

Home Care Standards

The complete ASF accreditation standard for home care facilities. Every criterion is published in full — statement, classification, and the verification questions used by Monitors and supervisors. Free. No account required.

8 standards · 45 criteria · 29 non-negotiable · 16 core · 0 standard · Version 3.0



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How to read this page: Each standard groups related criteria. Each criterion has a classification — **Non-Negotiable** (all must be met; any single failure bars accreditation), **Core** ($\geq 85\%$ for accreditation, $\geq 70\%$ for certification), or **Standard** ($\geq 70\%$ for accreditation). The verification questions show what a Monitor checks. To test your facility against these criteria, use the free self-assessment tool.

STANDARD 1 · MANDATORY

Client Rights & Dignity in the Home Setting

1.1 The Client's Home Remains Genuinely Theirs to Control

Non-Negotiable

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.

1. Does the caregiver genuinely respect the client's own household routines and living arrangements? — Real, active respect, not the caregiver rearranging things for their own convenience.
2. Is the client's personal property genuinely treated with care, not handled carelessly or without permission? — Real, careful, respectful handling, not an assumption that access to the home implies access to everything in it.
3. Does the client genuinely retain control over decisions about their own household, not deferred to the caregiver's preferences? — Real, retained client control, not decisions quietly shifting to the caregiver over time.

1.2 A Written Statement of Rights Is Provided and Genuinely Understood

Non-Negotiable

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.

1. Does every client genuinely receive a written statement of rights before care begins? — Real, prior provision, not a document given after care has already started.
2. Is this statement genuinely read aloud, in a language the client understands, when they cannot read it themselves? — Real, accessible communication, not a document left unread if literacy or language is a barrier.
3. Can the client genuinely explain back at least some of their own rights, not just confirm receiving a document? — Real, demonstrated understanding, not confirmation of receipt alone.

1.3 The Client Can Genuinely Request a Caregiver Replacement

Core

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.

1. Can a client genuinely request a different caregiver, with a real, known process for doing so? — A real, known, accessible process, not an unstated or discouraged option.
2. Is this request handled respectfully, without the client fearing conflict or reduced care quality as a result? — Real, respectful handling, not a request that creates tension or retaliation.
3. Is a replacement genuinely, practically arranged within a reasonable timeframe, not left unresolved indefinitely? — Real, timely resolution, not a request acknowledged but never actually fulfilled.

1.4 A Reachable Alternate Contact Exists Beyond the Caregiver Themselves

Non-Negotiable

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.

1. Does the client have a genuine, known way to reach the agency or a supervisor, separate from the caregiver? — A real, distinct contact, not the caregiver themselves as the only point of contact.
2. Is this contact genuinely reachable at any time care might occur, not limited to standard business hours? — Real, extended or 24/7 availability matching when care actually happens, not a narrow business-hours window.
3. Does the client genuinely know this contact exists and how to use it, not merely told once at intake? — Real, retained, practical awareness, not information given once and forgotten.

1.5 Freedom From Abuse and Neglect Is Actively Verified

Non-Negotiable

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.

1. Is freedom from abuse and neglect genuinely, actively verified through real, periodic independent check-ins? — Real, active verification, not an assumption of safety absent a specific complaint.
2. Are these check-ins genuinely conducted separate from the caregiver, not observed or overheard by them? — Real, genuine independence, not a check-in that occurs in the caregiver's presence.
3. Is there a specific, defined response process if a check-in reveals a genuine concern? — A real, defined response, not a concern noted without resulting action.

STANDARD 2 · MANDATORY

Caregiver Screening & Background Verification

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

Non-Negotiable

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.

1. Does every caregiver undergo a criminal record check verified against a unique identifier, not a name-based search alone? — Real, identity-verified screening, not a less reliable name-based alternative.
2. Is this screening genuinely completed before the caregiver has any unsupervised access to a client? — Real, prior completion, not access granted while screening is still pending.
3. Does the check draw on the most complete official record genuinely available in this jurisdiction, not a partial or limited search? — Real, comprehensive use of whatever official record system genuinely exists here, not the narrowest possible search.

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

Non-Negotiable

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.

1. Are relevant abuse registries genuinely checked for every jurisdiction the caregiver has worked? — Real, comprehensive checking, not limited to current location.
2. Is prior work history genuinely, specifically obtained to identify which jurisdictions require checking? — Real, specific inquiry, not an assumption of only local work history.
3. Is there a process for verifying the caregiver's stated work history, not accepted on self-report alone? — Real, independent verification, not self-report taken at face value.

2.3 Any National Care-Worker Exclusion Registry Is Specifically Checked

Non-Negotiable

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.

1. Where a national care-worker exclusion registry exists, is every caregiver specifically checked against it? — Real, distinct verification, not conflated with general criminal checking.
2. Where no such registry exists, is a genuine alternative verification effort made? — A real, active alternative, not a gap treated as an excuse to skip verification.
3. Is this check genuinely repeated periodically, not limited to a one-time check at hire? — Real, periodic reconfirmation, not a check assumed valid indefinitely.

2.4 Screening Is Genuinely Repeated Periodically

Non-Negotiable

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.

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.
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.
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.

2.5 A Disqualifying Finding Triggers Individualized Assessment

Core

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.

1. Does a criminal history finding trigger a genuine, individualized assessment, not an automatic blanket rejection? — Real, case-specific evaluation, not a policy that disqualifies regardless of context.
2. Does this assessment genuinely consider the nature, age, and relevance of the finding to caregiving specifically? — Real, specific consideration of these factors, not a superficial review.
3. Is the assessment process itself consistently applied, not varying arbitrarily between different candidates? — Genuine, consistent application, not inconsistent treatment of similar findings across different candidates.

STANDARD 3 · MANDATORY

Home Environment Safety Assessment

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

Non-Negotiable

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.

1. Does a genuine, structured home safety assessment occur before care begins, not a general impression alone? — Real, structured assessment using a defined checklist, not an informal, general impression.
2. Does this assessment genuinely cover flooring, lighting, stairs, bathroom hazards, and clear pathways specifically? — Complete, specific coverage of these real hazard categories, not a partial or generic check.
3. Is the assessment genuinely completed by someone trained to recognise these specific hazards, not left to informal observation? — Real, trained assessment, not an untrained caregiver's informal impression.

3.2 Identified Hazards Lead to Genuine, Tracked Remediation

Non-Negotiable

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.

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.
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.
3. Is remediation genuinely verified as completed, not assumed done without confirmation? — Real, confirmed completion, not an assumption the hazard was actually addressed.

3.3 A Fall Genuinely Triggers Reassessment

Non-Negotiable

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.

1. Does a client fall genuinely trigger a structured reassessment, not treated as an isolated event? — Real, structured reassessment, not routine continuation after first aid.
2. Does reassessment genuinely cover both the home environment and the client's own risk factors? — Complete reassessment of both, not one dimension alone.
3. Does reassessment happen promptly after the fall, not delayed to a routine review? — Real, prompt reassessment specifically triggered by the fall.

3.4 The Home Environment Is Reassessed Periodically

Core

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.

1. Is the home genuinely reassessed on a periodic schedule, not limited to initial assessment? — Real, periodic reassessment, not a one-time check treated as permanent.
2. Does the caregiver's regular presence genuinely inform this reassessment? — Real use of the caregiver's actual presence, not an infrequent separate visit alone.
3. Is a genuine change in the home's condition captured between scheduled reassessments? — Real, ongoing attentiveness, not hazard recognition limited to formal points.

3.5 Emergency Access to the Home Is Genuinely Confirmed

Non-Negotiable

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.

1. Does a genuine, verified emergency access plan exist for this home? — A real, confirmed arrangement, not an assumption responders will find a way in.
2. Is this plan genuinely known to the client, family, and caregiver? — Real, confirmed awareness, not a plan that exists only on paper.
3. Is the access arrangement genuinely verified as functional? — Real, verified functionality, not an assumption it would work when needed.

STANDARD 4 • MANDATORY

Medication Management & Family Coordination

4.1 Medication Reminders and Administration Are Genuinely Distinguished

Non-Negotiable

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.

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.
2. Are non-clinical caregivers specifically trained on this real medication boundary? — Real, specific training, not general awareness assumed sufficient.
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.

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

Non-Negotiable

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.

1. Does a single, genuinely current medication list exist and get actively shared across everyone involved in care? — Real, shared, current information, not separate lists maintained independently by each party.
2. Is this list genuinely updated immediately when a medication changes, not left outdated until a routine review? — Real, prompt updating, not a stale list corrected only periodically.
3. Do all parties — caregiver, family, other providers — genuinely know this shared list exists and where to find it? — Real, confirmed awareness across every party, not a list only one person actually knows about.

4.3 A Medication Change or Care Transition Triggers Structured Review

Non-Negotiable

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.

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.
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.
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.

4.4 Medications Belonging to Different Household Members Are Distinguished and Secured

Non-Negotiable

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.

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.
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.
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.

4.5 A Missed or Uncertain Dose Is Actively Followed Up

Core

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.

1. Does a genuinely missed or uncertain dose receive active, specific follow-up, not left unresolved? — Real, active follow-up, not a missed dose noted without genuine resulting action.
2. Is there a specific process for determining what to actually do when a dose was genuinely missed? — A real, defined process, not improvised or inconsistent handling case by case.
3. Are recurring missed or uncertain doses genuinely reviewed for a broader pattern, not treated as isolated incidents each time? — Real, pattern-level review, not each occurrence handled in isolation without noticing a recurring issue.

STANDARD 5 • MANDATORY

Caregiver Safety in an Uncontrolled Environment

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

Non-Negotiable

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.

1. Does a genuine risk assessment of the home and household occur before the caregiver's first visit? — Real, advance assessment, not the caregiver discovering hazards upon arrival.

2. Does this assessment specifically address household members, pets, and known environmental hazards? — Complete, specific coverage of these real risk categories, not a generic or partial check.
3. Is the caregiver genuinely briefed on identified risks before their first visit, not left to encounter them unprepared? — Real, prior briefing, not information gathered but never actually communicated to the caregiver.

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

Non-Negotiable

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.

1. Does a genuine workplace violence prevention program exist, specifically adapted for the home care setting? — Real, home-care-specific adaptation, not a generic facility-based program applied without change.
2. Does this program genuinely address the specific reality of a caregiver working alone, without on-site colleagues? — Real, specific attention to this genuine, distinct condition, not a program built assuming colleague proximity.
3. Are caregivers genuinely trained on this program, not assuming general awareness of workplace safety is sufficient? — Real, specific training on this program, not general safety awareness.

5.3 The Caregiver Has a Genuine Way to Signal Distress Discreetly

Non-Negotiable

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.

1. Does the caregiver have a genuine, practical way to discreetly signal distress or request help? — A real, discreet mechanism, not the caregiver's only option being to openly announce feeling unsafe.
2. Is this mechanism genuinely known and practiced by the caregiver, not merely described in a policy document? — Real, practiced familiarity, not theoretical awareness of a mechanism never actually used or tested.
3. Is there a genuine, defined response when this signal is triggered, not a signal that goes unanswered? — A real, defined response process, not a discreet signal with no actual, resulting action.

5.4 Hostile Animals and Environmental Hazards Are Specifically Assessed

Core

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.

1. Are hostile or unpredictable animals specifically assessed for each home, not overlooked? — Real, specific assessment of this genuine risk category, not treated as a minor or secondary concern.
2. Are other environmental hazards — lighting, walking conditions, temperature — specifically, genuinely assessed? — Complete, specific coverage of these real hazard categories, not a generic or partial check.
3. Does an identified hazard genuinely lead to a specific accommodation or precaution, not simply noted without resulting action? — Real, resulting action, not a documented hazard without any genuine, practical response.

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

Core

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.

1. Are caregivers genuinely encouraged and supported to report a near-miss, not discouraged from doing so? — Real, active encouragement, not a culture where near-misses go unreported for fear of consequence.
2. Does a reported near-miss genuinely lead to an updated risk assessment, not filed without resulting action? — Real, resulting update to the actual risk assessment, not a report that changes nothing.
3. Are near-miss reports genuinely reviewed for a broader pattern, not treated only as isolated, individual incidents? — Real, pattern-level review, not each report considered only in isolation.

STANDARD 6 · MANDATORY

Care Plan Development & Ongoing Supervision

6.1 Supervisory Visits Occur Genuinely On-Site

Non-Negotiable

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.

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.
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.
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.

6.2 Personal Care Supervision Includes Genuinely Observing the Aide Providing Care

Non-Negotiable

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.

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.
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.
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.

6.3 Supervision Documentation Captures Objective, Measurable Observations

Non-Negotiable

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.

1. Does supervisory documentation genuinely capture objective, measurable observations, not vague general statements? — Real, specific, measurable content, not a vague reassurance that provides no comparable information.
2. Can documentation from different visits genuinely be compared to identify a real change over time? — Real, comparable documentation, not language too vague to reveal any actual change.

3. Are staff genuinely trained on what constitutes adequate, objective documentation, not left to write vague reassurance by default? — Real, specific training on this documentation standard, not assumed general competence.

6.4 A Change in Client Needs Triggers Genuine Care Plan Review

Non-Negotiable

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.

- 1.** Does a genuine change in client needs actively trigger care plan review, not left unaddressed? — Real, active review triggered by the change itself, not routine continuation of an outdated plan.
- 2.** Is responsibility for the updated plan genuinely, clearly assigned when it shifts between disciplines? — Real, clear assignment of responsibility, not ambiguity about who now owns the plan's accuracy.
- 3.** Does the updated plan genuinely reflect the client's actual, current needs, not a partial update leaving stale elements in place? — Real, complete update, not selective revision that leaves outdated elements alongside new ones.

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

Core

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.

- 1.** Does an identified deficiency lead to genuine, documented retraining, not noted without resulting action? — Real, specific retraining actually delivered, not a deficiency recorded without follow-through.
- 2.** Does the caregiver genuinely undergo a subsequent competency evaluation before resuming independent care? — Real, confirmed re-evaluation, not resumed independent care assumed safe without verification.
- 3.** Is this evaluation genuinely conducted with the supervisor present, confirming the deficiency is actually resolved? — Real, supervised, confirmed resolution, not self-reported improvement accepted without verification.

STANDARD 7 · MANDATORY

Governance & Staffing

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

Non-Negotiable

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.

- 1.** Does a genuine, defined coverage arrangement exist for when a solo caregiver is unavailable? — A real, specific arrangement, not an assumption the client will manage without care.
- 2.** Is there a real, named alternative caregiver or service the client can be directed to during a coverage gap? — A specific, real alternative, not a vague suggestion to seek help elsewhere.
- 3.** Is the client genuinely informed of the coverage plan in advance, not left to discover it only when they need it? — Real, proactive client awareness, not information only encountered during an actual gap.

7.2 Caregiver Continuity Is Actively Tracked and Prioritized for High-Need Clients

Core

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.

1. Is caregiver continuity genuinely, actively tracked, not left to passive scheduling outcomes? — Real, active tracking of continuity as a specific, measured outcome, not an assumption it's adequate.
2. Do clients with the highest care needs genuinely receive specific priority for continuity, not treated the same as lower-need clients? — Real, specific prioritization, not uniform scheduling regardless of actual client need level.
3. Is there a specific, active response when continuity for a high-need client is identified as genuinely low? — A real, active, resulting response, not a low continuity score noted without genuine action.

7.3 New Caregiver Retention Receives Structured Attention in the First 100 Days

Core

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.

1. Does the service provide genuine, structured onboarding support specifically during the first 100 days? — Real, specific structure for this exact period, not general workplace culture applied uniformly.
2. Do regular, genuine check-ins occur with new caregivers during this specific window? — Real, scheduled check-ins, not informal or occasional contact left to chance.
3. Is scheduling for new caregivers genuinely realistic during this period, not immediately as demanding as for experienced staff? — Real, adjusted scheduling reflecting a new caregiver's actual, current experience level.

7.4 Caregiver Isolation Is Addressed Through Genuine, Regular Supervisor Contact

Core

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.

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.
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.
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.

7.5 Incident Reporting Accounts for Genuine Detection Delay in an Unsupervised Setting

Non-Negotiable

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.

1. Does incident reporting genuinely account for the real possibility of delayed discovery? — Real, specific accommodation, not a system designed only around real-time witnessing.
2. Are there specific mechanisms — check-ins, family contact — that could catch a delayed-discovery incident? — Real, specific mechanisms beyond the caregiver's own real-time reporting alone.

3. Is there a specific process for investigating a delayed-discovery incident without a real-time witness? — A real, defined process adapted to this evidentiary challenge, not treated identically to a witnessed incident.

STANDARD 8

Health & Migration

8.1 Care Is Genuinely Adapted to a Client's Migration and Displacement Experience

Non-Negotiable

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.

- 1.** Is care genuinely adapted to a client's migration and displacement experience, not delivered identically regardless of history? — Genuine adaptation, not a generic cultural-awareness statement.
- 2.** Is trauma-informed practice genuinely applied throughout the ongoing relationship, not only referenced once at intake? — Real, sustained practice adaptation, not a one-time consideration.
- 3.** Is the caregiver aware of legal-status barriers to access that may affect this specific client? — Specific awareness, not a general sense that barriers can exist.

8.2 Language Support Accounts for Persistent, Daily Interaction

Non-Negotiable

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.

- 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.
- 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.
- 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.

8.3 Cultural and Religious Practices in the Client's Home Are Genuinely Respected

Non-Negotiable

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.

- 1.** Does the caregiver genuinely respect the client's specific dietary, religious, and cultural practices? — Real, active respect for the client's actual practices, not the caregiver's own habits.
- 2.** Are gender-appropriate care preferences genuinely accommodated where expressed? — Real, active accommodation of the client's own stated preference.
- 3.** Was the caregiver genuinely asked about these preferences, not assumed from background? — Real, specific inquiry, not assumption based on broad cultural category.

8.4 Caregiver Work Authorization Is Verified Through Legal, Non-Discriminatory Practice

Core

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.

1. Is work authorization verified through the same standard, legal process for every candidate? — Real, consistent verification, not excess scrutiny applied selectively.
2. Is verification applied consistently, not varying by perceived national origin or accent? — Real, consistent application, not discriminatory differentiation.
3. Are staff trained on the requirement's actual legal scope, not exceeding what's required? — Real, specific training on the genuine standard, not over-scrutiny.

8.5 A Caregiver's Legal Status Change Is Handled With Genuine Support

Core

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.

1. Does the service provide genuine support when a caregiver's legal status changes? — Real, active support, not abrupt termination without transition.
2. Is the affected client genuinely supported through this transition? — Real, proactive support and coverage planning, not an unexplained loss.
3. Is the service genuinely, currently informed about relevant legal status changes? — Real, current awareness, not reactive discovery after a lapse.

8.6 Immigrant Caregivers' Genuine Retention Advantage Is Recognized and Supported

Core

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.

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.
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.
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.

8.7 Legal Status Diversity Recognition for Clients

Core

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.

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.
2. Does the service avoid applying a single, uniform assumption about access rights across all statuses? — Genuine differentiation, not treating all categories identically.
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.

8.8 Care Is Documented and Provided to Clients Regardless of Immigration or Legal Status

Non-Negotiable

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.

1. Is the same standard of care applied and documented the same way regardless of a client's immigration or legal status? — Genuinely equal treatment, not a lesser or informal standard for undocumented clients.
2. Are staff specifically trained that immigration status is never a reason to withhold or alter care or documentation? — Specific, documented training, not assumed understanding.
3. Is client information protected with the same confidentiality standard regardless of status, with no informal sharing of status-related information? — The same confidentiality protection extended to every client, without exception.

8.9 Staff Reflective Practice and Bias Awareness Extends to How Immigrant Caregivers Are Treated

Core

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.

1. Does bias awareness training address discrimination immigrant caregivers might experience? — Real, specific coverage, not training focused only on bias toward clients.
2. Is there a known process for a caregiver to report discrimination they experience? — A real, accessible process, not an assumption a caregiver would simply tolerate this.
3. Does the organization genuinely support a caregiver who reports this concern? — Real, active support, not a caregiver expected to resolve it alone.

8.10 Continuity Across a Client's Relocation Is Actively Supported

Core

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.

1. Does the service actively support continuity when a client relocates, not treat relocation as an automatic end to continuity? — Real, active support, not passive acceptance that continuity simply ends.
2. Is a portable, client-held summary of care needs genuinely provided, capturing the accumulated understanding built over time? — A real, usable summary reflecting genuine accumulated understanding, not a generic intake form.
3. Where a new provider is known, is active handover genuinely attempted, not assumed impossible? — A real, attempted handover, not an assumption that contact with a future provider isn't achievable.