occurs misses the real, earlier opportunity a near-miss provides to update risk assessments and prevent the harm from happening at all — treating a near-miss as a non-event wastes exactly the information that could have prevented a future, more serious incident.

**The evidence: [25] Near-misses are established as genuine warning signs of potential hazards, with caregiver reporting enabling agencies to update risk assessments, improve safety procedures, and prevent future injuries before actual harm occurs.**

| WHAT GOOD LOOKS LIKE | WHAT FAILURE LOOKS LIKE |
|---|---|
| ✓ Caregivers are genuinely encouraged and supported to report near-misses. | ✗ Near-misses go unreported, with no active encouragement or supportive culture. |
| ✓ Reported near-misses genuinely lead to updated risk assessments. | ✗ Reports are filed without any genuine, resulting update to risk assessments. |
| ✓ Near-miss reports are genuinely reviewed for broader patterns. | ✗ Reports are treated only as isolated incidents, missing broader patterns. |

## MOST COMMON REASONS PROVIDERS SCORE PARTIAL

1 **Reporting is encouraged for interpersonal safety near-misses but less consistently for environmental hazard near-misses.**
*Every genuine near-miss category carries the same real, protective value when reported and reviewed.*

2 **Reports lead to individual client-specific updates but aren't reviewed for patterns across the broader caregiver workforce.**
*A pattern visible only across multiple clients or caregivers can reveal a genuine, systemic risk an individual review would miss.*

3 **A reporting process exists but caregivers report some hesitation about whether reporting could reflect poorly on them.**
*Hesitation about reporting undermines the entire purpose of this practice, even where a formal process technically exists.*

## HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

**Week 1** Review current near-miss reporting culture for genuine encouragement and psychological safety.

**Week 2** Establish a clear, supportive process for reporting across all near-miss categories.

**Week 3** Build a process connecting reports to genuine, resulting risk assessment updates.

**Ongoing** Review near-miss reports collectively for broader, systemic patterns.

## FOR SURVEYORS — WHAT IS NOT OBVIOUS

**Ask a caregiver whether they would feel genuinely comfortable reporting a near-miss, and why.**
*A specific, honest answer reveals genuine psychological safety, not an assumption reporting culture is healthy.*

**Ask for a real, recent example of a near-miss report and what specifically changed as a result.**
*A real, traceable example reveals genuine, resulting action, not reporting without consequence.*

**E-LEARNING** academy.gmj.ge/hc-std5-5-near-miss-reporting — 30 min · complete before self-assessment

# STANDARD 6

## Care Plan Development & Ongoing Supervision

**MANDATORY**

*5 criteria*

| | Standard 6.1 NON-NEGOTIABLE · *Standard 6: Care Plan Development & Ongoing Supervision* **Supervisory Visits Occur Genuinely On-Site** | ASSESSMENT ASF-HC-STD6-v3.0 |
|---|---|---|
| CR FULL | TR FULL | SM ADAPTED / ST FULL |

**6.1**
NON-NEGOTIABLE
L1

THE STANDARD

## Supervisory Visits Occur Genuinely On-Site

Supervisory visits genuinely occur on-site and in person, on a real, defined schedule matching the actual level of care being provided — not substituted by a phone check-in, and not treated as satisfied by counting individual caregiver visits rather than genuine calendar-based intervals.

**PROVIDER SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.**

| | | | | |
|---|---|---|---|---|
| **1** | **Do supervisory visits genuinely occur on-site and in person, not substituted by phone check-ins?** *Real, on-site, in-person visits, not a phone call treated as equivalent.* Doc: Supervisory visit record | YES | PARTIAL | NO |
| **2** | **Is the visit schedule genuinely based on calendar time, not miscounted as a number of caregiver visits?** *Real, correct calendar-interval tracking, not the documented, common miscount.* Doc: N/A — tested directly | YES | PARTIAL | NO |
| **3** | **Does the visit schedule genuinely match the actual level of care being provided?** *Real, care-type-appropriate scheduling, not a single generic interval applied to every situation.* Doc: Schedule-to-care-level matching documentation | YES | PARTIAL | NO |

**ALL YES** Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

**WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks**

| | |
|---|---|
| **DOCUMENT** *Visit record review* | Reviews records confirming supervisory visits genuinely occur on-site and in person. |
| **DOCUMENT** *Interval calculation review* | Reviews whether the visit schedule is genuinely calculated by calendar days, not visit count. |
| **DOCUMENT** *Care-level matching review* | Reviews whether the visit schedule genuinely matches the actual level of care being provided. |

REFERENCES

*[26] Established supervisory practice for home-based caregiving specifies onsite, in-person visits at a defined calendar interval, with phone check-ins not satisfying this requirement, and treating a calendar-based interval as a count of visits rather than elapsed time identified as a documented, common compliance error.*

Standard 6.1 · *Standard 6: Care Plan Development & Ongoing Supervision*

# Guidance & Learning

GUIDANCE ASF-HC-STD6-v3.0

## WHY THIS STANDARD EXISTS

A phone check-in cannot genuinely observe how care is actually being delivered in the home, and treating a defined calendar interval as a count of visits rather than actual elapsed time is a well-documented, real mistake that can leave genuine gaps far longer than the interval actually intends — the whole protective value of supervision depends on it happening on the real schedule, in the real place.

**The evidence: [26] Established supervisory practice for home-based caregiving specifies onsite, in-person visits at a defined calendar interval, with phone check-ins not satisfying this requirement, and treating a calendar-based interval as a count of visits rather than elapsed time identified as a documented, common compliance error.**

| WHAT GOOD LOOKS LIKE | WHAT FAILURE LOOKS LIKE |
|---|---|
| ✓ Supervisory visits genuinely occur on-site and in person. | ✗ Phone check-ins are treated as equivalent to on-site supervisory visits. |
| ✓ The interval is genuinely calculated by calendar days, not visit count. | ✗ The interval is miscalculated as a count of visits rather than calendar days. |
| ✓ The schedule genuinely matches the actual level of care provided. | ✗ A single generic schedule is applied regardless of the actual care level. |

## MOST COMMON REASONS PROVIDERS SCORE PARTIAL

1 **On-site visits happen reliably but documentation doesn't clearly capture the exact calendar-day interval maintained.**
*Clear, specific documentation is what makes the interval genuinely verifiable, not assumed correct.*

2 **The correct interval is generally understood but a specific staff member's informal tracking occasionally miscounts it.**
*Every person tracking this interval needs the same accurate, genuine understanding of calendar-day counting.*

3 **Scheduling is correct for the most common care type but hasn't been specifically reconfirmed for a less common arrangement.**
*A less common care arrangement carries the same real need for a correctly matched supervisory schedule.*

## HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

**Week 1** Review current supervisory visit practice for genuine on-site occurrence and correct interval calculation.

**Week 2** Correct any miscounted interval and retrain staff on calendar-day, not visit-count, tracking.

**Week 3** Confirm the visit schedule genuinely matches the actual level of care for every client.

**Ongoing** Audit interval calculation accuracy periodically.

## FOR SURVEYORS — WHAT IS NOT OBVIOUS

**Ask staff to walk through how they calculate the supervisory visit interval for a specific, real client.**
*A specific, accurate answer reveals genuine understanding of calendar-day calculation, not the common visit-count error.*

**Ask whether a phone check-in has ever been counted as satisfying this requirement.**
*A direct question often surfaces informal practice a policy review wouldn't catch.*

**E-LEARNING** academy.gmj.ge/hc-std6-1-onsite-supervisory-visits — 30 min · complete before self-assessment

Standard 6.2 **NON-NEGOTIABLE** · *Standard 6: Care Plan Development & Ongoing Supervision*

# Personal Care Supervision Includes Genuinely Observing the Aide Providing Care

**ASSESSMENT** ASF-HC-STD6-v3.0

| CR FULL | TR FULL | SM ADAPTED | ST FULL |
|---|---|---|---|

**6.2**
**NON-NEGOTIABLE**
L1

THE STANDARD

## Personal Care Supervision Includes Genuinely Observing the Aide Providing Care

When a client receives only personal care services, the required supervisory visit genuinely includes observing the caregiver actually providing care, with the caregiver genuinely present — not a supervisory visit conducted without the caregiver there, which fails to actually assess how care is genuinely being delivered.

| PROVIDER SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question. | | | | |
|---|---|---|---|---|
| **1** | **Does the personal care supervisory visit genuinely include the caregiver actively present and providing care?** *Real, genuine presence and active observation, not a visit conducted in the caregiver's absence.* Doc: Personal care supervisory visit record | YES | PARTIAL | NO |
| **2** | **Is this visit genuinely conducted by a registered nurse specifically, not another staff type?** *Real, correct conductor of the visit, not substituted by an unauthorized role.* Doc: N/A — tested directly | YES | PARTIAL | NO |
| **3** | **Does the visit genuinely occur within the applicable defined interval, not exceeding it?** *Real, timely occurrence within the defined interval, not a lapse beyond it.* Doc: Visit timing record | YES | PARTIAL | NO |

**ALL YES** Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

| WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks | |
|---|---|
| **OBSERVE** *Presence verification* | Confirms the caregiver was genuinely present and actively providing care during the supervisory visit. |
| **DOCUMENT** *Conductor verification* | Reviews records confirming the visit was genuinely conducted by a registered nurse. |
| **DOCUMENT** *Timing review* | Reviews whether the visit genuinely occurs within the applicable defined interval. |

REFERENCES

*[27] Established supervisory practice for clients receiving only personal care services requires visits by a qualified supervising professional at a defined interval, with the caregiver required to be present and actively providing care during the visit, distinct from supervision arrangements for skilled clinical care.*

Standard 6.2 · *Standard 6: Care Plan Development & Ongoing Supervision*

# Guidance & Learning

**GUIDANCE** ASF-HC-STD6-v3.0

## WHY THIS STANDARD EXISTS

Unlike supervision for skilled care, personal-care-only supervision specifically requires the caregiver's genuine presence and active observation of care being provided, because this is the only way to actually assess whether care is genuinely being delivered safely and appropriately — a visit conducted without the caregiver present, however well-documented otherwise, doesn't actually accomplish what this specific requirement exists for.

**The evidence: [27] Established supervisory practice for clients receiving only personal care services requires visits by a qualified supervising professional at a defined interval, with the caregiver required to be present and actively providing care during the visit, distinct from supervision arrangements for skilled clinical care.**

| WHAT GOOD LOOKS LIKE | WHAT FAILURE LOOKS LIKE |
|---|---|
| ✓ The caregiver is genuinely present and actively providing care during the visit. | ✗ The visit is conducted without the caregiver genuinely present. |
| ✓ The visit is genuinely conducted by a registered nurse specifically. | ✗ The visit is conducted by an unauthorized role. |
| ✓ The visit genuinely occurs within the defined interval. | ✗ The visit occurs beyond the defined interval. |

## MOST COMMON REASONS PROVIDERS SCORE PARTIAL

1 **Presence is generally arranged but scheduling occasionally results in the caregiver's shift ending just before the visit occurs.**
*Genuine coordination of timing is what ensures the visit actually accomplishes its real purpose.*

2 **The correct conductor requirement is understood but not consistently confirmed before scheduling a specific visit.**
*Confirming the conductor's qualification before scheduling prevents a visit from being genuinely non-compliant after the fact.*

3 **Visits generally occur within the interval but timing is occasionally close to the outer limit without margin.**
*A genuine safety margin, not proximity to the outer limit, is what reliably prevents an actual lapse beyond the required interval.*

## HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

**Week 1** Review current personal care supervisory visit practice for genuine caregiver presence and correct conductor.

**Week 2** Establish scheduling coordination ensuring caregiver presence during the visit.

**Week 3** Confirm every supervisory visit is genuinely conducted by a registered nurse.

**Ongoing** Track visit timing with margin against the defined interval, not close to the outer limit.

## FOR SURVEYORS — WHAT IS NOT OBVIOUS

**Ask to see a real, recent supervisory visit record and confirm the caregiver's genuine presence.**
*A real, specific record reveals genuine practice, not an assumption of compliance.*

**Ask who specifically conducts these visits and confirm this matches the required role.**
*A specific, confident answer reveals genuine attention to this requirement, not assumed compliance.*

**E-LEARNING** academy.gmj.ge/hc-std6-2-personal-care-supervision-presence — 30 min · complete before self-assessment

| | Standard 6.3 **NON-NEGOTIABLE** · *Standard 6: Care Plan Development & Ongoing Supervision*<br>**Supervision Documentation Captures Objective, Measurable Observations** | **ASSESSMENT** ASF-HC-STD6-v3.0 |
|---|---|---|

| CR FULL | TR FULL | SM FULL | ST FULL |
|---|---|---|---|

**6.3**
**NON-NEGOTIABLE**
L1

THE STANDARD

## Supervision Documentation Captures Objective, Measurable Observations

Supervisory visit documentation genuinely captures objective, measurable observations — not a vague, general statement like "patient is progressing well, continue plan of care" that provides no real, comparable information for the next reviewer.

| PROVIDER SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question. | | | | |
|---|---|---|---|---|
| **1** | **Does supervisory documentation genuinely capture objective, measurable observations, not vague general statements?**<br>*Real, specific, measurable content, not a vague reassurance that provides no comparable information.*<br>Doc: Supervisory documentation sample | YES | PARTIAL | NO |
| **2** | **Can documentation from different visits genuinely be compared to identify a real change over time?**<br>*Real, comparable documentation, not language too vague to reveal any actual change.*<br>Doc: N/A — tested directly | YES | PARTIAL | NO |
| **3** | **Are staff genuinely trained on what constitutes adequate, objective documentation, not left to write vague reassurance by default?**<br>*Real, specific training on this documentation standard, not assumed general competence.*<br>Doc: Documentation training record | YES | PARTIAL | NO |

**ALL YES** Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

| WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks | |
|---|---|
| **DOCUMENT**<br>*Documentation quality review* | Reviews a sample of actual supervisory documentation for genuine, objective, measurable content. |
| **DOCUMENT**<br>*Comparability review* | Reviews whether documentation across different visits genuinely allows comparison over time. |
| **DOCUMENT**<br>*Training review* | Reviews training records confirming staff are specifically taught this documentation standard. |

REFERENCES

*[28] Established documentation standards for supervisory practice specifically require objective measurements enabling comparison across assessments, with a vague statement such as "client is progressing well, continue plan of care" explicitly identified as not meeting the required documentation standard.*

Standard 6.3 · *Standard 6: Care Plan Development & Ongoing Supervision*

# Guidance & Learning

**GUIDANCE** ASF-HC-STD6-v3.0

## WHY THIS STANDARD EXISTS

A vague statement that a client is doing well doesn't actually meet the genuine documentation standard, and this isn't a minor formatting preference — objective, measurable documentation is what actually allows a genuine comparison across assessments over time, catching a real decline or change that a vague, reassuring statement would obscure.

**The evidence: [28] Established documentation standards for supervisory practice specifically require objective measurements enabling comparison across assessments, with a vague statement such as "client is progressing well, continue plan of care" explicitly identified as not meeting the required documentation standard.**

| WHAT GOOD LOOKS LIKE | WHAT FAILURE LOOKS LIKE |
|---|---|
| ✓ Documentation genuinely captures objective, measurable observations. | ✗ Documentation consists of vague, general statements providing no real information. |
| ✓ Documentation across visits genuinely allows real comparison over time. | ✗ Documentation across visits can't genuinely be compared to reveal change. |
| ✓ Staff are specifically trained on this objective documentation standard. | ✗ Staff aren't specifically trained; vague documentation is the default. |

## MOST COMMON REASONS PROVIDERS SCORE PARTIAL

1 **Documentation is objective for physical observations but vague regarding cognitive or behavioral status.**
*Every dimension of a client's real status deserves the same objective, measurable documentation standard.*

2 **Training addresses the general principle but doesn't specifically model what genuinely adequate documentation looks like.**
*Concrete examples make an abstract documentation standard genuinely actionable in daily practice.*

3 **Documentation is generally objective but occasionally reverts to vague language during high-volume periods.**
*Genuine documentation quality shouldn't erode under time pressure, since that's exactly when careful tracking matters most.*

## HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

**Week 1** Review current supervisory documentation for genuine, objective, measurable content.

**Week 2** Train staff specifically on this documentation standard with concrete examples.

**Week 3** Establish documentation review to catch and correct vague language.

**Ongoing** Confirm documentation quality holds during high-volume periods specifically.

## FOR SURVEYORS — WHAT IS NOT OBVIOUS

**Ask to see actual, real supervisory documentation for a specific client across two or more visits.**
*A real, direct comparison reveals whether documentation genuinely allows tracking change over time.*

**Ask a staff member to explain what makes documentation genuinely objective, not just to confirm a policy exists.**
*A specific, confident answer reveals genuine, internalized understanding, not assumed general competence.*

**E-LEARNING** academy.gmj.ge/hc-std6-3-objective-documentation — 30 min · complete before self-assessment

Standard 6.4 **NON-NEGOTIABLE** · *Standard 6: Care Plan Development & Ongoing Supervision*

**A Change in Client Needs Triggers Genuine Care Plan Review**

**ASSESSMENT** ASF-HC-STD6-v3.0

| CR FULL | TR FULL | SM ADAPTED | ST FULL |
|---|---|---|---|

**6.4**
**NON-NEGOTIABLE**
L1

THE STANDARD

## A Change in Client Needs Triggers Genuine Care Plan Review

When a client's actual needs genuinely change — a service is no longer required, a new need emerges, responsibility shifts between disciplines — this genuinely triggers review and update of the care plan, not left to continue reflecting needs that no longer accurately describe the client's real, current situation.

| PROVIDER SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question. | | | | |
|---|---|---|---|---|
| **1** | **Does a genuine change in client needs actively trigger care plan review, not left unaddressed?**<br>*Real, active review triggered by the change itself, not routine continuation of an outdated plan.*<br>Doc: Care plan review trigger documentation | YES | PARTIAL | NO |
| **2** | **Is responsibility for the updated plan genuinely, clearly assigned when it shifts between disciplines?**<br>*Real, clear assignment of responsibility, not ambiguity about who now owns the plan's accuracy.*<br>Doc: N/A — tested directly | YES | PARTIAL | NO |
| **3** | **Does the updated plan genuinely reflect the client's actual, current needs, not a partial update leaving stale elements in place?**<br>*Real, complete update, not selective revision that leaves outdated elements alongside new ones.*<br>Doc: Updated care plan review | YES | PARTIAL | NO |

**ALL YES** Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

| WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks | |
|---|---|
| **DOCUMENT**<br>*Trigger review* | Reviews evidence that a genuine change in client needs actively triggers care plan review. |
| **DOCUMENT**<br>*Responsibility assignment review* | Reviews whether responsibility for the plan is genuinely, clearly assigned when it shifts. |
| **DOCUMENT**<br>*Update completeness review* | Reviews whether the updated plan genuinely reflects current needs, not a partial revision. |

REFERENCES

*[29] When a patient's needs change such that responsibility for supervision transfers between disciplines, the discipline assuming responsibility is expected to review and update the aide care plan, establishing genuine plan review at the point of real, changed circumstances as required practice.*

Standard 6.4 · *Standard 6: Care Plan Development & Ongoing Supervision*

# Guidance & Learning

**GUIDANCE** ASF-HC-STD6-v3.0

## WHY THIS STANDARD EXISTS

A care plan that no longer reflects a client's genuine, current needs isn't simply outdated paperwork — it's actively guiding care based on an inaccurate picture of what the client actually requires now, and the responsibility for keeping the plan genuinely current specifically transfers to whichever discipline is actually managing the client's current, real needs, not left unclear when a change occurs.

**The evidence: [29] When a patient's needs change such that responsibility for supervision transfers between disciplines, the discipline assuming responsibility is expected to review and update the aide care plan, establishing genuine plan review at the point of real, changed circumstances as required practice.**

| WHAT GOOD LOOKS LIKE | WHAT FAILURE LOOKS LIKE |
|---|---|
| ✓ A genuine change in client needs actively triggers care plan review. | ✗ Changed needs don't trigger any genuine plan review. |
| ✓ Responsibility for the plan is genuinely, clearly assigned when it shifts. | ✗ Responsibility for the plan is ambiguous when circumstances shift. |
| ✓ The updated plan genuinely, completely reflects current needs. | ✗ Updates are partial, leaving outdated elements alongside new ones. |

## MOST COMMON REASONS PROVIDERS SCORE PARTIAL

1 **Review is triggered for a major change like discontinued therapy but not consistently for a more gradual shift in need.**
*A gradual change carries the same real risk of an increasingly inaccurate plan as an abrupt one.*

2 **Responsibility is understood generally but isn't specifically documented at the moment it actually transfers.**
*Documented, specific assignment at the point of transfer prevents genuine ambiguity about current ownership.*

3 **Updates address the specific change but don't prompt a genuine review of the plan's other elements for continued accuracy.**
*A change in one area can genuinely signal that other elements of the plan deserve fresh reconsideration too, not isolated updating.*

## HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

**Week 1** Review current practice for genuine care plan review triggered by changed client needs.

**Week 2** Establish clear, documented responsibility assignment at the point of any discipline transfer.

**Week 3** Build a process ensuring complete, not partial, plan updates.

**Ongoing** Extend review triggers to gradual, not only abrupt, changes in need.

## FOR SURVEYORS — WHAT IS NOT OBVIOUS

**Ask for a real, recent example of a client whose needs changed and trace what happened to their care plan.**
*A real, traceable example reveals genuine practice, not policy language alone.*

**Ask who currently owns responsibility for a specific client's plan and how that was determined.**
*A specific, confident answer reveals genuine, clear assignment, not ambiguity.*

**E-LEARNING** academy.gmj.ge/hc-std6-4-needs-triggered-plan-review — 30 min · complete before self-assessment

Standard 6.5 **CORE** · *Standard 6: Care Plan Development & Ongoing Supervision*

# An Identified Deficiency Leads to Genuine Retraining and Re-Evaluation

**ASSESSMENT** ASF-HC-STD6-v3.0

| CR N/A | TR FULL | SM ADAPTED | ST FULL |
|---|---|---|---|

**6.5**
**CORE**
L1

THE STANDARD

## An Identified Deficiency Leads to Genuine Retraining and Re-Evaluation

When a supervisory visit identifies a genuine deficiency in a caregiver's performance, this leads to real, documented retraining and a genuine, subsequent competency evaluation before the caregiver resumes independent care — not a deficiency noted without resulting action, or the caregiver continuing independently without confirmed correction.

**PROVIDER SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.**

| | | | | |
|---|---|---|---|---|
| **1** | **Does an identified deficiency lead to genuine, documented retraining, not noted without resulting action?**<br>*Real, specific retraining actually delivered, not a deficiency recorded without follow-through.*<br>Doc: Retraining record | YES | PARTIAL | NO |
| **2** | **Does the caregiver genuinely undergo a subsequent competency evaluation before resuming independent care?**<br>*Real, confirmed re-evaluation, not resumed independent care assumed safe without verification.*<br>Doc: Post-retraining competency evaluation record | YES | PARTIAL | NO |
| **3** | **Is this evaluation genuinely conducted with the supervisor present, confirming the deficiency is actually resolved?**<br>*Real, supervised, confirmed resolution, not self-reported improvement accepted without verification.*<br>Doc: N/A — tested directly | YES | PARTIAL | NO |

**ALL YES** Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

**WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks**

| | |
|---|---|
| **DOCUMENT**<br>*Retraining record review* | Reviews documented evidence of genuine retraining following an identified deficiency. |
| **DOCUMENT**<br>*Re-evaluation review* | Reviews whether a genuine, subsequent competency evaluation occurred before independent care resumed. |
| **DOCUMENT**<br>*Supervised confirmation review* | Reviews whether the evaluation was genuinely conducted with the supervisor present. |

REFERENCES

*[30] When a supervisory visit identifies a deficiency, established practice requires the caregiver to receive retraining in the deficient skills and then pass a genuine, onsite competency evaluation with the supervisor present before resuming independent care.*

Standard 6.5 · *Standard 6: Care Plan Development & Ongoing Supervision*

# Guidance & Learning

**GUIDANCE** ASF-HC-STD6-v3.0

## WHY THIS STANDARD EXISTS

Identifying a genuine problem during supervision only provides real protective value if something actually changes afterward, and the established corrective sequence — retraining, then a genuine competency evaluation confirming the deficiency is actually resolved — is what ensures a caregiver doesn't simply continue the same practice that prompted the original concern.

**The evidence: [30] When a supervisory visit identifies a deficiency, established practice requires the caregiver to receive retraining in the deficient skills and then pass a genuine, onsite competency evaluation with the supervisor present before resuming independent care.**

| WHAT GOOD LOOKS LIKE | WHAT FAILURE LOOKS LIKE |
|---|---|
| ✓ Identified deficiencies genuinely lead to documented retraining. | ✗ Deficiencies are noted without any genuine, resulting retraining. |
| ✓ A genuine competency evaluation confirms resolution before independent care resumes. | ✗ Independent care resumes without a genuine, confirming evaluation. |
| ✓ The evaluation is genuinely conducted with the supervisor present. | ✗ Improvement is self-reported without genuine, supervised confirmation. |

## MOST COMMON REASONS PROVIDERS SCORE PARTIAL

1 **Retraining happens promptly for significant deficiencies but is delayed for more minor ones.**
*Every genuine deficiency deserves the same prompt, real correction, regardless of apparent severity.*

2 **Re-evaluation happens but isn't consistently documented as specifically addressing the original deficient skill.**
*Documentation specifically tied to the original concern is what confirms genuine resolution, not general competency confirmation.*

3 **The process works well for skills-based deficiencies but is less clearly defined for a judgment or communication concern.**
*A judgment or communication concern carries the same real risk as a skills deficiency and deserves the same clear, defined corrective process.*

## HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

**Week 1** Review current deficiency response for genuine retraining and re-evaluation practice.

**Week 2** Establish prompt retraining for every identified deficiency, regardless of apparent severity.

**Week 3** Build documentation specifically tying re-evaluation to the original identified concern.

**Ongoing** Extend clear process definition to judgment and communication concerns, not skills alone.

## FOR SURVEYORS — WHAT IS NOT OBVIOUS

**Ask for a real, recent example of an identified deficiency and trace the full retraining and re-evaluation sequence.**
*A real, traceable example reveals genuine follow-through, not policy language without practical application.*

**Ask how a judgment or communication-related deficiency would be specifically retrained and re-evaluated.**
*A specific, thoughtful answer reveals whether the process genuinely extends beyond straightforward skills-based concerns.*

**E-LEARNING** academy.gmj.ge/hc-std6-5-deficiency-retraining — 30 min · complete before self-assessment

# STANDARD 7

## Governance & Staffing

**MANDATORY**

*5 criteria*

Standard 7.1 **NON-NEGOTIABLE** · *Standard 7: Governance & Staffing*

# A Genuine Coverage Plan Exists for a Solo Caregiver's Absence

**ASSESSMENT** ASF-HC-STD7-v3.0

| CR FULL | TR FULL | SM FULL | ST FULL |
|---|---|---|---|

**7.1**
**NON-NEGOTIABLE**
L1

THE STANDARD

## A Genuine Coverage Plan Exists for a Solo Caregiver's Absence

For a client served by a single, independent caregiver, a genuine, defined coverage arrangement exists for when that caregiver is unavailable — illness, leave, emergency — with a real, named alternative for care in that gap, not an assumption that the client will simply manage without care.

**PROVIDER SELF-ASSESSMENT** Tick YES, PARTIAL, or NO for each question.

| | | | | |
|---|---|---|---|---|
| **1** | **Does a genuine, defined coverage arrangement exist for when a solo caregiver is unavailable?**<br>*A real, specific arrangement, not an assumption the client will manage without care.*<br>Doc: Coverage arrangement documentation | YES | PARTIAL | NO |
| **2** | **Is there a real, named alternative caregiver or service the client can be directed to during a coverage gap?**<br>*A specific, real alternative, not a vague suggestion to seek help elsewhere.*<br>Doc: Named alternative caregiver documentation | YES | PARTIAL | NO |
| **3** | **Is the client genuinely informed of the coverage plan in advance, not left to discover it only when they need it?**<br>*Real, proactive client awareness, not information only encountered during an actual gap.*<br>Doc: N/A — tested directly | YES | PARTIAL | NO |

**ALL YES** Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

**WHAT THE ASSESSOR DOES ON SITE** no surprises, no hidden checks

| | |
|---|---|
| **DOCUMENT**<br>*Coverage plan review* | Reviews the actual, defined coverage arrangement for when the sole caregiver is unavailable. |
| **DOCUMENT**<br>*Alternative caregiver review* | Reviews the specific, named alternative caregiver or service the client would be directed to. |
| **ASK**<br>*Client awareness interview* | Asks a client whether they know what to do if their caregiver were unavailable. |

REFERENCES

*[31] Defined coverage arrangements for a solo caregiver's unavailability, distinct from an assumed continuation of care without one, are established as necessary practice for genuine continuity in any single-caregiver home care arrangement.*

Standard 7.1 · *Standard 7: Governance & Staffing*

**Guidance & Learning**

**GUIDANCE** ASF-HC-STD7-v3.0

## WHY THIS STANDARD EXISTS

Home care's genuine, real advantage — that it can be delivered by a single, independent caregiver working directly for a client — carries the same specific vulnerability as any solo arrangement: without a defined coverage plan, a client's care simply stops the moment that one caregiver is unavailable, and given how often a home care client depends on daily assistance with basic needs, this gap can matter immediately, not eventually.

**The evidence: [31] Defined coverage arrangements for a solo caregiver's unavailability, distinct from an assumed continuation of care without one, are established as necessary practice for genuine continuity in any single-caregiver home care arrangement.**

| WHAT GOOD LOOKS LIKE | WHAT FAILURE LOOKS LIKE |
|---|---|
| ✓ A genuine, defined coverage arrangement exists and is real, not theoretical. | ✗ No defined coverage arrangement exists beyond an assumption the client will manage. |
| ✓ A specific, named alternative caregiver is identified for coverage gaps. | ✗ No specific alternative is identified; the client is vaguely told to seek help elsewhere. |
| ✓ Clients are genuinely, proactively aware of the coverage plan. | ✗ Clients only learn about coverage gaps when they actually encounter one. |

## MOST COMMON REASONS PROVIDERS SCORE PARTIAL

1 **A coverage plan exists for planned absences but not genuinely for sudden, unplanned unavailability.**
*A genuine emergency doesn't announce itself in advance, and the plan needs to cover this reality too.*

2 **An alternative caregiver is named but the relationship hasn't been recently reconfirmed as still active.**
*A coverage relationship needs to remain genuinely active, not just historically established.*

3 **The plan exists but client awareness relies on them happening to ask, not proactive communication.**
*Genuine, proactive awareness is more reliable than a plan clients only discover by chance.*

## HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

**Week 1** Review current coverage arrangements for genuine readiness, including sudden, unplanned absence.

**Week 2** Establish or reconfirm a specific, named alternative caregiver relationship.

**Week 3** Build proactive client communication about the coverage plan.

**Ongoing** Periodically reconfirm the coverage relationship remains genuinely active.

## FOR SURVEYORS — WHAT IS NOT OBVIOUS

**Ask what specifically would happen if the caregiver became suddenly, unexpectedly unavailable today.**
*A specific, confident answer reveals a genuine plan, not an assumption it would work out.*

**Ask a client directly whether they know what to do if their caregiver were unavailable.**
*This tests genuine, proactive awareness, not an assumption clients would figure it out.*

**E-LEARNING** academy.gmj.ge/hc-std7-1-solo-caregiver-coverage — 30 min · complete before self-assessment

Standard 7.2 **CORE** · *Standard 7: Governance & Staffing*

## Caregiver Continuity Is Actively Tracked and Prioritized for High-Need Clients

**ASSESSMENT** ASF-HC-STD7-v3.0

| CR N/A | TR FULL | SM ADAPTED | ST FULL |
|---|---|---|---|

**7.2**
**CORE**
L1

THE STANDARD

# Caregiver Continuity Is Actively Tracked and Prioritized for High-Need Clients

Caregiver continuity is genuinely, actively tracked, with specific priority given to clients with the highest care needs — not treated as a passive outcome of scheduling convenience, given real research shows exactly these highest-need clients currently experience the lowest continuity.

| PROVIDER SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question. | | | | |
|---|---|---|---|---|
| **1** | **Is caregiver continuity genuinely, actively tracked, not left to passive scheduling outcomes?**<br>*Real, active tracking of continuity as a specific, measured outcome, not an assumption it's adequate.*<br>Doc: Continuity tracking documentation | YES | PARTIAL | NO |
| **2** | **Do clients with the highest care needs genuinely receive specific priority for continuity, not treated the same as lower-need clients?**<br>*Real, specific prioritization, not uniform scheduling regardless of actual client need level.*<br>Doc: High-need client continuity priority documentation | YES | PARTIAL | NO |
| **3** | **Is there a specific, active response when continuity for a high-need client is identified as genuinely low?**<br>*A real, active, resulting response, not a low continuity score noted without genuine action.*<br>Doc: Low continuity response record | YES | PARTIAL | NO |

**ALL YES** Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

| WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks | |
|---|---|
| **DOCUMENT**<br>*Continuity tracking review* | Reviews whether caregiver continuity is genuinely, actively tracked as a measured outcome. |
| **DOCUMENT**<br>*High-need prioritization review* | Reviews whether high-need clients genuinely receive specific continuity prioritization. |
| **DOCUMENT**<br>*Low continuity response review* | Reviews evidence of genuine, active response when continuity for a high-need client is found to be low. |

REFERENCES

*[32] Research on home health aide continuity found that clients with the highest care needs and greatest cognitive impairment experience the lowest continuity scores, despite being the most dependent on stable, familiar caregivers and most likely to benefit from consistency.*

Standard 7.2 · *Standard 7: Governance & Staffing*

# Guidance & Learning

**GUIDANCE** ASF-HC-STD7-v3.0

## WHY THIS STANDARD EXISTS

Clients with the greatest cognitive or functional impairment are both the most dependent on a stable, familiar caregiver and, according to real research, the ones currently experiencing the least continuity — this is a genuine, documented pattern working directly against the clients who need stability most, and active prioritization is what's required to actually reverse it, not passive hope that scheduling will naturally work out in their favor.

**The evidence: [32] Research on home health aide continuity found that clients with the highest care needs and greatest cognitive impairment experience the lowest continuity scores, despite being the most dependent on stable, familiar caregivers and most likely to benefit from consistency.**

| WHAT GOOD LOOKS LIKE | WHAT FAILURE LOOKS LIKE |
|---|---|
| ✓ Caregiver continuity is genuinely, actively tracked as a measured outcome. | ✗ Continuity is assumed adequate, never genuinely tracked. |
| ✓ High-need clients genuinely receive specific continuity prioritization. | ✗ High-need clients receive no specific continuity priority over lower-need clients. |
| ✓ A real, active response follows when high-need client continuity is identified as low. | ✗ Low continuity for a high-need client is noted without any genuine, resulting action. |

## MOST COMMON REASONS PROVIDERS SCORE PARTIAL

1 **Continuity is tracked generally but not specifically broken out by client need level to reveal this real, documented pattern.**
*Genuine tracking needs to reveal exactly the disparity real research has documented, not obscure it in an aggregate figure.*

2 **Prioritization happens informally but isn't reflected in the actual scheduling system's structured logic.**
*Informal intention is less reliable than continuity priority genuinely built into how scheduling actually works.*

3 **A response exists for a severe continuity gap but not for a moderate, still genuinely concerning decline.**
*A moderate decline can still meaningfully affect a high-need client's real wellbeing and deserves genuine, not just severe-case, attention.*

## HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

**Week 1** Review current continuity tracking for genuine measurement broken out by client need level.

**Week 2** Build specific, structured continuity prioritization into scheduling for high-need clients.

**Week 3** Establish a genuine response process for identified continuity concerns, including moderate declines.

**Ongoing** Monitor continuity specifically for the highest-need clients over time.

## FOR SURVEYORS — WHAT IS NOT OBVIOUS

**Ask for the service's actual, current continuity data specifically for its highest-need clients.**
*A specific, real number reveals genuine tracking, not an assumption of adequacy.*

**Ask how scheduling logic specifically prioritizes continuity for a high-need client, not just convenience.**
*A specific, confident answer reveals genuine, structural prioritization, not informal intention.*

**E-LEARNING** academy.gmj.ge/hc-std7-2-high-need-continuity-priority — 30 min · complete before self-assessment

Standard 7.3 **CORE** · *Standard 7: Governance & Staffing*

**New Caregiver Retention Receives Structured Attention in the First 100 Days**

**ASSESSMENT** ASF-HC-STD7-v3.0

| CR N/A | TR FULL | SM ADAPTED | ST FULL |
|---|---|---|---|

**7.3**
**CORE**
L1

THE STANDARD

## New Caregiver Retention Receives Structured Attention in the First 100 Days

New caregiver retention receives specific, structured attention during their first 100 days of employment — genuine onboarding support, regular check-ins, realistic scheduling — not left to general workplace culture alone, given real industry data shows this exact period is where the overwhelming majority of caregiver departures actually occur.

| PROVIDER SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question. | | | | |
|---|---|---|---|---|
| **1** | **Does the service provide genuine, structured onboarding support specifically during the first 100 days?**<br>*Real, specific structure for this exact period, not general workplace culture applied uniformly.*<br>Doc: First-100-days onboarding program documentation | YES | PARTIAL | NO |
| **2** | **Do regular, genuine check-ins occur with new caregivers during this specific window?**<br>*Real, scheduled check-ins, not informal or occasional contact left to chance.*<br>Doc: Early-tenure check-in record | YES | PARTIAL | NO |
| **3** | **Is scheduling for new caregivers genuinely realistic during this period, not immediately as demanding as for experienced staff?**<br>*Real, adjusted scheduling reflecting a new caregiver's actual, current experience level.*<br>Doc: N/A — tested directly | YES | PARTIAL | NO |

**ALL YES** Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

| WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks | |
|---|---|
| **DOCUMENT**<br>*Onboarding program review* | Reviews the actual, structured onboarding program specifically covering the first 100 days. |
| **DOCUMENT**<br>*Check-in record review* | Reviews records of genuine, regular check-ins during this specific early period. |
| **DOCUMENT**<br>*Scheduling review* | Reviews whether new caregiver scheduling is genuinely adjusted to reflect their current experience level. |

REFERENCES

*[33] Nearly four in five departing caregivers leave within their first 100 days of employment, establishing this specific period as the point of greatest genuine retention risk and impact, distinct from general workplace culture applied without this specific, structured focus.*

Standard 7.3 · *Standard 7: Governance & Staffing*

## Guidance & Learning

**GUIDANCE** ASF-HC-STD7-v3.0

### WHY THIS STANDARD EXISTS

Real, current industry data shows nearly four in five caregivers who leave do so within their first 100 days, meaning this specific window isn't simply an early phase to get through — it's the single period where a genuine, structured retention effort would have the most real impact, and a service that doesn't specifically invest attention here is missing the point in the employment relationship where it actually matters most.

**The evidence: [33] Nearly four in five departing caregivers leave within their first 100 days of employment, establishing this specific period as the point of greatest genuine retention risk and impact, distinct from general workplace culture applied without this specific, structured focus.**

| WHAT GOOD LOOKS LIKE | WHAT FAILURE LOOKS LIKE |
|---|---|
| ✓ Genuine, structured onboarding support exists specifically for the first 100 days. | ✗ No specific structure exists beyond general workplace culture. |
| ✓ Regular, genuine check-ins occur with new caregivers during this window. | ✗ Check-ins are informal or occasional, not genuinely scheduled. |
| ✓ Scheduling for new caregivers is genuinely realistic, not immediately as demanding as for experienced staff. | ✗ New caregivers face the same demanding scheduling as experienced staff immediately. |

### MOST COMMON REASONS PROVIDERS SCORE PARTIAL

1 **Onboarding covers technical training but not the emotional and isolation-related challenges new caregivers genuinely face.**
*The real, documented drivers of early departure include isolation and emotional demand, not technical skill gaps alone.*

2 **Check-ins happen but the specific 100-day window isn't tracked as a distinct period requiring genuine, heightened attention.**
*Genuine attention aligned to the documented risk period is more effective than check-ins applied without this specific timing focus.*

3 **Scheduling is adjusted initially but ramps up to full demand faster than a new caregiver's actual, current comfort level.**
*Genuine comfort and confidence, not a fixed calendar timeline, should determine when full scheduling demand is actually appropriate.*

### HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

**Week 1** Review current onboarding and retention practice against the specific first-100-days risk window.

**Week 2** Build structured onboarding addressing both technical and emotional aspects of the role.

**Week 3** Establish genuine, scheduled check-ins throughout this specific period.

**Ongoing** Track early-tenure departure specifically to confirm the structured approach is genuinely working.

### FOR SURVEYORS — WHAT IS NOT OBVIOUS

**Ask a relatively new caregiver whether they've received genuine, structured check-ins since starting.**
*A specific, real answer reveals genuine practice, not an assumption of adequate support.*

**Ask the service for its own current departure rate within the first 100 days.**
*A specific, real number reveals whether this focus is genuinely producing results, not just existing as a stated priority.*

**E-LEARNING** academy.gmj.ge/hc-std7-3-first-100-days-retention — 30 min · complete before self-assessment

Standard 7.4 **CORE** · *Standard 7: Governance & Staffing*

## Caregiver Isolation Is Addressed Through Genuine, Regular Supervisor Contact

**ASSESSMENT** ASF-HC-STD7-v3.0

| CR N/A | TR FULL | SM ADAPTED | ST FULL |
|---|---|---|---|

**7.4**
**CORE**
L1

THE STANDARD

## Caregiver Isolation Is Addressed Through Genuine, Regular Supervisor Contact

Caregiver isolation is genuinely, actively addressed through regular, real supervisor contact and peer connection opportunities — not left unaddressed on the assumption that working alone is simply an inherent, unavoidable feature of the role that can't be meaningfully improved.

| PROVIDER SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question. | | | | |
|---|---|---|---|---|
| **1** | **Does the service genuinely provide regular, real supervisor contact beyond the isolated visit itself?** *Real, scheduled, meaningful contact, not isolation treated as unavoidable and unaddressed.* Doc: Supervisor contact schedule documentation | YES | PARTIAL | NO |
| **2** | **Are genuine peer connection opportunities offered, not left entirely absent given the isolated nature of visits?** *Real, actual opportunities for caregiver-to-caregiver connection, not an assumption this isn't feasible.* Doc: Peer connection opportunity documentation | YES | PARTIAL | NO |
| **3** | **Is this contact and connection genuinely valued and used by caregivers, not merely offered without real uptake?** *Real, genuine uptake, not a nominal offering caregivers don't actually engage with.* Doc: N/A — tested directly | YES | PARTIAL | NO |

**ALL YES** Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

| WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks | |
|---|---|
| **DOCUMENT** *Contact schedule review* | Reviews the actual, regular schedule of supervisor contact provided to caregivers. |
| **DOCUMENT** *Peer connection review* | Reviews genuine opportunities offered for caregiver-to-caregiver connection. |
| **ASK** *Caregiver uptake interview* | Asks a caregiver whether they genuinely value and use available contact and connection opportunities. |

REFERENCES

*[34] Caregivers working in isolation with little support from supervisors or colleagues is specifically identified as a genuine, documented contributor to caregiver burnout and turnover, establishing active mitigation through regular supervisor contact as necessary, distinct from isolation accepted as an unavoidable feature of the role.*

Standard 7.4 · *Standard 7: Governance & Staffing*

# Guidance & Learning

**GUIDANCE** ASF-HC-STD7-v3.0

## WHY THIS STANDARD EXISTS

Working in isolation with little supervisor or colleague support is specifically identified as a real, documented contributor to caregiver burnout and turnover, and while home care's structure genuinely means a caregiver works alone during actual visits, this doesn't mean the isolation has to extend to the caregiver's entire working experience — regular, genuine contact outside the visit itself is what actually addresses this real, documented driver.

**The evidence: [34] Caregivers working in isolation with little support from supervisors or colleagues is specifically identified as a genuine, documented contributor to caregiver burnout and turnover, establishing active mitigation through regular supervisor contact as necessary, distinct from isolation accepted as an unavoidable feature of the role.**

| WHAT GOOD LOOKS LIKE | WHAT FAILURE LOOKS LIKE |
|---|---|
| ✓ Regular, genuine supervisor contact is actively provided beyond isolated visits. | ✗ Isolation is treated as unavoidable, with no active mitigation. |
| ✓ Genuine peer connection opportunities are actually offered. | ✗ No genuine peer connection opportunities exist. |
| ✓ Caregivers genuinely value and use available contact and connection. | ✗ Contact and connection are offered nominally but not genuinely used. |

## MOST COMMON REASONS PROVIDERS SCORE PARTIAL

1 **Supervisor contact happens but is limited to scheduling logistics, not genuine check-in on the caregiver's actual wellbeing.**
*Genuine connection addresses the real emotional isolation this criterion exists to mitigate, not logistics alone.*

2 **Peer connection opportunities exist but aren't genuinely accessible given caregivers' varied, often conflicting schedules.**
*An opportunity that's practically inaccessible provides limited real value in addressing genuine isolation.*

3 **Contact is offered consistently but caregiver uptake is inconsistent, suggesting the format may not genuinely meet their needs.**
*Inconsistent uptake is a genuine signal worth investigating, not simply accepted as the natural limit of caregiver interest.*

## HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

**Week 1** Review current supervisor contact and peer connection practice for genuine, regular provision.

**Week 2** Establish contact specifically addressing caregiver wellbeing, not logistics alone.

**Week 3** Build genuinely accessible peer connection opportunities accounting for varied schedules.

**Ongoing** Monitor genuine caregiver uptake and adjust format based on real engagement.

## FOR SURVEYORS — WHAT IS NOT OBVIOUS

**Ask a caregiver directly how often they have genuine contact with a supervisor beyond scheduling logistics.**
*A specific, honest answer reveals genuine practice, not an assumption contact is meaningful.*

**Ask whether caregivers have ever used a peer connection opportunity and what their experience was.**
*A real, specific answer reveals genuine uptake, not a nominal offering without actual use.*

**E-LEARNING** academy.gmj.ge/hc-std7-4-caregiver-isolation-mitigation — 30 min · complete before self-assessment

Standard 7.5 **NON-NEGOTIABLE** · *Standard 7: Governance & Staffing*

**Incident Reporting Accounts for Genuine Detection Delay in an Unsupervised Setting**

**ASSESSMENT** ASF-HC-STD7-v3.0

| CR FULL | TR FULL | SM ADAPTED | ST FULL |
|---|---|---|---|

**7.5**
**NON-NEGOTIABLE**
L1

THE STANDARD

## Incident Reporting Accounts for Genuine Detection Delay in an Unsupervised Setting

Incident reporting practice genuinely accounts for the real possibility that a problem in an unsupervised home setting may not be discovered immediately — building in specific mechanisms for delayed discovery, not designed only around incidents that happen to be witnessed or reported in real time.

| PROVIDER SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question. | | | | |
|---|---|---|---|---|
| **1** | **Does incident reporting genuinely account for the real possibility of delayed discovery?**<br>*Real, specific accommodation, not a system designed only around real-time witnessing.*<br>Doc: Incident reporting protocol documentation | YES | PARTIAL | NO |
| **2** | **Are there specific mechanisms — check-ins, family contact — that could catch a delayed-discovery incident?**<br>*Real, specific mechanisms beyond the caregiver's own real-time reporting alone.*<br>Doc: Delayed-discovery detection mechanism documentation | YES | PARTIAL | NO |
| **3** | **Is there a specific process for investigating a delayed-discovery incident without a real-time witness?**<br>*A real, defined process adapted to this evidentiary challenge, not treated identically to a witnessed incident.*<br>Doc: Delayed-discovery investigation process | YES | PARTIAL | NO |

**ALL YES** Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

| WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks | |
|---|---|
| **DOCUMENT**<br>*Reporting protocol review* | Reviews the incident reporting protocol for genuine accommodation of delayed discovery. |
| **DOCUMENT**<br>*Detection mechanism review* | Reviews specific mechanisms in place that could catch a delayed-discovery incident. |
| **DOCUMENT**<br>*Investigation process review* | Reviews the defined investigation process adapted for incidents without a real-time witness. |

REFERENCES

*[35] The isolated, unsupervised nature of one-on-one home caregiving is established as creating genuine, distinct challenges for incident detection compared with facility-based care, requiring reporting mechanisms specifically designed to account for delayed discovery, not assumed real-time detection.*

Standard 7.5 · *Standard 7: Governance & Staffing*

## Guidance & Learning

**GUIDANCE** ASF-HC-STD7-v3.0

### WHY THIS STANDARD EXISTS

A facility with multiple staff present has real opportunities for an incident to be witnessed or discovered quickly, but a single caregiver working alone in a client's home has no colleague who might otherwise notice something sooner — an incident reporting system that assumes real-time detection misses the genuine, distinct reality of exactly the setting this whole document exists to address.

**The evidence: [35] The isolated, unsupervised nature of one-on-one home caregiving is established as creating genuine, distinct challenges for incident detection compared with facility-based care, requiring reporting mechanisms specifically designed to account for delayed discovery, not assumed real-time detection.**

| WHAT GOOD LOOKS LIKE | WHAT FAILURE LOOKS LIKE |
|---|---|
| ✓ Incident reporting genuinely accounts for the real possibility of delayed discovery. | ✗ Reporting assumes real-time detection, with no accommodation for delayed discovery. |
| ✓ Specific mechanisms exist that could catch a delayed-discovery incident. | ✗ No specific mechanisms exist beyond the caregiver's own real-time reporting. |
| ✓ A defined investigation process is genuinely adapted for this evidentiary challenge. | ✗ Investigation is treated identically regardless of whether a real-time witness exists. |

### MOST COMMON REASONS PROVIDERS SCORE PARTIAL

1 **Periodic client check-ins exist but aren't specifically designed to surface a delayed-discovery incident.**
*A check-in's real value for this purpose depends on genuinely being structured to catch this specific kind of concern.*

2 **Family contact happens but isn't consistently leveraged as a genuine detection mechanism for this purpose.**
*Family members present at other times represent a real, additional opportunity to catch what a caregiver's own reporting might miss.*

3 **An investigation process exists but hasn't been specifically tested against a real, delayed-discovery scenario.**
*An untested process may not function reliably when a genuine delayed-discovery incident actually occurs.*

### HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

**Week 1** Review current incident reporting for genuine accommodation of delayed discovery.

**Week 2** Establish specific mechanisms, including structured check-ins, designed to catch delayed-discovery incidents.

**Week 3** Build a defined investigation process adapted for the absence of a real-time witness.

**Ongoing** Test this process against a real or simulated delayed-discovery scenario.

### FOR SURVEYORS — WHAT IS NOT OBVIOUS

**Ask how the service would investigate a concern that surfaced days after it may have actually occurred.**
*A specific, thoughtful answer reveals genuine adaptation to this real challenge, not an assumption real-time detection is the norm.*

**Ask whether family contact is specifically used as a detection mechanism, not just general communication.**
*A specific, confident answer reveals genuine, deliberate use of this real opportunity.*

**E-LEARNING** academy.gmj.ge/hc-std7-5-delayed-discovery-reporting — 30 min · complete before self-assessment

# Endorsements

**What follows is an optional endorsement — an additional standard layered on top of the base seven, never issued alone. A provider must genuinely pass Standards 1 through 7 before the endorsement below is assessed. "Home Care Provider" alone means the base seven only. "Home Care Provider + Health & Migration" means the base seven, verified first, plus the endorsement that follows.**

## STANDARD 8

## Health & Migration

**OPTIONAL ENDORSEMENT**

*Requires Standards 1–7 verified first*

*10 criteria*

| | Standard 8.1 NON-NEGOTIABLE · *Standard 8: Health & Migration*<br>**Care Is Genuinely Adapted to a Client's Migration and Displacement Experience** | ASSESSMENT ASF-HC-STD8-v3.0 |
|---|---|---|

| CR FULL | TR FULL | SM FULL | ST FULL |
|---|---|---|---|

**8.1**
NON-NEGOTIABLE
L1

THE STANDARD

## Care Is Genuinely Adapted to a Client's Migration and Displacement Experience

Care is genuinely adapted to a client's migration and displacement experience — including trauma-informed practice and awareness of legal-status barriers to access — not delivered identically regardless of that history, given a caregiver's daily, ongoing presence in the home makes this context genuinely relevant to nearly every aspect of the relationship.

| PROVIDER SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question. | | | | |
|---|---|---|---|---|
| **1** | **Is care genuinely adapted to a client's migration and displacement experience, not delivered identically regardless of history?**<br>*Genuine adaptation, not a generic cultural-awareness statement.*<br>Doc: Training record on migration-adapted care | YES | PARTIAL | NO |
| **2** | **Is trauma-informed practice genuinely applied throughout the ongoing relationship, not only referenced once at intake?**<br>*Real, sustained practice adaptation, not a one-time consideration.*<br>Doc: N/A — tested directly | YES | PARTIAL | NO |
| **3** | **Is the caregiver aware of legal-status barriers to access that may affect this specific client?**<br>*Specific awareness, not a general sense that barriers can exist.*<br>Doc: N/A — tested directly | YES | PARTIAL | NO |

**ALL YES** Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

| WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks | |
|---|---|
| **ASK**<br>*Migration-adapted care interview* | Asks the caregiver how they adapt practice specifically for a client's migration and displacement history. |
| **OBSERVE**<br>*Trauma-informed practice observation* | Observes an actual visit for genuine trauma-informed practice, not generic sensitivity. |
| **DOCUMENT**<br>*Training content review* | Reviews training materials for specific coverage of migration-adapted, trauma-informed care. |

REFERENCES

*[36] WHO Competency Standard 1 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) requires health workers to adapt practice to migration and displacement experiences, address trauma-informed care and psychosocial needs, and support continuity of care regardless of legal status.*

Standard 8.1 · *Standard 8: Health & Migration*
**Guidance & Learning**

**GUIDANCE** ASF-HC-STD8-v3.0

## WHY THIS STANDARD EXISTS

A refugee or migrant client's health needs and vulnerabilities are shaped by what happened before home care ever began, and unlike an episodic clinical encounter, a home caregiver's genuine, daily presence means this history isn't background information reviewed once — it's actively relevant to how the relationship actually unfolds day after day.

**The evidence: [36] WHO Competency Standard 1 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) requires health workers to adapt practice to migration and displacement experiences, address trauma-informed care and psychosocial needs, and support continuity of care regardless of legal status.**

| WHAT GOOD LOOKS LIKE | WHAT FAILURE LOOKS LIKE |
|---|---|
| ✓ Care is genuinely, visibly adapted to migration and displacement history. | ✗ Care is delivered identically regardless of migration history. |
| ✓ Trauma-informed practice is sustained throughout the ongoing relationship. | ✗ Trauma-informed practice is referenced once at intake and not sustained. |
| ✓ The caregiver demonstrates specific awareness of legal-status access barriers. | ✗ The caregiver shows no specific awareness of legal-status barriers. |

## MOST COMMON REASONS PROVIDERS SCORE PARTIAL

1 **Adaptation happens for clients who disclose their history but isn't proactively considered otherwise.**
*Not every client will volunteer this history unprompted, even when it is clinically relevant.*

2 **The caregiver is aware of the principle but hasn't received specific training on applying it day to day.**
*General awareness doesn't reliably translate into sustained, genuine practice adaptation without specific training.*

3 **Adaptation is strong initially but isn't sustained as the caregiving relationship continues over months.**
*An ongoing relationship depends on this understanding genuinely persisting, not fading with familiarity.*

## HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

**Week 1** Review current practice for genuine adaptation to migration and displacement history.

**Week 2** Train caregivers specifically on trauma-informed, migration-adapted practice.

**Week 3** Build awareness of legal-status access barriers into standard practice.

**Ongoing** Revisit adaptation as the ongoing caregiving relationship continues.

## FOR SURVEYORS — WHAT IS NOT OBVIOUS

**Ask a caregiver to describe a specific example of adapting care for a client's migration history.**
*A real, specific example reveals genuine practice, not familiarity with the principle.*

**Ask how this awareness has been sustained over months of ongoing care, not just at the initial visit.**
*This reveals whether adaptation genuinely persists, not fading with familiarity.*

**E-LEARNING** academy.gmj.ge/hc-std8-1-migration-adapted-care — 30 min · complete before self-assessment

Standard 8.2 **NON-NEGOTIABLE** · *Standard 8: Health & Migration*

**Language Support Accounts for Persistent, Daily Interaction**

**ASSESSMENT** ASF-HC-STD8-v3.0

| CR FULL | TR FULL | SM ADAPTED | ST FULL |
|---|---|---|---|

**8.2**
**NON-NEGOTIABLE**
L1

THE STANDARD

## Language Support Accounts for Persistent, Daily Interaction

Language and communication support genuinely accounts for the persistent, daily nature of home care — not designed only around occasional, episodic interpreter access, given a caregiver and client with limited shared language must communicate meaningfully every single day care occurs.

**PROVIDER SELF-ASSESSMENT** Tick YES, PARTIAL, or NO for each question.

| | | | | |
|---|---|---|---|---|
| **1** | **Does language support genuinely account for the daily, ongoing nature of home care, not episodic interpreter access alone?** *Real, sustained communication planning, not a model built for a single scheduled encounter.* Doc: Ongoing communication support plan | YES | PARTIAL | NO |
| **2** | **Is the caregiver genuinely matched for shared language where feasible, or given practical daily communication tools where not?** *Real, practical accommodation for daily communication, not an assumption occasional interpretation is sufficient.* Doc: N/A — tested directly | YES | PARTIAL | NO |
| **3** | **Is a minor ever used to facilitate interpretation between caregiver and client?** *This should never happen — a specific, absolute rule, not a judgement call.* Doc: N/A — tested directly | YES | PARTIAL | NO |

**ALL YES** Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

**WHAT THE ASSESSOR DOES ON SITE** no surprises, no hidden checks

| | |
|---|---|
| **DOCUMENT** *Communication plan review* | Reviews the specific plan for sustained, daily communication support, not episodic interpretation alone. |
| **ASK** *Caregiver matching interview* | Asks how caregiver-client language matching or daily communication tools are genuinely arranged. |
| **ASK** *Minor-interpreter policy check* | Asks staff directly whether a minor has ever been used to interpret, confirming this is never acceptable. |

REFERENCES

*[37] WHO Competency Standard 3 establishes language access and cultural mediation as a genuine, ongoing responsibility, with home care's persistent, daily interaction structure requiring communication support planning distinct from episodic clinical encounter models.*

Standard 8.2 · *Standard 8: Health & Migration*

## Guidance & Learning

**GUIDANCE** ASF-HC-STD8-v3.0

### WHY THIS STANDARD EXISTS

Episodic clinical encounters can rely on scheduling a professional interpreter for a single visit, but home care's genuine, daily structure means language barriers persist continuously — a service that only plans for occasional interpreter access hasn't actually addressed the real, ongoing communication need this specific care model creates.

**The evidence: [37] WHO Competency Standard 3 establishes language access and cultural mediation as a genuine, ongoing responsibility, with home care's persistent, daily interaction structure requiring communication support planning distinct from episodic clinical encounter models.**

| WHAT GOOD LOOKS LIKE | WHAT FAILURE LOOKS LIKE |
|---|---|
| ✓ Language support genuinely accounts for daily, ongoing interaction, not episodic access alone. | ✗ Language support is planned only around occasional, scheduled interpretation. |
| ✓ Caregiver matching or practical daily tools are genuinely arranged for sustained communication. | ✗ No genuine matching or practical tools exist for daily communication needs. |
| ✓ Staff confirm, without hesitation, that a minor is never used to interpret. | ✗ A minor has been used to interpret, even occasionally. |

### MOST COMMON REASONS PROVIDERS SCORE PARTIAL

1 **Language matching is attempted for new client-caregiver pairings but not reconsidered if a pairing changes.**
*Every new pairing carries the same real communication need, not only the original assignment.*

2 **Practical daily tools exist but aren't proactively introduced, relying on the caregiver or client to request them.**
*A tool neither party knows to request provides limited real value for genuine, ongoing communication.*

3 **Awareness of the no-minors rule is strong among caregivers but not reinforced with family members who might otherwise step in.**
*Family members carry the same real risk of being used to interpret, and deserve the same clear, reinforced understanding as staff.*

### HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

**Week 1** Review current language support for genuine attention to daily, ongoing interaction needs.

**Week 2** Establish caregiver-client language matching practice where feasible.

**Week 3** Build practical daily communication tools for pairings without shared language.

**Ongoing** Reinforce the no-minors rule specifically with families, not caregivers alone.

### FOR SURVEYORS — WHAT IS NOT OBVIOUS

**Ask how a caregiver and client without shared language communicate on an ordinary, daily basis.**
*A specific, real answer reveals genuine, sustained practice, not an assumption occasional interpretation covers it.*

**Ask staff directly whether a child has ever interpreted between a caregiver and a family member.**
*A direct question often surfaces informal practice a policy review wouldn't catch.*

**E-LEARNING** academy.gmj.ge/hc-std8-2-daily-language-support — 30 min · complete before self-assessment

Standard 8.3 **NON-NEGOTIABLE** · *Standard 8: Health & Migration*

## Cultural and Religious Practices in the Client's Home Are Genuinely Respected

**ASSESSMENT** ASF-HC-STD8-v3.0

| CR FULL | TR FULL | SM ADAPTED | ST FULL |
|---|---|---|---|

**8.3**
**NON-NEGOTIABLE**
L1

THE STANDARD

### Cultural and Religious Practices in the Client's Home Are Genuinely Respected

A client's cultural and religious practices are genuinely respected within their own home — dietary requirements, prayer routines, gender-appropriate care preferences — not overridden by the caregiver's own habits or convenience, given this document's own foundational principle that the home remains genuinely the client's to control.

**PROVIDER SELF-ASSESSMENT** Tick YES, PARTIAL, or NO for each question.

| | | | | |
|---|---|---|---|---|
| **1** | **Does the caregiver genuinely respect the client's specific dietary, religious, and cultural practices?**<br>*Real, active respect for the client's actual practices, not the caregiver's own habits.*<br>Doc: N/A — tested directly | YES | PARTIAL | NO |
| **2** | **Are gender-appropriate care preferences genuinely accommodated where expressed?**<br>*Real, active accommodation of the client's own stated preference.*<br>Doc: Care preference documentation | YES | PARTIAL | NO |
| **3** | **Was the caregiver genuinely asked about these preferences, not assumed from background?**<br>*Real, specific inquiry, not assumption based on broad cultural category.*<br>Doc: N/A — tested directly | YES | PARTIAL | NO |

**ALL YES** Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

**WHAT THE ASSESSOR DOES ON SITE** no surprises, no hidden checks

| | |
|---|---|
| **OBSERVE**<br>*Practice respect observation* | Observes an actual visit for genuine respect of the client's specific cultural and religious practices. |
| **DOCUMENT**<br>*Preference documentation review* | Reviews whether gender-appropriate care preferences are genuinely documented and accommodated. |
| **ASK**<br>*Specific inquiry interview* | Asks whether the caregiver specifically asked about the client's own practices, not assumed from background. |

REFERENCES

*[38] Genuine respect for a client's cultural and religious practices within their own home, consistent with established client autonomy principles in home care, carries particular relevance for refugee and migrant clients for whom these practices often represent continuity preserved through displacement.*

Standard 8.3 · *Standard 8: Health & Migration*
**Guidance & Learning**

**GUIDANCE** ASF-HC-STD8-v3.0

## WHY THIS STANDARD EXISTS

This standard's very first criterion established that a client's home remains genuinely theirs, and for a refugee or migrant client, cultural and religious practice is often a genuine, real source of continuity and comfort specifically preserved through displacement — a caregiver who doesn't actively respect these practices undermines exactly the client autonomy this whole document is built around, in a way that carries particular real weight for someone who has already lost so much else.

**The evidence: [38] Genuine respect for a client's cultural and religious practices within their own home, consistent with established client autonomy principles in home care, carries particular relevance for refugee and migrant clients for whom these practices often represent continuity preserved through displacement.**

| WHAT GOOD LOOKS LIKE | WHAT FAILURE LOOKS LIKE |
|---|---|
| ✓ The caregiver genuinely respects the client's specific dietary, religious, and cultural practices. | ✗ The caregiver's own habits or convenience override the client's actual practices. |
| ✓ Gender-appropriate care preferences are genuinely accommodated where expressed. | ✗ Gender-appropriate preferences are disregarded or not genuinely accommodated. |
| ✓ Specific inquiry, not assumption from background, informed these accommodations. | ✗ Accommodations are assumed from general background, not specifically confirmed with the client. |

## MOST COMMON REASONS PROVIDERS SCORE PARTIAL

1 **Dietary practices are respected but prayer routines aren't specifically accommodated in the daily care schedule.**
*Every genuine practice the client values deserves the same specific accommodation, not only the most visible one.*

2 **Gender-appropriate preferences are accommodated for personal care but not consistently for other aspects of daily assistance.**
*This preference reflects the client's genuine comfort across the full scope of care, not personal care alone.*

3 **Inquiry happened at intake but hasn't been revisited as the caregiving relationship has continued.**
*A preference the client held initially can genuinely change, and periodic revisiting reflects this real possibility.*

## HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

**Week 1** Review current practice for genuine, specific respect of client cultural and religious practices.

**Week 2** Establish specific inquiry into dietary, religious, and gender-appropriate care preferences.

**Week 3** Build these preferences into the actual daily care schedule and routine.

**Ongoing** Revisit preferences periodically as the caregiving relationship continues.

## FOR SURVEYORS — WHAT IS NOT OBVIOUS

**Ask a client directly whether their specific cultural or religious practices are genuinely respected during care.**
*A specific, honest answer reveals genuine respect, not an assumption based on general politeness.*

**Ask the caregiver how they learned about the client's specific preferences.**
*A specific, confident answer reveals genuine inquiry, not an assumption based on broad cultural background.*

**E-LEARNING** academy.gmj.ge/hc-std8-3-cultural-religious-respect — 30 min · complete before self-assessment

Standard 8.4 **CORE** · *Standard 8: Health & Migration*

**Caregiver Work Authorization Is Verified Through Legal, Non-Discriminatory Practice**

**ASSESSMENT** ASF-HC-STD8-v3.0

| CR N/A | TR FULL | SM FULL | ST FULL |
|---|---|---|---|

**8.4**
**CORE**
L1

THE STANDARD

## Caregiver Work Authorization Is Verified Through Legal, Non-Discriminatory Practice

Caregiver work authorization is genuinely verified through the same legal, standard employment practice applied to every prospective employee — not subjected to excess scrutiny beyond what the law actually requires, and not applied inconsistently based on a caregiver's perceived national origin or accent.

**PROVIDER SELF-ASSESSMENT** Tick YES, PARTIAL, or NO for each question.

| | | | | |
|---|---|---|---|---|
| **1** | **Is work authorization verified through the same standard, legal process for every candidate?**<br>*Real, consistent verification, not excess scrutiny applied selectively.*<br>Doc: Work authorization verification process | YES | PARTIAL | NO |
| **2** | **Is verification applied consistently, not varying by perceived national origin or accent?**<br>*Real, consistent application, not discriminatory differentiation.*<br>Doc: N/A — tested directly | YES | PARTIAL | NO |
| **3** | **Are staff trained on the requirement's actual legal scope, not exceeding what's required?**<br>*Real, specific training on the genuine standard, not over-scrutiny.*<br>Doc: Staff training on verification scope | YES | PARTIAL | NO |

**ALL YES** Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

**WHAT THE ASSESSOR DOES ON SITE** no surprises, no hidden checks

| | |
|---|---|
| **DOCUMENT**<br>*Verification process review* | Reviews the standard, legal work authorization verification process applied to candidates. |
| **OBSERVE**<br>*Consistency observation* | Observes or reviews records for consistent application regardless of perceived national origin. |
| **DOCUMENT**<br>*Staff training review* | Reviews training records confirming staff understand the verification requirement's actual, legal scope. |

REFERENCES

*[39] Work authorization or right-to-work verification is a standard legal employment requirement in most countries, applying equally to every prospective employee, with migrant caregivers representing a genuine, substantial share of the home care workforce in many countries and often remaining in direct care positions longer than caregivers born in the country where they work, providing important workforce stability.*

Standard 8.4 · *Standard 8: Health & Migration*

## Guidance & Learning

**GUIDANCE** ASF-HC-STD8-v3.0

## WHY THIS STANDARD EXISTS

Work authorization verification is a genuine, real legal requirement for every employer, and the real risk this criterion addresses runs in both directions — a service that skips genuine verification creates real legal exposure, while a service that subjects some candidates to excess scrutiny beyond what the law requires, based on assumptions about who looks or sounds like they might lack authorization, engages in exactly the kind of discriminatory practice fair employment principles prohibit.

**The evidence: [39] Work authorization or right-to-work verification is a standard legal employment requirement in most countries, applying equally to every prospective employee, with migrant caregivers representing a genuine, substantial share of the home care workforce in many countries and often remaining in direct care positions longer than caregivers born in the country where they work, providing important workforce stability.**

| WHAT GOOD LOOKS LIKE | WHAT FAILURE LOOKS LIKE |
|---|---|
| ✓ Work authorization is verified through the same standard, legal process for every candidate. | ✗ Verification is skipped or informal, creating real legal exposure. |
| ✓ Verification is genuinely consistent, not varying by perceived national origin or accent. | ✗ Some candidates face excess scrutiny based on perceived national origin or accent. |
| ✓ Staff are specifically trained on the legal requirement's actual scope. | ✗ Staff apply verification inconsistently, without specific training on its actual legal scope. |

## MOST COMMON REASONS PROVIDERS SCORE PARTIAL

1 **Verification is consistent for direct hires but less standardized for contracted or agency-placed caregivers.**
*Every caregiver entering a client's home carries the same real legal and practical requirement.*

2 **The process is generally consistent but hasn't been specifically reviewed to confirm no unconscious pattern of differential scrutiny exists.**
*A genuine review for unintended patterns is what confirms the process is actually fair in practice, not just in written policy.*

3 **Training covers basic requirements but not the specific legal boundary against exceeding what's actually required.**
*A specific, clear legal boundary is what prevents well-intentioned diligence from tipping into genuine, unlawful over-scrutiny.*

## HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

**Week 1** Review current verification practice for genuine, consistent, legally appropriate scope.

**Week 2** Establish standardized verification applying equally to direct hires and contracted caregivers.

**Week 3** Train staff specifically on the legal requirement's actual scope, avoiding excess scrutiny.

**Ongoing** Review verification records periodically for any unintended pattern of differential treatment.

## FOR SURVEYORS — WHAT IS NOT OBVIOUS

**Ask staff to describe the specific verification process, not a general assurance of legal compliance.**
*A specific, real process description reveals genuine, standardized practice, not an assumption of adequacy.*

**Ask how the service would ensure verification doesn't vary based on a candidate's accent or apparent background.**
*A specific, thoughtful answer reveals genuine attention to consistency, not an assumption bias couldn't occur.*

**E-LEARNING** academy.gmj.ge/hc-std8-4-work-authorization-verification — 30 min · complete before self-assessment

Standard 8.5 **CORE** · *Standard 8: Health & Migration*

**A Caregiver's Legal Status Change Is Handled With Genuine Support**

**ASSESSMENT** ASF-HC-STD8-v3.0

| CR N/A | TR FULL | SM ADAPTED | ST FULL |
|---|---|---|---|

**8.5**
**CORE**
L1

THE STANDARD

## A Caregiver's Legal Status Change Is Handled With Genuine Support

When a caregiver's own legal work authorization status genuinely changes — a permit expiring, a visa category ending, a policy shift removing a pathway that existed when they were hired — the service provides genuine support and transition time, not abrupt termination without any real transition process.

| PROVIDER SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question. | | | | |
|---|---|---|---|---|
| **1** | **Does the service provide genuine support when a caregiver's legal status changes?**<br>*Real, active support, not abrupt termination without transition.*<br>Doc: Status change support process | YES | PARTIAL | NO |
| **2** | **Is the affected client genuinely supported through this transition?**<br>*Real, proactive support and coverage planning, not an unexplained loss.*<br>Doc: Client transition support documentation | YES | PARTIAL | NO |
| **3** | **Is the service genuinely, currently informed about relevant legal status changes?**<br>*Real, current awareness, not reactive discovery after a lapse.*<br>Doc: N/A — tested directly | YES | PARTIAL | NO |

**ALL YES** Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

| WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks | |
|---|---|
| **DOCUMENT**<br>*Support process review* | Reviews the specific process for supporting a caregiver through a genuine legal status change. |
| **DOCUMENT**<br>*Client transition review* | Reviews whether affected clients receive genuine support and coverage planning during this transition. |
| **ASK**<br>*Current awareness interview* | Asks leadership how they stay genuinely, currently informed about relevant legal status changes. |

REFERENCES

*[40] Changes to immigration or work-permit policy can disrupt legal work authorization for caregivers who built their employment relationships around a pathway that existed at the time of hire, establishing genuine transition support as necessary practice distinct from abrupt termination, a pattern documented across multiple countries that rely on migrant care workers.*

Standard 8.5 · *Standard 8: Health & Migration*

**Guidance & Learning**

**GUIDANCE** ASF-HC-STD8-v3.0

## WHY THIS STANDARD EXISTS

Immigration and work-permit policies can and do change, sometimes removing a legal pathway a caregiver reasonably relied on when accepting employment, and a service's response to this genuinely affects both a caregiver who has done nothing wrong and a client whose care depends on that specific caregiver's continued presence — genuine support and transition planning, not abrupt termination, is what treats this real situation with the seriousness it deserves for everyone involved.

**The evidence: [40] Changes to immigration or work-permit policy can disrupt legal work authorization for caregivers who built their employment relationships around a pathway that existed at the time of hire, establishing genuine transition support as necessary practice distinct from abrupt termination, a pattern documented across multiple countries that rely on migrant care workers.**

| WHAT GOOD LOOKS LIKE | WHAT FAILURE LOOKS LIKE |
|---|---|
| ✓ Genuine support and transition time are provided when a caregiver's status changes. | ✗ A status change results in abrupt termination without any genuine transition process. |
| ✓ Affected clients receive genuine support and coverage planning through the transition. | ✗ Affected clients are left without notice or a coverage plan. |
| ✓ The service maintains genuine, current awareness of the relevant regulatory landscape. | ✗ The service is caught unaware, reactive only after a status has already lapsed. |

## MOST COMMON REASONS PROVIDERS SCORE PARTIAL

1 **Support exists for a caregiver whose status change is identified in advance but not for one discovered after the fact.**
*Every genuine status change deserves the same support, regardless of how much advance notice existed.*

2 **Client coverage planning happens but isn't communicated to the client with genuine transparency about what's actually happening.**
*Genuine transparency helps a client understand and adjust to a transition, not simply experience an unexplained change.*

3 **Awareness of the regulatory landscape exists at a leadership level but isn't specifically monitored on an ongoing basis.**
*Ongoing, specific monitoring is what actually catches a relevant change before it affects a real caregiver, not awareness alone.*

## HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

**Week 1** Review current practice for genuine support versus abrupt response to a caregiver status change.

**Week 2** Establish a defined support and transition process for affected caregivers and clients.

**Week 3** Build ongoing monitoring of the relevant regulatory landscape.

**Ongoing** Communicate transitions to affected clients with genuine transparency.

## FOR SURVEYORS — WHAT IS NOT OBVIOUS

**Ask for a real, recent example of a caregiver status change and how it was actually handled.**
*A real, traceable example reveals genuine support, not an assumption of adequate response.*

**Ask how leadership currently stays informed about relevant legal status developments affecting the workforce.**
*A specific, confident answer reveals genuine, ongoing awareness, not reactive discovery.*

**E-LEARNING** academy.gmj.ge/hc-std8-5-status-change-support — 30 min · complete before self-assessment

Standard 8.6 **CORE** · *Standard 8: Health & Migration*

**Immigrant Caregivers' Genuine Retention Advantage Is Recognized and Supported**

**ASSESSMENT** ASF-HC-STD8-v3.0

| CR N/A | TR FULL | SM ADAPTED | ST FULL |
|---|---|---|---|

**8.6**
**CORE**
L1

THE STANDARD

## Immigrant Caregivers' Genuine Retention Advantage Is Recognized and Supported

The service genuinely recognizes and supports the real, documented retention advantage immigrant caregivers bring to continuity of care — not undermining this advantage through precarious employment practices that create instability regardless of a caregiver's own genuine commitment to staying.

| PROVIDER SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question. | | | | |
|---|---|---|---|---|
| **1** | **Does the service genuinely recognize immigrant caregivers' documented retention advantage, not overlook this real strength?** *Real, specific recognition of this documented pattern, not treated as incidental or unnoticed.* Doc: N/A — tested directly | YES | PARTIAL | NO |
| **2** | **Are employment practices genuinely supportive, not precarious in ways that undermine this real advantage?** *Real, stable employment practice, not conditions that create instability regardless of a caregiver's own commitment.* Doc: Employment practice review | YES | PARTIAL | NO |
| **3** | **Is this recognition reflected in genuine, practical support — benefits, advancement opportunities — not merely acknowledged in principle?** *Real, practical support, not recognition that remains only theoretical.* Doc: Practical support documentation | YES | PARTIAL | NO |

**ALL YES** Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

| WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks | |
|---|---|
| **ASK** *Recognition interview* | Asks leadership whether and how they specifically recognize this documented retention pattern. |
| **DOCUMENT** *Employment practice review* | Reviews employment practices for genuine stability, not precarious conditions undermining retention. |
| **DOCUMENT** *Practical support review* | Reviews whether recognition translates into genuine, practical support, not remaining theoretical. |

REFERENCES

*[41] Migrant direct care workers are documented in multiple countries as remaining in direct care positions longer than caregivers born in the country where they work, providing important workforce stability and continuity of care, establishing genuine recognition and support of this documented advantage as directly relevant to addressing the home care sector's broader turnover challenges.*

Standard 8.6 · *Standard 8: Health & Migration*

**Guidance & Learning**

**GUIDANCE** ASF-HC-STD8-v3.0

## WHY THIS STANDARD EXISTS

Given Standard 7's whole focus on this industry's genuine turnover crisis, the real, documented finding that migrant caregivers often remain in direct care positions longer than caregivers born in the country where they work is directly relevant, valuable information — a service that fails to recognize and actively support this genuine strength, instead treating migrant caregivers with the same precarious, unstable employment practices driving turnover generally, squanders a real, evidence-based opportunity to improve the exact continuity this whole document cares about.

**The evidence: [41] Migrant direct care workers are documented in multiple countries as remaining in direct care positions longer than caregivers born in the country where they work, providing important workforce stability and continuity of care, establishing genuine recognition and support of this documented advantage as directly relevant to addressing the home care sector's broader turnover challenges.**

| WHAT GOOD LOOKS LIKE | WHAT FAILURE LOOKS LIKE |
|---|---|
| ✓ The service genuinely recognizes immigrant caregivers' documented retention advantage. | ✗ This documented advantage goes unrecognized or unused. |
| ✓ Employment practices are genuinely stable and supportive, not precarious. | ✗ Precarious employment practices undermine genuine retention regardless of caregiver commitment. |
| ✓ Recognition translates into real, practical support, not remaining theoretical. | ✗ Any recognition remains theoretical, without practical, resulting support. |

## MOST COMMON REASONS PROVIDERS SCORE PARTIAL

1 **Recognition exists informally but isn't reflected in specific, structural employment policy.**
*Genuine, structural support provides more reliable benefit than informal acknowledgment alone.*

2 **Support exists for full-time immigrant caregivers but not consistently for those in part-time or contracted arrangements.**
*Every immigrant caregiver contributing to genuine retention deserves the same recognition and support.*

3 **Practical support exists but hasn't been specifically evaluated to confirm it's genuinely improving retention outcomes.**
*Genuine evaluation is what confirms this support is actually working, not simply assumed effective because it exists.*

## HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

**Week 1** Review current employment practices for genuine stability versus precariousness.

**Week 2** Establish specific, structural recognition of immigrant caregivers' documented contribution.

**Week 3** Build practical support extending to part-time and contracted caregivers, not full-time staff alone.

**Ongoing** Evaluate whether practical support is genuinely improving retention outcomes.

## FOR SURVEYORS — WHAT IS NOT OBVIOUS

**Ask leadership how they specifically recognize and support immigrant caregivers' documented retention contribution.**
*A specific, thoughtful answer reveals genuine, active recognition, not incidental awareness.*

**Ask a caregiver whether they feel genuinely supported in stable, ongoing employment.**
*A specific, honest answer reveals whether recognition translates into real, felt support.*

**E-LEARNING** academy.gmj.ge/hc-std8-6-immigrant-retention-recognition — 30 min · complete before self-assessment

Standard 8.7 **CORE** · *Standard 8: Health & Migration*

**Legal Status Diversity Recognition for Clients**

**ASSESSMENT** ASF-HC-STD8-v3.0

| CR N/A | TR FULL | SM ADAPTED | ST FULL |
|---|---|---|---|

**8.7**
**CORE**
L1

THE STANDARD

## Legal Status Diversity Recognition for Clients

The service can name which legal status categories its clients actually represent — asylum seeker, recognised refugee, stateless person, and others — and demonstrates it doesn't apply a single, uniform assumption about access rights across all of them.

| PROVIDER SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question. | | | | |
|---|---|---|---|---|
| **1** | **Can staff name the specific legal status categories this service's clients actually represent?** *Specific, named categories, not a general sense that "migrants" are served.* Doc: N/A — tested directly | YES | PARTIAL | NO |
| **2** | **Does the service avoid applying a single, uniform assumption about access rights across all statuses?** *Genuine differentiation, not treating all categories identically.* Doc: Status-specific access policy documentation | YES | PARTIAL | NO |
| **3** | **Is there a specific process for verifying which category applies when it's genuinely unclear?** *A real, defined process, not guesswork or assumption when status is ambiguous.* Doc: Status verification process | YES | PARTIAL | NO |

**ALL YES** Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

| WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks | |
|---|---|
| **ASK** *Status category awareness interview* | Asks staff to name the specific legal status categories this service's clients actually represent. |
| **DOCUMENT** *Status-specific policy review* | Reviews documentation for genuine differentiation across status categories, not a uniform assumption. |
| **DOCUMENT** *Verification process review* | Reviews the process for verifying status when it's genuinely unclear. |

REFERENCES

*[42] WHO's Competency Standards explicitly distinguish these legal status categories throughout, noting that access to health care and legal entitlements vary meaningfully by status and by country, and that health workers need specific awareness of this rather than a single generalised assumption.*

Standard 8.7 · *Standard 8: Health & Migration*

# Guidance & Learning

**GUIDANCE** ASF-HC-STD8-v3.0

## WHY THIS STANDARD EXISTS

Asylum seeker, recognised refugee, and stateless person are not interchangeable categories — they carry genuinely different legal access rights in different countries, and treating them as one undifferentiated group risks either wrongly denying care someone is entitled to, or missing a specific vulnerability tied to a particular status.

**The evidence: [42] WHO's Competency Standards explicitly distinguish these legal status categories throughout, noting that access to health care and legal entitlements vary meaningfully by status and by country, and that health workers need specific awareness of this rather than a single generalised assumption.**

| WHAT GOOD LOOKS LIKE | WHAT FAILURE LOOKS LIKE |
|---|---|
| ✓ Staff can name the specific legal status categories clients actually represent. | ✗ Staff have only a general sense that "migrants" are served, without specific categories. |
| ✓ Policy genuinely differentiates access considerations across status categories. | ✗ A single, uniform assumption about access rights is applied regardless of status. |
| ✓ A specific, defined process exists for verifying unclear status. | ✗ No process exists for verifying status when it's genuinely unclear. |

## MOST COMMON REASONS PROVIDERS SCORE PARTIAL

1 **Staff can name the most common category served but not less frequent ones the service still encounters.**
*Even infrequent categories deserve genuine, specific awareness, not the risk of misapplied assumptions.*

2 **Differentiation exists in one staff member's own understanding but isn't shared with the wider caregiving team.**
*Every caregiver interacting with clients benefits from the same genuine understanding.*

3 **A verification process exists but staff are inconsistently confident applying it.**
*Consistent, confident application across the whole team is what makes this process genuinely reliable.*

## HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

**Week 1** Review current staff awareness of the specific legal status categories clients actually represent.

**Week 2** Build specific, differentiated access guidance for each relevant status category.

**Week 3** Establish a clear verification process for genuinely unclear status.

**Ongoing** Refresh staff awareness periodically, particularly for less frequently encountered categories.

## FOR SURVEYORS — WHAT IS NOT OBVIOUS

**Ask staff to name every specific legal status category the service has served recently.**
*Specificity reveals genuine, current awareness rather than a general assumption.*

**Ask what happens when a client's specific status is genuinely unclear.**
*A confident, specific answer reveals a genuine process, not improvisation.*

**E-LEARNING** academy.gmj.ge/hc-std8-7-client-legal-status-recognition — 30 min · complete before self-assessment

| | Standard 8.8 NON-NEGOTIABLE · *Standard 8: Health & Migration*<br>**Care Is Documented and Provided to Clients Regardless of Immigration or Legal Status** | ASSESSMENT ASF-HC-STD8-v3.0 |
|---|---|---|
| CR FULL | TR FULL | SM FULL | ST FULL |

**8.8**
NON-NEGOTIABLE
L1

THE STANDARD

## Care Is Documented and Provided to Clients Regardless of Immigration or Legal Status

Care is provided and fully documented for every client regardless of immigration or legal status, with no differential standard of care, documentation practice, or record-keeping applied based on status — not a lesser or informal standard applied to a client without documented status.

| PROVIDER SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question. | | | | |
|---|---|---|---|---|
| **1** | **Is the same standard of care applied and documented the same way regardless of a client's immigration or legal status?**<br>*Genuinely equal treatment, not a lesser or informal standard for undocumented clients.*<br>Doc: N/A — tested directly | YES | PARTIAL | NO |
| **2** | **Are staff specifically trained that immigration status is never a reason to withhold or alter care or documentation?**<br>*Specific, documented training, not assumed understanding.*<br>Doc: Staff training record | YES | PARTIAL | NO |
| **3** | **Is client information protected with the same confidentiality standard regardless of status, with no informal sharing of status-related information?**<br>*The same confidentiality protection extended to every client, without exception.*<br>Doc: N/A — tested directly | YES | PARTIAL | NO |

**ALL YES** Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

| WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks | |
|---|---|
| **OBSERVE**<br>*Care standard observation* | Observes whether care and documentation practice is genuinely consistent regardless of client status. |
| **DOCUMENT**<br>*Staff training review* | Reviews training records confirming staff understand immigration status is never a basis for differential care. |
| **ASK**<br>*Confidentiality practice interview* | Asks staff how client status information, where known, is protected. |

REFERENCES

*[43] Equal standard of care and documentation regardless of immigration or legal status, without differential record-keeping practice, is established practice in international guidance on healthcare access for migrant and refugee populations.*

Standard 8.8 · *Standard 8: Health & Migration*

## Guidance & Learning

**GUIDANCE** ASF-HC-STD8-v3.0

## WHY THIS STANDARD EXISTS

A client who fears that receiving home care will expose their immigration status to consequences may delay or avoid care entirely, and any indication that this service applies a different standard based on status only reinforces that fear — genuine equal treatment, documented the same way for everyone, is what makes home care genuinely accessible to this population.

**The evidence: [43] Equal standard of care and documentation regardless of immigration or legal status, without differential record-keeping practice, is established practice in international guidance on healthcare access for migrant and refugee populations.**

| WHAT GOOD LOOKS LIKE | WHAT FAILURE LOOKS LIKE |
|---|---|
| ✓ Care and documentation are genuinely consistent regardless of status. | ✗ Care or documentation practice differs based on a client's known or assumed status. |
| ✓ Staff are specifically trained on this principle, not assumed to understand it. | ✗ No specific training addresses this principle. |
| ✓ Confidentiality protection is applied equally without exception. | ✗ Status-related information is handled less carefully than other confidential information. |

## MOST COMMON REASONS PROVIDERS SCORE PARTIAL

1 **The principle is understood by caregivers but not consistently by administrative or scheduling staff.**
*A client's first interaction is often with administrative staff, where the same principle needs to hold.*

2 **Care is consistent but documentation habits vary informally based on individual staff assumptions.**
*Consistency needs to extend to documentation practice specifically, not only the clinical care itself.*

3 **The principle is followed but has never been specifically, formally trained.**
*Informal adherence is less reliable than specific, formal training, particularly as staff change over time.*

## HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

**Week 1** Review current practice for any differential treatment based on status.

**Week 2** Establish specific staff training on this principle, covering all staff, not only caregiving roles.

**Week 3** Confirm documentation practice is genuinely consistent regardless of status.

**Ongoing** Reinforce training periodically, particularly for new staff.

## FOR SURVEYORS — WHAT IS NOT OBVIOUS

**Ask administrative staff, not only caregivers, about this principle.**
*This reveals whether the principle genuinely extends beyond caregiving staff.*

**Ask how client status information, where it becomes known, is protected.**
*A specific, confident answer reveals genuine practice, not just a stated value.*

**E-LEARNING** academy.gmj.ge/hc-std8-8-status-neutral-client-care — 30 min · complete before self-assessment

Standard 8.9 **CORE** · *Standard 8: Health & Migration*

**Staff Reflective Practice and Bias Awareness Extends to How Immigrant Caregivers Are Treated**

**ASSESSMENT** ASF-HC-STD8-v3.0

| CR N/A | TR FULL | SM ADAPTED | ST FULL |
|---|---|---|---|

**8.9**
**CORE**
L1

THE STANDARD

## Staff Reflective Practice and Bias Awareness Extends to How Immigrant Caregivers Are Treated

Staff reflective practice and bias awareness genuinely extends to how immigrant caregivers themselves are treated by the organization, clients, and families — not limited to awareness of bias toward migrant clients alone, given a caregiver can face genuine discrimination in the course of their own employment.

| PROVIDER SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question. | | | | |
|---|---|---|---|---|
| **1** | **Does bias awareness training address discrimination immigrant caregivers might experience?**<br>*Real, specific coverage, not training focused only on bias toward clients.*<br>Doc: Bias awareness training content review | YES | PARTIAL | NO |
| **2** | **Is there a known process for a caregiver to report discrimination they experience?**<br>*A real, accessible process, not an assumption a caregiver would simply tolerate this.*<br>Doc: Caregiver discrimination reporting process | YES | PARTIAL | NO |
| **3** | **Does the organization genuinely support a caregiver who reports this concern?**<br>*Real, active support, not a caregiver expected to resolve it alone.*<br>Doc: N/A — tested directly | YES | PARTIAL | NO |

**ALL YES** Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

| WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks | |
|---|---|
| **DOCUMENT**<br>*Training content review* | Reviews bias awareness training for genuine coverage of discrimination toward immigrant caregivers. |
| **DOCUMENT**<br>*Reporting process review* | Reviews the specific, known process for a caregiver to report discrimination experienced. |
| **ASK**<br>*Caregiver support interview* | Asks a caregiver whether they would feel genuinely supported reporting this kind of concern. |

REFERENCES

*[44] WHO Competency Standards 8 and 9 require structured awareness of bias and its impact, with genuine application of this principle extending to recognizing and addressing bias directed at immigrant workers within the care relationship itself, not limited to bias affecting migrant clients alone.*

Standard 8.9 · *Standard 8: Health & Migration*

## Guidance & Learning

**GUIDANCE** ASF-HC-STD8-v3.0

### WHY THIS STANDARD EXISTS

A genuine commitment to addressing bias in migration contexts is incomplete if it only looks outward toward how clients are treated — an immigrant caregiver can experience real discrimination from a client, a family member, or within the organization itself, and this document's own commitment to dignity and respect applies to the caregiver's real experience of the workplace, not only the client's experience of care.

**The evidence: [44] WHO Competency Standards 8 and 9 require structured awareness of bias and its impact, with genuine application of this principle extending to recognizing and addressing bias directed at immigrant workers within the care relationship itself, not limited to bias affecting migrant clients alone.**

| WHAT GOOD LOOKS LIKE | WHAT FAILURE LOOKS LIKE |
|---|---|
| ✓ Bias awareness training genuinely covers discrimination toward immigrant caregivers themselves. | ✗ Bias awareness training addresses only bias toward clients, not caregivers. |
| ✓ A real, known reporting process exists for a caregiver experiencing this. | ✗ No known process exists for a caregiver to report discrimination they experience. |
| ✓ The organization genuinely, actively supports a caregiver who reports this concern. | ✗ A caregiver reporting this concern is left to manage the situation without organizational support. |

### MOST COMMON REASONS PROVIDERS SCORE PARTIAL

1 **Training mentions this direction of bias but doesn't provide specific, practical guidance for caregivers or supervisors.**
*Concrete, practical guidance is what makes this awareness genuinely actionable, not acknowledgment alone.*

2 **A reporting process exists but caregivers report uncertainty about whether using it would be genuinely welcomed.**
*Genuine psychological safety in using this process matters as much as the process technically existing.*

3 **Support exists for severe incidents but not for the more common, subtler forms of bias caregivers may experience.**
*Subtler, more common forms of bias deserve the same genuine attention, since they're what caregivers are actually most likely to encounter.*

### HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

**Week 1** Review current bias awareness training for genuine coverage of discrimination toward caregivers.

**Week 2** Establish specific, practical guidance and a known reporting process for caregivers.

**Week 3** Train supervisors on genuinely supporting a caregiver who reports this concern.

**Ongoing** Extend genuine attention to subtler, more common forms of bias, not only severe incidents.

### FOR SURVEYORS — WHAT IS NOT OBVIOUS

**Ask a caregiver whether they would feel genuinely comfortable reporting discrimination from a client or family member.**
*A specific, honest answer reveals genuine psychological safety, not an assumption a process alone is sufficient.*

**Ask a supervisor how they would specifically support a caregiver who raised this kind of concern.**
*A specific, thoughtful answer reveals genuine, practical readiness, not a stated policy alone.*

**E-LEARNING** academy.gmj.ge/hc-std8-9-bias-toward-caregivers — 30 min · complete before self-assessment

Standard 8.10 **CORE** · *Standard 8: Health & Migration*

**Continuity Across a Client's Relocation Is Actively Supported**

**ASSESSMENT** ASF-HC-STD8-v3.0

| CR N/A | TR FULL | SM ADAPTED | ST FULL |
|---|---|---|---|

**8.10**
**CORE**
L1

THE STANDARD

## Continuity Across a Client's Relocation Is Actively Supported

When a migrant or refugee client relocates, the service actively supports continuity of care — a portable, patient-held summary of care needs, active handover where a new provider is known — not treating relocation as an automatic, unavoidable end to the caregiving relationship's accumulated understanding of the client.

**PROVIDER SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.**

| | | | | |
|---|---|---|---|---|
| **1** | **Does the service actively support continuity when a client relocates, not treat relocation as an automatic end to continuity?**<br>*Real, active support, not passive acceptance that continuity simply ends.*<br>Doc: Relocation continuity support process | YES | PARTIAL | NO |
| **2** | **Is a portable, client-held summary of care needs genuinely provided, capturing the accumulated understanding built over time?**<br>*A real, usable summary reflecting genuine accumulated understanding, not a generic intake form.*<br>Doc: Portable care summary documentation | YES | PARTIAL | NO |
| **3** | **Where a new provider is known, is active handover genuinely attempted, not assumed impossible?**<br>*A real, attempted handover, not an assumption that contact with a future provider isn't achievable.*<br>Doc: N/A — tested directly | YES | PARTIAL | NO |

**ALL YES** Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

**WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks**

| | |
|---|---|
| **DOCUMENT**<br>*Relocation support process review* | Reviews the service's actual process for supporting continuity when a client relocates. |
| **DOCUMENT**<br>*Portable summary review* | Reviews whether clients genuinely receive a portable summary reflecting real, accumulated understanding. |
| **ASK**<br>*Handover attempt interview* | Asks staff whether they've genuinely attempted handover to a new provider when one becomes known. |

REFERENCES

*[45] Continuity of care as genuine infrastructure, distinct from an assumption that relocation automatically ends the possibility of continuity, is established practice for protecting health outcomes in mobile and displaced populations specifically.*

Standard 8.10 · *Standard 8: Health & Migration*

## Guidance & Learning

**GUIDANCE** ASF-HC-STD8-v3.0

## WHY THIS STANDARD EXISTS

A home caregiver builds a genuine, real depth of understanding of a client's specific needs, preferences, and routines over time, and a client who relocates — whether by choice or displacement-related necessity — shouldn't lose all of this accumulated understanding simply because their location changed; active, genuine support for this transition preserves real value the caregiving relationship has actually built.

**The evidence: [45] Continuity of care as genuine infrastructure, distinct from an assumption that relocation automatically ends the possibility of continuity, is established practice for protecting health outcomes in mobile and displaced populations specifically.**

| WHAT GOOD LOOKS LIKE | WHAT FAILURE LOOKS LIKE |
|---|---|
| ✓ The service actively supports continuity when a client relocates. | ✗ Relocation is treated as an automatic, unavoidable end to continuity. |
| ✓ A genuine, portable summary reflects real, accumulated understanding of the client. | ✗ Any summary provided is generic, not reflecting genuine accumulated understanding. |
| ✓ Active handover is genuinely attempted when a new provider becomes known. | ✗ No handover is attempted, even when a new provider is known. |

## MOST COMMON REASONS PROVIDERS SCORE PARTIAL

1 **A summary is provided but isn't updated close to the point of relocation, quickly becoming outdated.**
*A summary's real value depends on reflecting the client's genuinely current status at the time they carry it forward.*

2 **Handover is attempted when the new provider is known well in advance but not for sudden, unplanned relocations.**
*Sudden relocation doesn't reduce a client's genuine need for continuity support.*

3 **Support exists in principle but staff aren't confident in how to actually provide a portable summary in practice.**
*Genuine confidence in the actual process is what ensures this support happens reliably, not only when a situation is straightforward.*

## HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

**Week 1** Review current practice for genuine continuity support versus assumed end at relocation.

**Week 2** Establish a standard, portable care summary format reflecting genuine accumulated understanding.

**Week 3** Train staff on attempting genuine handover when a new provider becomes known.

**Ongoing** Confirm summaries are updated close to the actual point of relocation.

## FOR SURVEYORS — WHAT IS NOT OBVIOUS

**Ask for a real, recent example of continuity support provided to a relocating client.**
*A real example reveals whether this is genuine practice, not an assumed impossibility.*

**Ask to see an actual client-held summary and check how current and specific it genuinely is.**
*A specific, current document is the real evidence of genuine support, not a stale or generic one.*

**E-LEARNING** academy.gmj.ge/hc-std8-10-relocation-continuity — 30 min · complete before self-assessment

# References

*Numbered references below are formal citations, in Vancouver style, each individually verified against the original source before inclusion. The [N] marker on each criterion's Reference line and "The evidence" line corresponds to its number here.*


1. Home care clients' bill of rights establishes the right to be treated with courtesy, dignity, and respect, and to control one's own household and lifestyle, with personal property treated with respect, as a foundational right distinct from facility-based care settings.

2. Home care providers are required by statute to provide each client with a written copy of their rights in advance of or during the initial evaluation visit and before care begins, with the statement read to the client in a language they understand if they cannot read it themselves.

3. Home care clients' bill of rights specifically establishes the right to request caregiver replacement when necessary, reflecting the genuinely singular nature of the home care caregiver relationship compared with facility-based care.

4. Home care clients' bill of rights specifically establishes the right to contact the agency directly, separate from the caregiver, at any time care might occur, reflecting the necessary safeguard this represents given the isolated nature of one-on-one home caregiving.

5. Home care clients' bill of rights establishes freedom from physical, verbal, emotional, and sexual abuse and from neglect as a foundational right, requiring active protective measures given the isolated, largely unsupervised nature of one-on-one home caregiving.

6. Established vetting practice across multiple countries' care-sector screening systems requires criminal record checks verified against a fingerprint or other unique official identifier, distinct from and more reliable than a name-based search alone, particularly in regions where common names or limited civil registration make name-matching unreliable.

7. Comprehensive caregiver background screening requires searching abuse and neglect registries, where they exist, in the caregiver's current location as well as other jurisdictions where they have previously worked, given that a substantiated finding in a prior location remains genuinely relevant regardless of subsequent relocation.

8. Comprehensive caregiver background screening in jurisdictions that maintain a dedicated care-worker exclusion or barred-persons registry requires this to be specifically checked, distinct from and not covered by a general criminal history search alone, given such registries can capture substantiated misconduct that a criminal record search would not.

9. Established care-sector screening practice increasingly recommends periodic rescreening for caregivers, distinct from a one-time check completed only at initial hire, reflecting that a caregiver's record can genuinely change during active employment.

10. Established good practice in employment vetting recognizes individualized assessment of criminal history findings as more accurate and fairer than blanket disqualification policies, distinct from automatic rejection applied without regard to the finding's actual nature, age, or relevance.

11. A meta-analysis of home safety intervention found it could reduce falls by 39 percent among at-risk seniors, with structured home fall-hazard checklists established as an effective, evidence-based fall prevention strategy distinct from a general, unstructured impression of the home.

12. Home fall-hazard checklists are established as effective specifically when paired with genuine remediation of identified hazards, with the underlying evidence for fall reduction depending on hazards actually being addressed, not merely documented.

13. Research found nearly 57 percent of seniors experienced a second fall within one year of an initial fall, establishing a documented fall as a strong, genuine predictor requiring structured reassessment, distinct from treatment as an isolated, resolved event.

14. Therapist home visits to identify and remediate hazards are considered the gold-standard method for fall prevention but are rarely feasible for most patients, establishing the genuine, structural value of a home caregiver's regular, ongoing presence for periodic reassessment that a typical clinical model cannot otherwise provide.

15. Verified emergency access arrangements for a client unable to reach the door, distinct from an assumption that responders will resolve access in the moment, are established as necessary home safety planning, reflecting a risk specific to care delivered in a private residence.

16. The distinction between medication reminders, appropriately provided by non-clinical caregivers, and medication administration, requiring clinical training and supervision, is established as a foundational scope-of-practice boundary in home care, with role confusion identified as a genuine contributing factor in caregiver-related medication errors.

17. A documented case found an automated dose dispensing package missing a medication while home care separately omitted to administer it, illustrating a genuine coordination failure between multiple parties each managing medication without a single, shared, current source.

18. Treatment complexity is identified as the leading contributing factor in caregiver-related medication errors, with structured review of the complete medication regimen specifically recommended after treatment changes or transitions of care, distinct from routine, unstructured continuation of the existing arrangement.

**19.** Research on medication safety in family caregiving of older adults specifically identifies taking another person's medication as a documented error type, alongside restricted, secure storage as an established, more powerful safeguard against medication errors generally.

**20.** Forgetting to take medicine is identified among the most common medication errors in family caregiving of older adults, establishing active follow-up on a missed or uncertain dose as necessary practice, distinct from noting the occurrence without genuine resulting action.

**21.** Documented occupational hazard research for home-based care work identifies hostile animals, violence, and unpredictable household conditions among the genuine risks caregivers face, establishing genuine advance risk assessment of the home and household as necessary practice, distinct from the caregiver discovering hazards upon arrival.

**22.** Enforcement and inspection findings from multiple jurisdictions have specifically penalized home care providers for failing to protect staff from workplace violence, establishing genuine, adapted violence prevention programming as a real compliance and safety necessity in home care specifically, distinct from a generic facility-based program applied without adaptation.

**23.** Adaptations proposed for home healthcare violence prevention specifically include logging systems and discreet safety mechanisms distinct from openly announced distress, reflecting the genuine, practical need for a caregiver to signal for help without alerting anyone present in the home.

**24.** Documented occupational hazard research for home-based care work identifies hostile animals, dangerous walking conditions, and temperature extremes among the genuine risks caregivers face, establishing these as genuine risk categories requiring specific assessment alongside interpersonal safety concerns.

**25.** Near-misses are established as genuine warning signs of potential hazards, with caregiver reporting enabling agencies to update risk assessments, improve safety procedures, and prevent future injuries before actual harm occurs.

**26.** Established supervisory practice for home-based caregiving specifies onsite, in-person visits at a defined calendar interval, with phone check-ins not satisfying this requirement, and treating a calendar-based interval as a count of visits rather than elapsed time identified as a documented, common compliance error.

**27.** Established supervisory practice for clients receiving only personal care services requires visits by a qualified supervising professional at a defined interval, with the caregiver required to be present and actively providing care during the visit, distinct from supervision arrangements for skilled clinical care.

**28.** Established documentation standards for supervisory practice specifically require objective measurements enabling comparison across assessments, with a vague statement such as "client is progressing well, continue plan of care" explicitly identified as not meeting the required documentation standard.

**29.** When a patient's needs change such that responsibility for supervision transfers between disciplines, the discipline assuming responsibility is expected to review and update the aide care plan, establishing genuine plan review at the point of real, changed circumstances as required practice.

**30.** When a supervisory visit identifies a deficiency, established practice requires the caregiver to receive retraining in the deficient skills and then pass a genuine, onsite competency evaluation with the supervisor present before resuming independent care.

**31.** Defined coverage arrangements for a solo caregiver's unavailability, distinct from an assumed continuation of care without one, are established as necessary practice for genuine continuity in any single-caregiver home care arrangement.

**32.** Research on home health aide continuity found that clients with the highest care needs and greatest cognitive impairment experience the lowest continuity scores, despite being the most dependent on stable, familiar caregivers and most likely to benefit from consistency.

**33.** Nearly four in five departing caregivers leave within their first 100 days of employment, establishing this specific period as the point of greatest genuine retention risk and impact, distinct from general workplace culture applied without this specific, structured focus.

**34.** Caregivers working in isolation with little support from supervisors or colleagues is specifically identified as a genuine, documented contributor to caregiver burnout and turnover, establishing active mitigation through regular supervisor contact as necessary, distinct from isolation accepted as an unavoidable feature of the role.

**35.** The isolated, unsupervised nature of one-on-one home caregiving is established as creating genuine, distinct challenges for incident detection compared with facility-based care, requiring reporting mechanisms specifically designed to account for delayed discovery, not assumed real-time detection.

**36.** WHO Competency Standard 1 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) requires health workers to adapt practice to migration and displacement experiences, address trauma-informed care and psychosocial needs, and support continuity of care regardless of legal status.

**37.** WHO Competency Standard 3 establishes language access and cultural mediation as a genuine, ongoing responsibility, with home care's persistent, daily interaction structure requiring communication support planning distinct from episodic clinical encounter models.

**38.** Genuine respect for a client's cultural and religious practices within their own home, consistent with established client autonomy principles in home care, carries particular relevance for refugee and migrant clients for whom these practices often represent continuity preserved through displacement.

**39.** Work authorization or right-to-work verification is a standard legal employment requirement in most countries, applying equally to every prospective employee, with migrant caregivers representing a genuine, substantial share of the home care workforce in many countries and often remaining in direct care positions longer than caregivers born in the country where they work, providing important workforce stability.

**40.** Changes to immigration or work-permit policy can disrupt legal work authorization for caregivers who built their employment relationships around a pathway that existed at the time of hire, establishing genuine transition support as necessary practice distinct from abrupt termination, a pattern documented across multiple countries that rely on migrant care workers.

**41.** Migrant direct care workers are documented in multiple countries as remaining in direct care positions longer than caregivers born in the country where they work, providing important workforce stability and continuity of care, establishing genuine recognition and support of this documented advantage as directly relevant to addressing the home care sector's broader turnover challenges.

**42.** WHO's Competency Standards explicitly distinguish these legal status categories throughout, noting that access to health care and legal entitlements vary meaningfully by status and by country, and that health workers need specific awareness of this rather than a single generalised assumption.

**43.** Equal standard of care and documentation regardless of immigration or legal status, without differential record-keeping practice, is established practice in international guidance on healthcare access for migrant and refugee populations.

**44.** WHO Competency Standards 8 and 9 require structured awareness of bias and its impact, with genuine application of this principle extending to recognizing and addressing bias directed at immigrant workers within the care relationship itself, not limited to bias affecting migrant clients alone.

**45.** Continuity of care as genuine infrastructure, distinct from an assumption that relocation automatically ends the possibility of continuity, is established practice for protecting health outcomes in mobile and displaced populations specifically.

## Established Practice — Not Attributed to a Single Source

*The statements below reflect genuine, widely recognised professional consensus — drawn from accreditation frameworks, quality improvement literature, and established clinical practice broadly — but are not attributed to one specific paper or document. They are listed here, honestly and separately from the numbered citations above, rather than assigned an invented formal reference.*

# Annex — ISO 9001:2015 Correlation Table

*A single-place summary of every criterion's correlation to ISO 9001:2015, for anyone checking this standard's alignment without searching page by page. Criteria not listed here carry no ISO 9001:2015 correlation — this is stated honestly, not implied as a gap in the standard itself; many client-safety and dignity criteria simply fall outside a quality-management-system standard's scope.*

| CRITERION | TITLE | ISO 9001:2015 |
|---|---|---|

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*Alphabetical, correlated to page number.*


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