

Home Care Standards — Full Guidance

Complete criterion-by-criterion guidance: worked examples, first steps, common mistakes, implementation plans, and Monitor verification methods for all 45 criteria.

8 standards · 45 criteria · Version 3.0

ASF STANDARDS · HOME CARE · STANDARD 1

Standard 1 — Client Rights & Dignity in the Home Setting

5 criteria · 4 non-negotiable · 1 core · Version 3.0

CRITERIA IN THIS STANDARD

- 1.1 — The Client's Home Remains Genuinely Theirs to Control
- 1.2 — A Written Statement of Rights Is Provided and Genuinely Understood
- 1.3 — The Client Can Genuinely Request a Caregiver Replacement
- 1.4 — A Reachable Alternate Contact Exists Beyond the Caregiver Themselves
- 1.5 — Freedom From Abuse and Neglect Is Actively Verified

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.

In plain terms: The caregiver works in the client's home on the client's terms — the client decides the routine, the rules, who enters, and how things are done.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

A caregiver who rearranges the kitchen, sets the schedule for their own convenience, lets colleagues in without asking, or overrides the client's choices has turned the client's home into a workplace the client no longer controls. That is a loss of autonomy more damaging than most physical decline. The home belongs to the client; the caregiver is a guest with a job. Practically: the client decides when care happens within agreed hours, how tasks are done, what is touched, who comes in. Preferences are documented and honoured. Staff are trained that control stays with the client even when the client's choices are not what the caregiver would make.

WHAT GOOD LOOKS LIKE

- The caregiver genuinely respects the client's own household routines.
- Personal property is genuinely treated with care and permission.
- The client genuinely retains control over their own household decisions.

COMMON FAILURE MODES

- The caregiver rearranges the household for their own convenience.
- Personal property is handled carelessly or without permission.
- Household decisions have quietly shifted to the caregiver over time.

WORKED EXAMPLE

IN PRACTICE

A 120-client home care agency serving elderly clients living alone.

BEFORE

Caregivers set visit times for their own route efficiency. One caregiver reorganised a client's cupboards 'to be safer.' Another brought a trainee without asking. Clients described feeling 'invaded.' The care plan listed tasks but not the client's preferences about how they should be done.

ACTION

The care plan now includes a 'How I want things done in my home' section completed with the client: preferred visit times, routine, what may and may not be moved, who may enter, how the client wishes to be addressed. Caregivers are trained that this section governs. Visit times are agreed with the client, not assigned. Any additional person entering requires the client's prior consent. Supervisors ask clients about control at every supervisory visit.

AFTER

The Monitor reviewed 20 care plans with completed preference sections, supervisory visit notes recording client feedback on control, and interviewed three clients who described the home as 'still mine.' Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask five clients: 'Does the caregiver do things your way or their way?'
2. Add a client preferences section to every care plan.
3. Agree visit times with clients rather than assigning them.
4. Train caregivers: it is the client's home.

The most common mistake: Organising care for the caregiver's efficiency — the client's home becomes a stop on a route.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: N/A — tested directly

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.*

Evidence: N/A — tested directly

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.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **Control is generally respected but decisions during high-stress moments sometimes default to the caregiver's judgment.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Client household control interview	Asks the client directly whether they feel genuine control over their own household has been maintained.
OBSERVE	Property handling observation	Observes whether the caregiver genuinely handles the client's property with care and permission.

Method	What	Detail
ASK	Caregiver respect interview	Asks the caregiver how they specifically respect the client's household routines and preferences.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

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.

In plain terms: Before care starts, the client gets a written statement of their rights, read aloud in their language, and can tell you what some of those rights are.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

A client who does not know they can refuse a task, change caregiver, complain to the agency, or end the service, is a client at the mercy of whoever comes through the door. Rights must be given in writing, explained aloud (many clients cannot read small print, or at all), in a language they understand, with a family member present if the client wishes, and the client's understanding checked. The signed acknowledgement is filed. The rights are on the fridge, not in a folder.

WHAT GOOD LOOKS LIKE

- Every client genuinely receives the written statement before care begins.
- The statement is genuinely read aloud in an understandable language when needed.
- Clients can genuinely explain back some of their own rights.

COMMON FAILURE MODES

- The statement is provided after care has already started, or not at all.
- No accommodation exists for a client who cannot read the statement themselves.
- Clients cannot describe any of their own rights beyond having received a document.

WORKED EXAMPLE

IN PRACTICE

A 100-client home care agency with a rights document in the intake pack.

BEFORE

The rights sheet was one of twelve documents signed at intake. It was not read aloud. Interviewed clients could not name a right. One client had tolerated a caregiver she disliked for a year because she did not know she could ask for another.

ACTION

A one-page plain-language rights statement (large print, eight rights, pictorial) is read aloud by the intake nurse in the client's language, with time for questions; the client is asked to name

two rights; a copy is left on the fridge and one in the file with the client's signature. Rights are revisited at each supervisory visit.

AFTER

The Monitor reviewed 20 intake records with rights read-aloud documented and teach-back noted. Asked five clients to name a right; all could. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask five clients to name one right they have.
2. Rewrite the rights on one large-print page.
3. Read it aloud at intake and ask the client to repeat two.
4. Leave it on the fridge.

The most common mistake: Burying the rights statement in the intake pack and calling the signature understanding.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: Client rights statement documentation

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.*

Evidence: N/A — tested directly

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.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **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.

- **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.
- **The statement is provided to the client but a legal representative, where one exists, isn't consistently also informed.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Rights statement provision review	Reviews records confirming the written statement was genuinely provided before care began.
OBSERVE	Accessibility observation	Observes or confirms whether the statement is genuinely read aloud in an understandable language when needed.
ASK	Client understanding check	Asks a client to explain back some of their own rights, not just confirm receiving a document.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

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.

In plain terms: A client can ask for a different caregiver when the match is not working, without having to justify it, and the agency actually changes it.

Facility category	Crisis	Transition	Small	Standard
Applicability	N/A	Full	Adapted	Full

WHY THIS MATTERS

The caregiver relationship is intimate: bathing, toileting, being alone together for hours. When it does not work — personality clash, discomfort, a feeling the client cannot name — the client must be able to say so and be heard, without being made to explain, without being told 'she's our best,' without retaliation. The agency must have a defined process: how to request, who to tell, how fast the change happens, what if no alternative is immediately available. The request itself is the reason.

WHAT GOOD LOOKS LIKE

- Clients genuinely know they can request a caregiver replacement and how.
- Requests are handled respectfully, without conflict or reduced care quality.
- Replacements are genuinely, practically arranged within a reasonable timeframe.

COMMON FAILURE MODES

- Clients don't know this option exists or feel discouraged from raising it.
- Requests create tension or a perceived risk of reduced care quality.
- Requests are acknowledged but never actually fulfilled.

WORKED EXAMPLE

IN PRACTICE

A 150-client agency where replacement requests were discouraged.

BEFORE

Clients who asked for a different caregiver were asked why, told the caregiver was highly rated, and often given no change. One client stopped using the service rather than continue with a caregiver who frightened her. The agency saw replacement requests as complaints against staff.

ACTION

A replacement policy was written: any client may request a change by phone or in person to the supervisor; no reason required; change within five working days; interim cover arranged; the client is not asked to justify; the caregiver is not told the client's reason unless the client wishes. Requests are tracked as a quality measure, not a disciplinary one. Clients are told the policy at intake.

AFTER

The Monitor reviewed the policy, 14 replacement requests in six months all fulfilled within five days, and interviewed a client who described asking and receiving a change without difficulty. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask five clients whether they know they can request a different caregiver.
2. Write the policy: no reason required, five days.
3. Tell every client at intake.
4. Track requests as data, not discipline.

The most common mistake: Asking the client why — the question itself makes the request feel like an accusation.

SELF-ASSESSMENT QUESTIONS

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.*
Evidence: Caregiver replacement request process

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.*
Evidence: N/A — tested directly

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.*
Evidence: Replacement resolution record

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **The process works well for straightforward mismatches but isn't clearly defined for a more serious concern about the caregiver.**

IMPLEMENTATION PLAN

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

When	What
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.

HOW THE MONITOR VERIFIES THIS

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

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

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.

In plain terms: The client has a phone number that reaches the agency or a supervisor directly — not through the caregiver — and knows it.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

If the only way to reach the agency is through the caregiver, the client cannot report the caregiver. A client who is being neglected, stolen from, or frightened needs a channel the caregiver does not control: a direct supervisor number, an office line answered by a person, a card on the fridge. The client must know it exists and have used it at least once (a welcome call from the supervisor). A client without an independent channel is alone with whoever comes.

WHAT GOOD LOOKS LIKE

- A genuine, distinct contact exists, separate from the caregiver.
- This contact is genuinely reachable across the actual hours care occurs.
- Clients genuinely, currently know how to use this contact.

COMMON FAILURE MODES

- The caregiver is effectively the only point of contact for any concern.
- The alternate contact is only reachable during limited business hours.
- Clients were told once at intake but no longer recall how to reach this contact.

WORKED EXAMPLE

IN PRACTICE

A 100-client agency where clients reached the office by asking the caregiver.

BEFORE	The agency number was in the intake pack. Most clients did not know it. Contact went through the caregiver. A client whose caregiver was taking money from her purse had no way to tell anyone until a relative visited.
ACTION	Every client receives a large-print card with the supervisor's direct number and the office line, placed on the fridge. The supervisor phones each new client in the first week to introduce themselves and confirm the client can reach them. The number is confirmed at every supervisory visit. An out-of-hours line is provided.
AFTER	The Monitor found the card in five clients' homes, reviewed welcome call records, and asked three clients how to reach the supervisor; all pointed to the card. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask five clients how they would contact the agency without the caregiver.
2. Give every client a fridge card with a direct number.
3. Have the supervisor phone every new client in week one.
4. Confirm at every supervisory visit.

The most common mistake: Putting the number in the intake pack — the client who needs it cannot find it.

SELF-ASSESSMENT QUESTIONS

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.*
Evidence: Alternate contact documentation

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.*

Evidence: N/A — tested directly

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.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **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.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Alternate contact review	Reviews documentation confirming a genuine, distinct contact separate from the caregiver.

Method	What	Detail
DOCUMENT	Availability review	Reviews whether this contact is genuinely reachable across the actual hours care occurs.
ASK	Client awareness interview	Asks a client whether they currently know how to reach this alternate contact.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

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.

In plain terms: The agency actively checks that clients are not being abused or neglected — private conversations, unannounced visits, looking for signs — not just waiting for a complaint.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Adapted	Full

WHY THIS MATTERS

Home care is unsupervised. The caregiver is alone with a dependent person for hours. Abuse — financial, physical, verbal, sexual — and neglect happen in that privacy, and the client often cannot or will not report it: fear, dependence, shame, cognitive impairment. Active verification means the agency looks: supervisory visits include a private conversation with the client without the caregiver present; unannounced visits occur; staff are trained to recognise signs (unexplained bruises, weight loss, withdrawn mood, missing money, fear of the caregiver); family are asked; findings are acted on. Waiting for a complaint is waiting for the rare client who can make one.

WHAT GOOD LOOKS LIKE

- Freedom from abuse and neglect is genuinely, actively verified through periodic independent check-ins.
- Check-ins are genuinely conducted separate from the caregiver's presence.
- A specific, defined response process exists for any identified concern.

COMMON FAILURE MODES

- Safety is assumed absent a specific complaint, with no active verification.
- Check-ins, if any, occur in the caregiver's presence, undermining genuine independence.
- No defined response exists if a concern is identified.

WORKED EXAMPLE

IN PRACTICE

A 120-client agency whose abuse policy was 'report any concern.'

BEFORE

No active checking. Supervisory visits were scheduled and the caregiver was present throughout. A client with dementia had been physically handled roughly for months; bruising

	was attributed to falls. A relative eventually complained.
ACTION	Every supervisory visit now includes 15 minutes alone with the client, using a structured set of questions about how they are treated. One in four supervisory visits is unannounced. Supervisors are trained on abuse and neglect indicators with a checklist. Family contacts are asked quarterly. Any indicator triggers a defined investigation with the caregiver suspended pending outcome. Financial checks (receipts, bank statements with consent) for clients whose caregivers handle money.
AFTER	The Monitor reviewed 30 supervisory visit records with private conversation documented, the unannounced visit log, the indicator checklist, and two investigations with outcomes. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Add 15 minutes alone with the client to every supervisory visit.
2. Make one in four visits unannounced.
3. Train supervisors on abuse indicators.
4. Ask family quarterly.

The most common mistake: Conducting supervisory visits with the caregiver in the room — the client will not speak.

SELF-ASSESSMENT QUESTIONS

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.*
Evidence: Independent check-in record
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.*
Evidence: N/A — tested directly

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.

Evidence: Concern response protocol

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **A response process exists but hasn't been specifically tested against a real identified concern.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Check-in record review	Reviews records of genuine, periodic, independent check-ins with clients.
OBSERVE	Independence verification	Confirms check-ins are genuinely conducted separate from the caregiver's presence.
DOCUMENT	Response protocol review	Reviews the specific, defined response process for a concern identified during a check-in.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

← **Home Care Standards — all standards**

Self-assess against these criteria →

Standard 2 — Caregiver Screening & Background Verification →

© 2026 Accréditation Sans Frontières · PHIG · Sheni Network

ASF STANDARDS · HOME CARE · STANDARD 2

Standard 2 — Caregiver Screening & Background Verification

5 criteria · 4 non-negotiable · 1 core · Version 3.0

CRITERIA IN THIS STANDARD

- 2.1 — Background Screening Uses Verified Identity, Not Name-Based Matching Alone
- 2.2 — Abuse Registries Are Checked in Every Jurisdiction the Caregiver Has Worked
- 2.3 — Any National Care-Worker Exclusion Registry Is Specifically Checked
- 2.4 — Screening Is Genuinely Repeated Periodically
- 2.5 — A Disqualifying Finding Triggers Individualized Assessment

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.

In plain terms: Criminal record checks are matched to the caregiver's verified identity — fingerprint, government ID number — not just their name, which can be common or false.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

A name-based check for 'Maria Garcia' returns nothing useful, or the wrong person. A caregiver using a false name passes. A caregiver with a common name is either wrongly cleared or wrongly flagged. Identity-verified checks — fingerprint-based where available, or against a government ID number with the document inspected — tie the record to the person in front of you. In home care, where the caregiver is alone with a vulnerable client, the cost of a wrong clearance is the client's safety.

WHAT GOOD LOOKS LIKE

- Every caregiver genuinely undergoes identity-verified criminal record screening.
- Screening is genuinely completed before any unsupervised client access.
- The check genuinely uses the most complete official record system available here.

COMMON FAILURE MODES

- Screening relies on a name-based check alone, without identity verification.
- Caregivers have unsupervised access while screening is still pending.
- The check uses only a minimal or partial search when a more complete official record system is genuinely available.

WORKED EXAMPLE

IN PRACTICE

A 150-client agency using name-based online criminal record checks.

BEFORE

Checks were run by name and date of birth through a commercial service. No identity verification. A caregiver hired under a false name

	was later found to have a conviction for theft from an elderly person under her real name.
ACTION	The screening process was rewritten: government photo ID inspected and copied at interview; the criminal record check run through the official channel using the ID number (fingerprint-based where the jurisdiction offers it); the result matched to the ID; any discrepancy stops the hire. Existing staff were re-screened over three months.
AFTER	The Monitor reviewed 20 staff files with ID-verified checks and the re-screening log. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. How are your criminal checks run — by name or by ID number?
2. Switch to the official channel with ID verification.
3. Inspect and copy government ID at interview.
4. Re-screen existing staff.

The most common mistake: A name-based check that clears a person who is not who they say they are.

SELF-ASSESSMENT QUESTIONS

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.*
Evidence: Identity-verified screening record

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.*
Evidence: Screening completion timing record

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.*
Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **A genuinely more complete record system exists in this jurisdiction but the service defaults to a narrower, easier search instead.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Identity-verified screening review	Reviews records confirming genuine, identity-verified screening for every caregiver.
DOCUMENT	Timing review	Reviews whether screening genuinely completed before any unsupervised client access.
DOCUMENT	Record completeness review	Reviews whether the check genuinely draws on the most complete official record system available in this jurisdiction.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

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.

In plain terms: Abuse and neglect registries are checked in every place the caregiver has lived or worked — not just here.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Adapted	Full

WHY THIS MATTERS

A caregiver dismissed for abuse in one region moves to another and starts again. The registry in the new region is clean because the finding is in the old one. The check must cover every jurisdiction in the caregiver's work and residence history — from their application, their references, their ID history. It is tedious. The alternative is hiring someone another agency already found abusing clients.

WHAT GOOD LOOKS LIKE

- Registry checks genuinely cover every jurisdiction the caregiver has previously worked, where a registry exists.
- Work history is genuinely, specifically obtained to identify relevant jurisdictions.
- Self-reported work history is independently, genuinely verified.

COMMON FAILURE MODES

- Registry checks are limited to the caregiver's current location.
- Work history isn't specifically obtained; only current location is checked.
- Self-reported work history is accepted without any independent verification.

WORKED EXAMPLE

IN PRACTICE

A 100-client agency that checked the local abuse registry only.

BEFORE

The local registry was checked. Work history in other regions was not verified against those regions' registries. A caregiver with a substantiated neglect finding in a neighbouring region was hired and later neglected a client here.

ACTION

The application now requires a complete work and residence history for ten years. Each jurisdiction's abuse registry (where one exists) is checked and the result filed. Gaps in history are explained and verified. The screening checklist lists every jurisdiction checked. Existing staff were re-screened.

AFTER

The Monitor reviewed 20 files with multi-jurisdiction registry checks documented. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Require a ten-year work and residence history on every application.
2. List the abuse registry for every jurisdiction named.
3. Check each one and file the result.
4. Re-screen existing staff.

The most common mistake: Checking only your own region's registry — the abuser from next door is invisible.

SELF-ASSESSMENT QUESTIONS

1. Are relevant abuse registries genuinely checked for every jurisdiction the caregiver has worked? — *Real, comprehensive checking, not limited to current location.*

Evidence: Multi-jurisdiction registry check record

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.*

Evidence: Work history disclosure record

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.*

Evidence: Work history verification process

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **The process is thorough for caregivers with a clearly documented history but less rigorous for those with gaps in their reported history.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Multi-jurisdiction check review	Reviews records confirming registry checks genuinely cover every jurisdiction the caregiver has worked, where such registries exist.
DOCUMENT	Work history disclosure review	Reviews whether work history is genuinely, specifically obtained to identify relevant jurisdictions.
DOCUMENT	Verification process review	Reviews the process for independently verifying self-reported work history.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

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.

In plain terms: Where a national or regional registry specifically bars people from care work, it is checked for every caregiver before hire — as a separate step, not assumed to be part of the criminal check.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

Many countries maintain a specific list of individuals barred from working with vulnerable adults — separate from criminal records, populated by employer reports, regulatory findings, and safeguarding investigations that never reached court. A caregiver with no criminal record may be on it. The check is distinct, often through a different authority, and must be done explicitly. A file that shows a criminal check and no barred-list check has a hole.

WHAT GOOD LOOKS LIKE

COMMON FAILURE MODES

- Every caregiver is specifically, distinctly checked against any relevant national exclusion registry.
- Where no registry exists, a genuine alternative verification effort is made.
- This check is genuinely repeated periodically, not a one-time verification.

- An existing exclusion registry is assumed covered by general criminal background checking alone.
- Absence of a national registry is treated as reason to skip this verification entirely.
- The check happens once at hire and is never repeated.

WORKED EXAMPLE

IN PRACTICE

A 120-client agency that assumed the criminal check covered barring.

BEFORE	Criminal record checks were done. The care-worker barred list was not checked separately; staff believed the criminal check included it. A caregiver on the barred list — for a safeguarding finding that never went to court — was hired.
ACTION	The barred-list check was added as a distinct, mandatory step through the responsible authority, with the result filed separately. The screening checklist names it. No caregiver starts without it. Existing staff were checked.
AFTER	The Monitor reviewed 20 files with the barred-list check as a separate documented item. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Find out whether your country has a care-worker barred list and who maintains it.
2. Add it as a separate step on the screening checklist.
3. Check every existing caregiver.
4. File the result separately from the criminal check.

The most common mistake: Assuming the criminal record check includes the barred list — they are different databases.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: Exclusion registry check record

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.*

Evidence: Alternative verification documentation

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.*

Evidence: Periodic recheck schedule

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **Rechecking happens but isn't consistently documented in a way that's genuinely verifiable.**

IMPLEMENTATION PLAN

When	What
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.

When	What
Ongoing	Document each periodic recheck for genuine verifiability.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Exclusion registry check review	Reviews records confirming specific, distinct verification against any relevant national exclusion registry.
DOCUMENT	Alternative verification review	Where no such registry exists, reviews evidence of a genuine alternative verification effort.
DOCUMENT	Periodic recheck review	Reviews whether this check is genuinely repeated periodically.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

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.

In plain terms: Background screening is repeated on a fixed schedule for every active caregiver — every one to three years — not only at hire.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A caregiver cleared five years ago may have been convicted, barred, or reported since. Home care agencies employ people for years; a hire-only check goes stale. Repeat screening on a defined cycle (annually where feasible, every three years at most), plus a requirement that caregivers self-report any charge or investigation, keeps the clearance current. The schedule is tracked; a caregiver whose repeat check is overdue is not scheduled until it is done.

WHAT GOOD LOOKS LIKE

- Screening is genuinely repeated on a periodic, defined schedule.
- Rescreening genuinely matches the comprehensive scope of initial screening.
- A real, defined response addresses any new disqualifying finding.

COMMON FAILURE MODES

- Screening happens once at hire and is never genuinely repeated.
- Rescreening, if any, is abbreviated compared with initial screening.
- No defined response exists for a new finding identified through rescreening.

WORKED EXAMPLE

IN PRACTICE

A 150-client agency that screened at hire only.

BEFORE	Caregivers employed for up to twelve years had never been re-screened. A caregiver convicted of assault three years into employment continued working; the agency did not know. No self-reporting requirement existed.
ACTION	A two-year re-screening cycle was implemented: criminal, registry, and barred-list checks repeated with tracked due dates; a self-reporting requirement signed by every caregiver; scheduling blocked for anyone overdue. The first cycle re-screened all 80 caregivers over four months.
AFTER	The Monitor reviewed the re-screening register (no caregiver overdue), signed self-reporting agreements, and the scheduling block configuration. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List every caregiver with the date of their last screening.
Anything over three years is a gap.
2. Set a two-year cycle with tracked due dates.
3. Require signed self-reporting of any charge.
4. Block scheduling for overdue checks.

The most common mistake: A clearance from the year the caregiver was hired, treated as permanent.

SELF-ASSESSMENT QUESTIONS

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.*
Evidence: Periodic rescreening schedule documentation
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.*
Evidence: N/A — tested directly

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.*

Evidence: Rescreening finding response process

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **A response process exists but hasn't been applied to a real, identified rescreening finding to date.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

Method	What	Detail
DOCUMENT	Finding response review	Reviews the defined response process for a new disqualifying finding identified through rescreening.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

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.

In plain terms: When a criminal check finds something, the agency assesses whether it actually matters for caregiving — what, when, how relevant — rather than rejecting automatically or ignoring it.

Facility category	Crisis	Transition	Small	Standard
Applicability	N/A	Full	Adapted	Full

WHY THIS MATTERS

A shoplifting conviction at 19, twenty years ago, is not the same as a theft from an elderly person last year. A drink-driving offence is not the same as assault. Automatic rejection loses good caregivers and may be unlawful; automatic acceptance ignores real risk. Individualised assessment means: what was the offence, how long ago, what has happened since, how does it relate to caregiving (access to vulnerable people, money, medications, the home), and is there mitigation. The assessment is documented, made by a senior person, and consistent. Some findings — violence, sexual offences, abuse of vulnerable people — are always disqualifying; the policy names them.

WHAT GOOD LOOKS LIKE

- A genuine, individualized assessment occurs for every criminal history finding.
- The assessment genuinely considers nature, age, and relevance to caregiving.
- The process is applied consistently across different candidates.

COMMON FAILURE MODES

- Blanket disqualification is applied automatically, regardless of the finding's context.
- Assessment, if any, doesn't genuinely consider relevant factors.
- The process varies arbitrarily between different candidates with similar findings.

WORKED EXAMPLE

IN PRACTICE

A 100-client agency with no policy for handling findings.

BEFORE

Findings were handled inconsistently: one manager rejected any finding; another ignored all but violence. A candidate with a 25-year-old minor conviction was rejected; a candidate with a recent fraud conviction was hired.

ACTION

A findings assessment policy was written: a list of always-disqualifying offences (violence, sexual offences, abuse or neglect of vulnerable people, theft from a person in care); for other findings, a structured assessment (offence, date, relevance to caregiving, subsequent history, mitigation) by the registered manager, documented, with the

decision and reasoning. Consistency is reviewed annually.

AFTER

The Monitor reviewed the policy and six documented assessments with consistent reasoning; two candidates accepted with historical minor findings, one rejected for recent fraud. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Write the always-disqualifying list.
2. Write the assessment questions for everything else.
3. Require the registered manager to decide and document.
4. Review past decisions for consistency.

The most common mistake: Rejecting a candidate for a minor offence from decades ago while hiring one with a recent relevant conviction — inconsistency is the failure.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: Individualized assessment documentation

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.*

Evidence: N/A — tested directly

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.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **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.

- **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.
- **The process is generally consistent but hasn't been specifically reviewed for potential disparate impact across candidates.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

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

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

← **Home Care Standards —
all standards**

**Self-assess against these
criteria →**

← **Standard 1 — Client
Rights & Dignity in the Home
Setting**

**Standard 3 — Home
Environment Safety
Assessment →**

© 2026 Accréditation Sans Frontières · PHIG · Sheni Network

ASF STANDARDS · HOME CARE · STANDARD 3

Standard 3 — Home Environment Safety Assessment

5 criteria · 4 non-negotiable · 1 core · Version 3.0

CRITERIA IN THIS STANDARD

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

**3.2 — Identified Hazards Lead
to Genuine, Tracked
Remediation**

**3.3 — A Fall Genuinely Triggers
Reassessment**

**3.4 — The Home Environment Is
Reassessed Periodically**

**3.5 — Emergency Access to the
Home Is Genuinely Confirmed**

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.

In plain terms: Before care begins, someone walks through the client's home with a checklist — floors, lighting, stairs, bathroom, clutter, heating, smoke alarms — and writes down every hazard.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

The client's home is where they will fall, burn, trip, or be unable to escape a fire. A loose rug, a dark staircase, a bath with no rail, a kitchen with a gas leak, a blocked exit — each is a preventable injury. A structured assessment (a defined checklist, done by a trained person, at the first visit) finds them. An unstructured 'look around' finds what happens to catch the eye. The assessment is the baseline for remediation (3.2) and reassessment (3.4). Without it, the agency is delivering care into an unknown environment.

WHAT GOOD LOOKS LIKE

- A genuine, structured assessment occurs before care begins for every client.
- The assessment genuinely covers all specific, defined hazard categories.
- The assessment is genuinely completed by someone trained to recognise these hazards.

COMMON FAILURE MODES

- Assessment relies on a general impression, not a structured checklist.
- The assessment covers some hazard categories but misses others.
- The assessment is completed by someone without genuine, specific training.

WORKED EXAMPLE

IN PRACTICE

A 120-client agency where the first visit was a care needs assessment only.

BEFORE

The intake nurse assessed the client's care needs. The home was not assessed. A client fell on a loose stair carpet in her second week of service; the caregiver had noticed it but had nowhere to record it. No checklist existed.

ACTION

A 30-item home safety checklist was adopted from national occupational therapy guidance: flooring and rugs, lighting, stairs and rails,

bathroom (rails, non-slip, bath/shower access), kitchen (gas, electrical, storage height), heating, smoke and CO alarms, exits, clutter, pets, medication storage. Completed at the first visit by the intake nurse, with hazards rated and recorded. The client and family are given a copy.

AFTER

The Monitor reviewed 20 completed home assessments with hazards identified and rated. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Adopt a structured checklist — 30 items from OT guidance.
2. Complete it at every new client's first visit.
3. Rate each hazard.
4. Give the client a copy.

The most common mistake: Assessing the client and not the home — the home is where the injury will happen.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: Home safety assessment documentation

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.*

Evidence: N/A — tested directly

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.*

Evidence: Assessor training record

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **Assessor training covers general hazard awareness but not the specific, structured checklist categories used.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Assessment documentation review	Reviews the actual, structured home safety assessment record for a sample of clients.
DOCUMENT	Coverage completeness review	Reviews whether the assessment genuinely covers all specific, defined hazard categories.
DOCUMENT	Assessor training review	Reviews training records confirming the assessor is genuinely trained to recognise these hazards.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

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.

In plain terms: Every hazard found leads to a specific action — a grab rail installed, a rug removed, a referral made — tracked until done, not just noted in the file.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Adapted	Full

WHY THIS MATTERS

The assessment found the loose rug. Three months later, the client fell on it. The hazard was documented; nothing was done. Remediation means: for each hazard, a specific action (remove, fix, install, refer to OT, advise the family), a person responsible, a target date, and a

check that it happened. Some remediation is the agency's (removing a rug with consent); some is the family's (installing a rail); some is a referral (OT, housing). All are tracked. A hazard list without a remediation log is a list of future injuries.

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

WORKED EXAMPLE

IN PRACTICE	
<i>A 100-client agency with home assessments completed but no follow-through.</i>	
BEFORE	Hazards were recorded on the assessment form and filed. No action tracking. The Coordinator reviewed 30 assessments from six months earlier: 60% of identified hazards were unchanged at reassessment. Two falls had occurred on documented hazards.
ACTION	A remediation log was added to every assessment: hazard, action, responsible party, target date, completion date. The supervisor reviews open items weekly and chases. Simple fixes (rugs, lighting, clutter) are done at the next visit with consent. Grab rails and equipment are referred to OT or the family with a follow-up call. Hazards that cannot be fixed are noted with a risk mitigation (e.g. caregiver escorts on stairs).
AFTER	The Monitor reviewed 20 remediation logs: 85% of hazards closed within target; open items had

mitigations documented. Falls on documented hazards: 0 in six months. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Review your last 20 home assessments. How many hazards have been fixed?
2. Add a remediation log with owner and date to every assessment.
3. Fix simple things at the next visit.
4. Chase open items weekly.

The most common mistake: Documenting the hazard and filing the form — the rug is still there.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: Hazard remediation tracking record

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.*

Evidence: N/A — tested directly

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

Evidence: Remediation completion verification

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.

- **Verification happens through caregiver report but isn't independently confirmed for higher-risk hazards.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

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.

In plain terms: When a client falls, the home and the client are reassessed within days — what caused it, what has changed, what needs fixing — not just an incident report.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

A fall is a signal. Something changed: the client's balance, a new medication, a hazard that was not there before, a change in lighting or footwear. The fall tells you the current plan is not enough.

Reassessment means: within a defined time (72 hours), a structured review of the environment (3.1 repeated), the client's mobility and medications, the circumstances of the fall, and an updated plan with new actions. An incident report that records the fall and changes nothing invites the next one.

WHAT GOOD LOOKS LIKE

- A fall genuinely triggers a specific, structured reassessment.
- Reassessment genuinely covers both home environment and client risk factors.

COMMON FAILURE MODES

- A fall is treated as an isolated event, with no triggered reassessment.
- 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.

WORKED EXAMPLE

IN PRACTICE

A 150-client agency where falls were logged as incidents.

BEFORE	Falls were reported on an incident form and filed. No reassessment. A client fell three times in two months; each was logged; the cause — a new sedating medication — was never identified because nobody looked.
ACTION	A post-fall protocol was written: within 72 hours, the supervisor visits and completes a structured reassessment — home safety checklist repeated, mobility assessment, medication review with the GP, circumstances of the fall (time, location, activity, footwear), and an updated care plan with specific actions. Recurrent falls trigger a GP referral. Falls are trended monthly.
AFTER	The Monitor reviewed 15 post-fall reassessments with documented causes and actions; falls per client down 35%. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Pull your last ten falls. What was done after each?
2. Write a 72-hour post-fall reassessment protocol.
3. Include a medication review with the GP.
4. Update the care plan every time.

The most common mistake: Treating a fall as an incident to record rather than a signal to investigate.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: Post-fall reassessment record

2. Does reassessment genuinely cover both the home environment and the client's own risk factors? — *Complete reassessment of both, not one dimension alone.*

Evidence: N/A — tested directly

3. Does reassessment happen promptly after the fall, not delayed to a routine review? — *Real, prompt reassessment specifically triggered by the fall.*

Evidence: Reassessment timing record

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **Reassessment happens within a reasonable time but isn't specifically documented as fall-triggered, making the pattern harder to track over time.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Post-fall reassessment review	Reviews records for genuine, structured reassessment following a documented fall.
DOCUMENT	Reassessment scope review	Reviews whether reassessment genuinely covers both home environment and client risk factors.
DOCUMENT	Timing review	Reviews whether reassessment genuinely occurs promptly after the fall, not delayed.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

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.

In plain terms: The home is reassessed on a schedule — every six months, or when the client's condition changes — because homes and clients change.

Facility category	Crisis	Transition	Small	Standard
Applicability	N/A	Full	Adapted	Full

WHY THIS MATTERS

The client who could manage stairs six months ago cannot now. The family moved the furniture. The heating broke. A new pet arrived. The home assessed at intake is not the home today. A defined reassessment cycle — six months, and at any significant change in the client's condition or living situation — keeps the hazard list current. Caregivers are also trained to report changes between formal reassessments.

WHAT GOOD LOOKS LIKE

- The home environment is genuinely reassessed on a periodic, defined schedule.
- The caregiver's regular presence genuinely informs ongoing reassessment.
- Genuine changes are captured between scheduled reassessment points, not missed until the next formal check.

COMMON FAILURE MODES

- Reassessment is limited to the initial visit, never genuinely repeated.
- Periodic reassessment happens but doesn't draw on the caregiver's actual regular presence.
- Changes between scheduled reassessments go unnoticed until the next formal check.

WORKED EXAMPLE

IN PRACTICE

A 100-client agency with intake home assessments only.

BEFORE

Homes were assessed once. Clients served for years had assessments from their first week. A client's home had acquired a new hazard (a

	family member's exercise equipment in the hallway) that caused a fall eighteen months after the original assessment.
ACTION	A six-monthly home reassessment was scheduled for every client, with the full checklist, by the supervisor. Triggers for earlier reassessment were defined: hospital discharge, new diagnosis, mobility change, change in household, any fall. Caregivers report environmental changes on a simple form at any visit. The reassessment feeds the remediation log.
AFTER	The Monitor reviewed the reassessment schedule (no client overdue), 20 reassessments with new hazards identified and remediated, and caregiver change reports. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List every client and the date of their last home assessment.
2. Schedule a reassessment for anyone over six months.
3. Define change triggers.
4. Give caregivers a form to report changes.

The most common mistake: An intake assessment treated as permanent — the home changes.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: Periodic reassessment schedule documentation

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.*

Evidence: N/A — tested directly

3. Is a genuine change in the home's condition captured between scheduled reassessments? — *Real, ongoing attentiveness, not hazard*

recognition limited to formal points.

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **Reassessment documentation exists but isn't compared against the initial assessment to identify what's genuinely changed.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

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

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

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.

In plain terms: There is a confirmed plan for how an ambulance crew would get into the home if the client cannot open the door — a key safe, a neighbour, a code — tested and recorded.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

The client collapses. The caregiver, or the alarm service, calls an ambulance. The ambulance arrives at a locked door. The client is inside, unconscious. Minutes are lost forcing entry, or the crew leaves. A confirmed access plan — a key safe with the code recorded for emergency services, a neighbour with a key who is home, a family member within minutes — is checked at intake, recorded in the file and with the emergency alarm service, and tested. 'The client always answers the door' is not a plan.

WHAT GOOD LOOKS LIKE

- A genuine, specific emergency access plan exists for the home.
- The plan is genuinely known and confirmed with client, family, and caregiver.
- The arrangement is genuinely verified as functional, not assumed to work.

COMMON FAILURE MODES

- No specific access plan exists beyond an assumption responders will manage.
- The plan exists on paper but relevant parties aren't genuinely aware of it.
- The arrangement's functionality has never been verified.

WORKED EXAMPLE

IN PRACTICE

A 120-client agency serving many clients living alone.

BEFORE

Emergency access was not addressed. A client with a personal alarm pressed it after a fall; the ambulance arrived; the door was locked; the client was inside for 40 minutes while the crew arranged forced entry. The agency had no record of how emergency services could enter.

ACTION

Emergency access became an intake item: for each client living alone, an access method is agreed (key safe installed by the agency with the code registered with the alarm service and emergency services where the jurisdiction permits; or a named nearby keyholder with confirmed availability; or a door code). The method is recorded in the care plan and on the

	emergency contact card. It is tested at intake and checked at each reassessment.
AFTER	The Monitor reviewed 20 care plans with confirmed access methods, the key safe register, and test records. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. For every client living alone, ask: how would an ambulance get in if you could not open the door?
2. Install key safes where needed and register the codes.
3. Record the method in the care plan.
4. Test it.

The most common mistake: Assuming the client will open the door — the emergency is when they cannot.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: Emergency access plan documentation

2. Is this plan genuinely known to the client, family, and caregiver? — *Real, confirmed awareness, not a plan that exists only on paper.*

Evidence: N/A — tested directly

3. Is the access arrangement genuinely verified as functional? — *Real, verified functionality, not an assumption it would work when needed.*

Evidence: Access arrangement verification

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.

- **A plan exists for the primary caregiver's shifts but isn't consistently communicated to a covering or substitute caregiver.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

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

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

← **Home Care Standards —
all standards**

**Self-assess against these
criteria →**

← **Standard 2 — Caregiver
Screening & Background
Verification**

**Standard 4 — Medication
Management & Family
Coordination →**

© 2026 Accréditation Sans Frontières · PHIG · Sheni Network

ASF STANDARDS · HOME CARE · STANDARD 4

Standard 4 — Medication Management & Family Coordination

5 criteria · 4 non-negotiable · 1 core · Version 3.0

CRITERIA IN THIS STANDARD

4.1 — Medication Reminders and Administration Are Genuinely Distinguished

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

4.3 — A Medication Change or Care Transition Triggers Structured Review

4.4 — Medications Belonging to Different Household Members Are Distinguished and Secured

4.5 — A Missed or Uncertain Dose Is Actively Followed Up

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.

In plain terms: The agency is clear about the difference between reminding a client to take their medication (which a care worker can do) and administering it (which needs clinical training) — and each caregiver knows which they are allowed to do.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

A care worker saying 'it's time for your tablets' and watching the client take them is a reminder. A care worker opening the packet, selecting the dose, and putting it in the client's mouth is administration — a clinical act that requires training, competency assessment, and in many jurisdictions a specific qualification. Blurring the line means untrained staff administering medications, with errors nobody is qualified to catch. The care plan states which level each client needs; the caregiver assigned is qualified for that level; a care worker who reminds does not administer, even when the client asks.

WHAT GOOD LOOKS LIKE

- The service genuinely, clearly distinguishes reminders from administration.
- Non-clinical caregivers are specifically trained on this real boundary.
- A real process identifies when needs exceed a non-clinical caregiver's scope.

COMMON FAILURE MODES

- Reminders and administration are conflated, with no genuine distinction in practice.
- Caregivers aren't specifically trained on this boundary, relying on general awareness.
- Caregivers continue performing tasks genuinely beyond their scope without escalation.

WORKED EXAMPLE

IN PRACTICE

A 150-client agency where caregivers 'helped with medications' without definition.

BEFORE

Care workers with no clinical training were selecting doses from bottles, crushing tablets,

and applying prescribed creams. The care plan said 'assist with medication.' A care worker gave a client a double dose of a blood thinner from a confusing bottle; the client was hospitalised.

ACTION

A medication support policy was written with three levels: prompting/reminding (any trained care worker); assisting from a pharmacy-filled dosette box (care workers with medication support training and competency); administering (registered nurses or care workers with a recognised administration qualification, competency-assessed). Each client's care plan specifies the level. Caregivers are assigned accordingly. Dosette boxes replaced loose bottles for all clients at the assisting level.

AFTER

The Monitor reviewed the policy, 20 care plans with medication level specified, caregiver competency records matching assignments, and the dosette box roll-out. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask five caregivers what they actually do with clients' medications.
2. Define three levels: remind, assist from dosette, administer.
3. Specify the level in every care plan.
4. Assign only qualified caregivers to each level.

The most common mistake: Calling dose selection 'assistance' — if the caregiver chooses what goes in the client's mouth, that is administration.

SELF-ASSESSMENT QUESTIONS

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.*
Evidence: Scope of practice policy documentation
2. Are non-clinical caregivers specifically trained on this real medication boundary? — *Real, specific training, not general awareness*

assumed sufficient.

Evidence: Caregiver scope training record

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.*

Evidence: Scope escalation process

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **Escalation happens for entirely new medication needs but not consistently when an existing arrangement quietly becomes more complex.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

Method	What	Detail
OBSERVE	Task observation	Observes an actual medication-related interaction to confirm the caregiver's role genuinely matches their actual scope.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

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.

In plain terms: There is one current medication list for each client, shared with everyone involved — caregivers, family, GP, pharmacy — so nobody is working from a different version.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Adapted	Full

WHY THIS MATTERS

The GP changed the dose last week. The pharmacy still dispenses the old one. The daughter bought an over-the-counter painkiller. The caregiver has a list from three months ago. Four people, four lists, one client taking something wrong. A single current list — maintained by the agency, updated at every change, shared with all parties, in the client's home — is the only defence. It includes everything: prescribed, over-the-counter, supplements. It is dated. Everyone works from it.

WHAT GOOD LOOKS LIKE

- A single, genuinely current medication list is actively shared across everyone involved.
- The list is genuinely updated promptly when a medication changes.
- All parties genuinely know this list exists and how to access it.

COMMON FAILURE MODES

- Multiple parties maintain separate lists, with no single shared, current source.
- The list becomes outdated, updated only periodically rather than promptly.
- Some parties don't know a shared list exists or how to find it.

WORKED EXAMPLE

IN PRACTICE

A 100-client agency where medication lists were in the care plan at intake and rarely updated.

BEFORE

Lists were months out of date. A client's diuretic had been stopped by the GP but was still on the agency's list; the caregiver continued to prompt it from the old supply. The family did not know the GP's change either.

ACTION

A single medication list template was adopted: kept in the client's home in a folder, with a copy in the agency record; updated by the supervisor at any change (GP, hospital discharge, pharmacy, family report); dated and initialled; shared with the GP and pharmacy at each update. Caregivers check the list at every medication support visit. A monthly reconciliation with the pharmacy's dispensing record catches discrepancies.

AFTER

The Monitor checked five clients' home lists against agency records and pharmacy records: all matched and dated within the month. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Pick five clients and compare the agency's medication list to what is actually in their home.
2. Create one list per client kept in the home.
3. Update it at every change and share with the GP and pharmacy.
4. Reconcile monthly with the pharmacy.

The most common mistake: Four lists in four places — the client takes whatever the least current one says.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: Shared medication list documentation

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.*

Evidence: N/A — tested directly

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.

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **Awareness of the shared list is strong among regular caregivers but weaker among occasional or covering staff.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

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

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

[ASF training courses on GMJ Academy](#) →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

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.

In plain terms: Any medication change, hospital discharge, new prescriber, or change of caregiver triggers a structured review of the client's medications — not assumed to sort itself out.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Transitions are where medication errors concentrate. The hospital discharged the client on a new list that duplicates what the GP prescribed. A new caregiver does not know the client's routine. A specialist added a drug that interacts with an existing one. Each transition needs a structured review: the medication list reconciled against the new information, discrepancies resolved with the prescriber, the care plan updated, the caregiver briefed. Defined triggers, a defined process, a defined person — within 48 hours of the transition.

WHAT GOOD LOOKS LIKE

- A medication change or care transition genuinely triggers structured review.
- The review genuinely confirms the current list and checks for confusing instructions.
- Caregiver understanding of the new regimen is genuinely verified.

COMMON FAILURE MODES

- Changes are folded into routine care without any dedicated, structured review.
- The review, if any, doesn't specifically confirm the list or check for confusion.
- Caregiver understanding is assumed, never actually verified.

WORKED EXAMPLE

IN PRACTICE

A 120-client agency with frequent hospital discharges.

BEFORE

Hospital discharges were followed by resumed care. The discharge medication list was not reconciled against the agency's list. A client returned from hospital with a new anticoagulant and continued her old one too; both were on different lists. She bled.

ACTION

A transition medication review was written: triggered by hospital discharge, any new prescription, new prescriber, or caregiver change; within 48 hours, the supervisor (a nurse) reconciles the medication list against the new information, resolves discrepancies with the prescriber, updates the single list (4.2), and briefs the caregiver. The review is documented.

	Discharge summaries are requested from every hospital admission.
AFTER	The Monitor reviewed 20 transition reviews with reconciliation documented and 6 discrepancies resolved. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List your last ten hospital discharges. Was the medication list reconciled?
2. Define the transition triggers.
3. Assign a nurse to reconcile within 48 hours.
4. Brief the caregiver every time.

The most common mistake: Resuming care after hospital discharge with the old medication list.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: Structured review trigger documentation

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.*

Evidence: N/A — tested directly

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.*

Evidence: Caregiver understanding verification

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.

- **Verification happens through a brief check-in but isn't specific enough to confirm genuine, detailed understanding.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

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.

In plain terms: In a home with more than one person's medications, each person's are kept separately, labelled, and secure — the client's cannot be mixed up with a spouse's or taken by a grandchild.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

A couple both on heart medications, in the same drawer, with similar packaging. A grandchild who finds the client's opioids. A client with dementia who takes her husband's tablets. Household medications are a mix-up and diversion risk that hospitals do not have. The agency's role: at the home assessment, identify all medications in the home; ensure the client's are separated, labelled, and stored securely (locked if there are children, cognitive impairment, or controlled drugs); advise the household on the others; record the arrangement.

WHAT GOOD LOOKS LIKE

- Medications for different household members are genuinely, physically separated.
- Storage is genuinely secure, with real restricted access.
- The household's specific risk for this error type has been genuinely assessed.

COMMON FAILURE MODES

- Medications for different people are commingled without genuine separation.
- Storage is separated but not genuinely secure or access-restricted.
- This specific risk was never assessed for this particular household.

WORKED EXAMPLE

IN PRACTICE

A 100-client agency serving many clients in multi-generational households.

BEFORE

Medication storage was not assessed. A client's warfarin was in a kitchen cupboard with her husband's similar-looking tablets; she took his by mistake. A grandchild accessed a client's morphine. No guidance was given to families.

ACTION

Medication storage was added to the home safety checklist (3.1): all medications in the home identified; the client's separated into a labelled container; controlled drugs and any medications in homes with children or cognitively impaired residents stored in a lockable box (provided by the agency); the family advised on their own storage; the arrangement recorded. Checked at every reassessment.

AFTER

The Monitor visited five homes: client medications separated, labelled, and secured as recorded. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Add medication storage to the home assessment.
2. Separate and label each client's medications.

3. Provide lockable boxes where children, dementia, or controlled drugs are present.
4. Check at every reassessment.

The most common mistake: Not noticing that the client's tablets and the spouse's are in the same drawer.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: Medication storage arrangement documentation

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.*

Evidence: N/A — tested directly

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.*

Evidence: Household medication risk assessment

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **Assessment happened at initial care setup but hasn't been reconfirmed as household composition or medications have changed.**

IMPLEMENTATION PLAN

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

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

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.

In plain terms: When a dose is missed, or nobody is sure whether it was taken, someone follows up that day — not left as a blank on the chart.

Facility category	Crisis	Transition	Small	Standard
Applicability	N/A	Full	Adapted	Full

WHY THIS MATTERS

The caregiver arrives to find the morning tablets still in the dosette. Did the client take yesterday's? The chart has a gap. A missed dose of insulin, an anticoagulant, an anti-epileptic, a heart medication, matters — and an uncertain dose is worse, because the choice is between a double dose and a missed one. Follow-up means: the caregiver reports it immediately; the supervisor or nurse decides (call the GP, call the pharmacy, give or skip per protocol); the decision is recorded; the pattern is reviewed. Gaps on the chart are questions, not blanks.

WHAT GOOD LOOKS LIKE

- A missed or uncertain dose genuinely receives active, specific follow-up.
- A real, defined process guides what to do when a dose is missed.
- Recurring missed doses are genuinely reviewed for a broader pattern.

COMMON FAILURE MODES

- A missed dose is noted but receives no genuine, resulting follow-up.
- Handling varies inconsistently, without a defined process.
- Recurring missed doses are treated as isolated incidents each time, missing the pattern.

WORKED EXAMPLE

IN PRACTICE

A 150-client agency where missed doses were noted on the chart and nothing else.

BEFORE

Charts had gaps. Nobody followed up. A client on anti-epileptics missed three doses over a week with no one noticing the pattern; she had a seizure. Caregivers did not know what to do about an uncertain dose.

ACTION

A missed-dose protocol was written: any missed or uncertain dose is reported to the supervisor by phone before the caregiver leaves; the supervisor consults the medication protocol or the GP and instructs (give, skip, seek advice); the decision is recorded; the chart is reviewed weekly for patterns; recurrent misses trigger a care plan review (more visits, a compliance aid, a GP review). High-risk medications are flagged for same-hour follow-up.

AFTER

The Monitor reviewed 25 missed-dose reports with same-day decisions documented and two pattern reviews leading to care plan changes. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Review last month's medication charts for gaps. What happened after each?
2. Write the protocol: report before leaving, supervisor decides, record.
3. Flag high-risk medications for same-hour follow-up.
4. Review charts weekly for patterns.

The most common mistake: A blank on the chart that nobody asks about.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: Missed dose follow-up record

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.*

Evidence: Missed dose response protocol

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.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **Individual incidents are followed up but aren't reviewed collectively to identify a genuine, recurring pattern.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Follow-up record review	Reviews evidence of genuine, active follow-up on missed or uncertain doses.
DOCUMENT	Response protocol review	Reviews the specific, defined process for handling a missed dose.
DOCUMENT	Pattern review	Reviews whether recurring missed doses are genuinely examined for a broader pattern.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

← **Home Care Standards — all standards**

Self-assess against these criteria →

← **Standard 3 — Home Environment Safety Assessment**

**Standard 5 — Caregiver
Safety in an Uncontrolled
Environment →**

© 2026 Accréditation Sans Frontières · PHIG · Sheni Network

ASF STANDARDS · HOME CARE · STANDARD 5

Standard 5 — Caregiver Safety in an Uncontrolled Environment

5 criteria · 3 non-negotiable · 2 core · Version 3.0

CRITERIA IN THIS STANDARD

- 5.1 — A Genuine Risk Assessment of the Home Occurs Before the First Visit
- 5.2 — A Workplace Violence Prevention Program Exists, Adapted for the Home Setting
- 5.3 — The Caregiver Has a Genuine Way to Signal Distress Discreetly
- 5.4 — Hostile Animals and Environmental Hazards Are Specifically Assessed
- 5.5 — Near-Misses Are Actively Reported and Used to Update Risk Assessments

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.

In plain terms: Before the first visit, someone assesses the risk to the caregiver — who else lives there, pets, known behaviours, the neighbourhood, access at night — and the caregiver is told.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Adapted	Full

WHY THIS MATTERS

The caregiver walks alone into a home they have never seen, with people they have never met. The client's son with a history of violence. The dog that bites. The neighbourhood where cars are broken into. The stairs with no light. The agency owes the caregiver knowledge before the door. A risk assessment — done at intake, from the referral, the family, the initial visit by a supervisor — identifies risks to the worker and the measures (two-person visits, daytime only, a specific approach to the dog, a code word). It is shared with every caregiver assigned and updated when things change.

WHAT GOOD LOOKS LIKE

- A genuine risk assessment occurs before every caregiver's first visit.
- The assessment specifically covers household members, pets, and environmental hazards.
- Caregivers are genuinely briefed on identified risks before arriving.

COMMON FAILURE MODES

- No advance assessment occurs; caregivers discover risks upon arrival.
- The assessment misses key categories like household members or pets.
- Risks are identified but never actually communicated to the caregiver.

WORKED EXAMPLE

IN PRACTICE

A 120-client agency that assessed clients but not risks to caregivers.

BEFORE

Caregivers were sent to new clients with an address and a care plan. One was bitten by an unmentioned dog. One was threatened by a client's intoxicated son who had not been

	mentioned. The agency knew of the son from the referral; the caregiver did not.
ACTION	A caregiver risk assessment was added to intake: household members and any known concerns, pets and their behaviour, substance use in the home, neighbourhood and parking, access and lighting, previous incidents with other providers. Risks are rated; controls are specified (two-person visits, daytime only, pet secured before entry, supervisor escort for the first visit). The assessment is in the care plan and read by every assigned caregiver before their first visit.
AFTER	The Monitor reviewed 20 caregiver risk assessments with rated risks and controls, and interviewed two caregivers who described reading them before first visits. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask five caregivers what they knew about the home before their first visit.
2. Add a caregiver risk assessment to intake.
3. Specify controls for each risk.
4. Require caregivers to read it before the first visit.

The most common mistake: Sending a caregiver to a home the agency knows has risks without telling them.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: Pre-visit home risk assessment documentation

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.*

Evidence: N/A — tested directly

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.*

Evidence: Caregiver briefing record

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **Briefing happens verbally but isn't documented in a way that's genuinely verifiable later.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Pre-visit assessment review	Reviews the actual, documented risk assessment conducted before a caregiver's first visit.
DOCUMENT	Coverage completeness review	Reviews whether the assessment genuinely covers household members, pets, and environmental hazards.

Method	What	Detail
ASK	Caregiver briefing interview	Asks a caregiver whether they were genuinely briefed on identified risks before their first visit.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

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.

In plain terms: There is a workplace violence prevention programme designed for caregivers working alone in homes — assessment, de-escalation training, a way to leave, a way to call for help, and a rule that no one has to stay.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Adapted	Full

WHY THIS MATTERS

Home care workers experience violence — from clients, family members, others in the home — at high rates, alone, unwitnessed. A prevention programme adapted to the home setting is different from a facility's: risk assessment per client (5.1); training in recognising escalation and de-escalating; the explicit right to leave any situation that feels unsafe, without penalty; a discreet distress signal (5.3); check-in systems for lone workers; a post-incident response. The programme is written, trained, and reviewed. Caregivers must believe the agency will back them if they leave.

WHAT GOOD LOOKS LIKE

- A genuine, home-care-adapted workplace violence prevention program exists.
- The program genuinely addresses the caregiver's real, lone-worker condition.
- Caregivers are specifically trained on this program, not general safety awareness alone.

COMMON FAILURE MODES

- No violence prevention program exists, or a generic facility-based one is applied unadapted.
- The program doesn't genuinely address the caregiver's lone-worker reality.
- Caregivers rely on general safety awareness, without specific program training.

WORKED EXAMPLE

IN PRACTICE

A 150-client agency with a generic violence policy.

BEFORE

The policy said 'report incidents to your manager.'
No training, no lone-worker check-in, no explicit right to leave. Caregivers had stayed in

	threatening situations because they feared being blamed for an incomplete visit. Incidents were under-reported.
ACTION	A home care violence prevention programme was written: risk assessment per client; half-day de-escalation training for all caregivers; a written right to leave any unsafe situation without penalty, signed by the director; a lone-worker check-in app; a discreet distress signal (5.3); a post-incident support and review process; a monthly review of incidents and near-misses. Caregivers were told the programme at a team meeting and given a card.
AFTER	The Monitor reviewed the programme, training records (95%), the check-in app deployment, and the incident log (reports up 300% with better reporting; injuries down). Interviewed two caregivers who described leaving a situation with the agency's full support. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask five caregivers when they last felt unsafe and what they did.
2. Write the right to leave, signed by the director.
3. Train de-escalation.
4. Deploy a lone-worker check-in.

The most common mistake: Caregivers staying in unsafe situations because they think an incomplete visit will be held against them.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: Workplace violence prevention program documentation

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.*

Evidence: N/A — tested directly

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.*

Evidence: Caregiver violence prevention training record

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **The program exists but hasn't been reviewed since first developed, potentially missing changes in known risk patterns.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Program documentation review	Reviews the actual workplace violence prevention program for genuine home-care-specific adaptation.

Method	What	Detail
DOCUMENT	Lone-worker adaptation review	Reviews whether the program genuinely addresses the reality of a caregiver working alone.
DOCUMENT	Caregiver training review	Reviews training records confirming caregivers are specifically trained on this program.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

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.

In plain terms: The caregiver has a discreet way to signal that they need help during a visit — a code phrase to the office, a button on an app — without alerting the person who is threatening them.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Adapted	Full

WHY THIS MATTERS

A caregiver being threatened by a client's relative cannot say 'I'm calling the police' — that escalates. They need a way to summon help that looks like something else: a code phrase in a routine call ('can you check the Tuesday schedule?'), a duress button on a lone-worker app, a text shortcut. The office knows what it means and acts: calls back, sends someone, calls emergency services. The signal is agreed, trained, and tested. Every caregiver knows it. It has been practised.

WHAT GOOD LOOKS LIKE

- A genuine, discreet signaling mechanism exists and is practical to use.
- Caregivers are genuinely familiar with and have practiced using it.
- A real, defined response follows when the signal is triggered.

COMMON FAILURE MODES

- No discreet option exists beyond openly announcing distress.
- Caregivers know a mechanism exists in policy but haven't genuinely practiced using it.
- A triggered signal has no defined, resulting response.

WORKED EXAMPLE

IN PRACTICE

A 120-client agency where caregivers could only call the office openly.

BEFORE

A caregiver cornered by a client's aggressive son could not make a call without escalating the

	situation. She waited until he left. The agency had no discreet signal.
ACTION	A duress protocol was implemented: a lone-worker app with a silent duress button that opens a line to the office and shares location; a backup code phrase for a voice call ('I need to check the blue folder'); the office response (call back on a pretext, dispatch a supervisor, call police if no response); quarterly practice with each caregiver. Every caregiver carries a card with the code phrase.
AFTER	The Monitor reviewed the app deployment (100% of caregivers), the code phrase protocol, and three practice drills. Asked two caregivers the code phrase; both knew it. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Agree a code phrase and tell every caregiver.
2. Define exactly what the office does when it hears it.
3. Deploy a duress app if you can.
4. Practise quarterly.

The most common mistake: Assuming a caregiver can just call for help — in a threatening situation, an open call makes it worse.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: Discreet signaling mechanism documentation

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.*

Evidence: Caregiver mechanism familiarity record

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.

Evidence: Signal response protocol

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **A response protocol exists but hasn't been specifically tested to confirm it actually triggers a timely, real response.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Signaling mechanism review	Reviews the actual, documented discreet signaling mechanism available to caregivers.
ASK	Caregiver familiarity interview	Asks a caregiver to describe how they would use this mechanism in a real situation.
DOCUMENT	Response protocol review	Reviews the defined response process for when this signal is triggered.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

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.

In plain terms: Aggressive animals, unsafe stairs, exposed wiring, hoarding, smoking around oxygen — the hazards specific to working in someone's home — are assessed and controlled for each client.

Facility category	Crisis	Transition	Small	Standard
Applicability	N/A	Full	Adapted	Full

WHY THIS MATTERS

A hospital does not have a dog that bites, a hoarded flat with no floor space, a client who smokes next to their oxygen concentrator, or a rotten step at the back door. Home care does. These hazards injure caregivers and clients. The caregiver risk assessment (5.1) must specifically cover them: animals (behaviour, secured before entry), environmental hazards (structure, electrical, fire, hoarding, hygiene), and the controls (client agrees to secure the dog; agency provides a step or refuses the route; fire safety intervention for oxygen and smoking). Each is recorded and each caregiver knows.

WHAT GOOD LOOKS LIKE

- Hostile animal risk is genuinely, specifically assessed for each home.
- Other environmental hazards are genuinely, comprehensively assessed.
- An identified hazard genuinely leads to a specific, resulting accommodation.

COMMON FAILURE MODES

- Animal risk is overlooked or treated as a lesser concern.
- Environmental hazard assessment is generic or incomplete.
- An identified hazard is documented but leads to no genuine, resulting action.

WORKED EXAMPLE

IN PRACTICE

A 100-client agency where environmental hazards were noted informally.

BEFORE

A caregiver was bitten by a client's dog that 'was usually fine.' Another slipped on a rotten step. A client smoked while using oxygen; caregivers were uncomfortable but nothing was done. None of this was in any assessment.

ACTION

The caregiver risk assessment gained a specific section: animals (species, behaviour, secured before entry — agreed with the client as a condition of service), structural hazards, electrical, fire risks (smoking, oxygen, heating), hoarding, hygiene. Controls are specified and are conditions of service where safety requires (dog

in another room during visits; no smoking during visits with oxygen present; a fire service referral). The section is reviewed at every reassessment.

AFTER

The Monitor reviewed 20 assessments with the hazard section completed and controls specified; two showed conditions of service applied. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask caregivers about animals and hazards they have encountered.
2. Add a specific hazard section to the caregiver risk assessment.
3. Make securing animals a condition of service.
4. Refer oxygen-and-smoking homes to the fire service.

The most common mistake: Trusting the client that the dog is friendly.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: Animal risk assessment documentation

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.*

Evidence: N/A — tested directly

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.*

Evidence: Hazard accommodation record

COMMON REASONS FOR A PARTIAL ANSWER

- **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.

- **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.
- **Hazards are identified but the resulting accommodation is informal, not consistently documented as a specific response.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Animal risk assessment review	Reviews whether hostile animal risk is specifically, genuinely assessed for each home.
DOCUMENT	Environmental hazard review	Reviews whether other environmental hazards are specifically, comprehensively assessed.
DOCUMENT	Accommodation review	Reviews whether an identified hazard genuinely leads to a specific, resulting accommodation.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

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.

In plain terms: Caregivers report near-misses — the situation that almost went wrong — and the agency uses them to update the risk assessment for that client.

Facility category	Crisis	Transition	Small	Standard
Applicability	N/A	Full	Adapted	Full

WHY THIS MATTERS

The dog lunged but did not bite. The son was drunk but did not threaten. The step gave slightly but held. Each is a warning about the next visit. Near-misses are free intelligence if caregivers report them and the agency acts: the client's risk assessment is updated, controls are added, other caregivers are told. If near-misses are not reported — because reporting is hard, or seems pointless, or feels like complaining — the agency learns only from injuries.

WHAT GOOD LOOKS LIKE

COMMON FAILURE MODES

- Caregivers are genuinely encouraged and supported to report near-misses.
- Reported near-misses genuinely lead to updated risk assessments.
- Near-miss reports are genuinely reviewed for broader patterns.

- Near-misses go unreported, with no active encouragement or supportive culture.
- Reports are filed without any genuine, resulting update to risk assessments.
- Reports are treated only as isolated incidents, missing broader patterns.

WORKED EXAMPLE

IN PRACTICE

A 150-client agency with incident reporting for injuries only.

BEFORE	No near-miss reporting. Caregivers mentioned close calls to each other but not to the office. A dog that had lunged at two caregivers bit a third. Nobody had connected the warnings.
ACTION	A near-miss report was introduced: one screen on the caregiver app, 30 seconds, no blame. Every report is reviewed by the supervisor within 24 hours; the client's risk assessment is updated; assigned caregivers are notified. Near-misses are reviewed monthly for patterns. Caregivers who report are thanked publicly.
AFTER	The Monitor reviewed 40 near-miss reports in three months, each with a risk assessment update, and the monthly pattern review. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask caregivers about close calls in the last month. Were any reported?
2. Add a 30-second near-miss report to the app or a card.
3. Update the client's risk assessment for every one.
4. Thank reporters.

The most common mistake: Learning about the dog after the bite.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: Near-miss reporting process documentation

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.*

Evidence: Risk assessment update record

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.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **A reporting process exists but caregivers report some hesitation about whether reporting could reflect poorly on them.**

IMPLEMENTATION PLAN

When	What
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.

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

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Reporting process review	Reviews the specific, active process encouraging caregivers to report near-misses.
DOCUMENT	Risk assessment update review	Reviews evidence that near-miss reports genuinely lead to updated risk assessments.
DOCUMENT	Pattern review	Reviews whether near-miss reports are genuinely examined collectively for broader patterns.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

← **Home Care Standards — all standards**

Self-assess against these criteria →

← **Standard 4 — Medication
Management & Family
Coordination**

**Standard 6 — Care Plan
Development & Ongoing
Supervision** →

© 2026 **Accréditation Sans Frontières · PHIG · Sheni Network**