

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 6

Standard 6 — Care Plan Development & Ongoing Supervision

6 criteria · 5 non-negotiable · 1 core · Version 4.0

CRITERIA IN THIS STANDARD

- 6.1 — Supervisory Visits Occur Genuinely On-Site
- 6.2 — Personal Care Supervision Includes Genuinely Observing the Aide Providing Care
- 6.3 — Supervision Documentation Captures Objective, Measurable Observations
- 6.4 — A Change in Client Needs Triggers Genuine Care Plan Review
- 6.5 — An Identified Deficiency Leads to Genuine Retraining and Re-Evaluation
- 6.6 — The Initial Comprehensive Assessment Actually Builds the Care Plan

6.1 Supervisory Visits Occur Genuinely On-Site

NON-NEGOTIABLE

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

In plain terms: Supervisors visit clients in their homes, in person, on a schedule that matches the level of care — not by phone, not 'when they can.'

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Adapted	Full

WHY THIS MATTERS

Home care is invisible unless someone goes and looks. A supervisor who checks by phone hears what the caregiver and client say; a supervisor who visits sees the client's condition, the home, the care being given, and the things nobody mentions. The schedule must match the care: monthly for personal care and complex clients, less often for low-intensity domestic support, and always after a change. The visits happen, are documented, and are tracked — a client whose supervisory visit is overdue is a client nobody has seen.

WHAT GOOD LOOKS LIKE

- Supervisory visits genuinely occur on-site and in person.
- The interval is genuinely calculated by calendar days, not visit count.
- The schedule genuinely matches the actual level of care provided.

COMMON FAILURE MODES

- Phone check-ins are treated as equivalent to on-site supervisory visits.
- The interval is miscalculated as a count of visits rather than calendar days.
- A single generic schedule is applied regardless of the actual care level.

WORKED EXAMPLE

IN PRACTICE

A 150-client agency where supervisory contact was by phone.

BEFORE

Supervisors phoned clients monthly. In-person visits happened 'when there was a problem.' A client had lost 8 kg and her home had become unhygienic before anyone saw her. The caregiver had not mentioned it.

ACTION

An in-person supervisory visit schedule was set: monthly for personal care and complex clients,

quarterly for domestic support only, within two weeks of any change or complaint. Visits are logged with date and findings. The schedule is tracked; overdue visits are flagged weekly. Supervisor caseloads were adjusted to make it achievable.

AFTER	The Monitor reviewed the visit schedule (no client overdue), 30 visit records with findings, and the caseload adjustment. Verified.
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IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List every client and the date of their last in-person supervisory visit.
2. Set a schedule by care level.
3. Track it and flag overdue weekly.
4. Adjust supervisor caseloads if needed.

The most common mistake: Supervision by phone — you hear only what is said.

SELF-ASSESSMENT QUESTIONS

1. Do supervisory visits genuinely occur on-site and in person, not substituted by phone check-ins? — *Real, on-site, in-person visits, not a phone call treated as equivalent.*

Evidence: Supervisory visit record

2. Is the visit schedule genuinely based on calendar time, not miscounted as a number of caregiver visits? — *Real, correct calendar-interval tracking, not the documented, common miscount.*

Evidence: N/A — tested directly

3. Does the visit schedule genuinely match the actual level of care being provided? — *Real, care-type-appropriate scheduling, not a single generic interval applied to every situation.*

Evidence: Schedule-to-care-level matching documentation

COMMON REASONS FOR A PARTIAL ANSWER

- **On-site visits happen reliably but documentation doesn't clearly capture the exact calendar-day interval maintained.** — Clear,

specific documentation is what makes the interval genuinely verifiable, not assumed correct.

- **The correct interval is generally understood but a specific staff member's informal tracking occasionally miscounts it.** — Every person tracking this interval needs the same accurate, genuine understanding of calendar-day counting.
- **Scheduling is correct for the most common care type but hasn't been specifically reconfirmed for a less common arrangement.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current supervisory visit practice for genuine on-site occurrence and correct interval calculation.
Week 2	Correct any miscounted interval and retrain staff on calendar-day, not visit-count, tracking.
Week 3	Confirm the visit schedule genuinely matches the actual level of care for every client.
Ongoing	Audit interval calculation accuracy periodically.

HOW THE MONITOR VERIFIES THIS

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

SUPERVISOR TIPS

- **Ask staff to walk through how they calculate the supervisory visit interval for a specific, real client.** — A specific, accurate answer reveals genuine understanding of calendar-day calculation, not the common visit-count error.
- **Ask whether a phone check-in has ever been counted as satisfying this requirement.** — A direct question often surfaces informal practice a policy review wouldn't catch.

EVIDENCE BASE

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

[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.

6.2 Personal Care Supervision Includes Genuinely Observing the Aide Providing Care

NON-NEGOTIABLE

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

In plain terms: For personal care clients, the supervisor watches the caregiver actually giving care — a transfer, a wash, a meal — not just talks to the client afterward.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Adapted	Full

WHY THIS MATTERS

The only way to know whether a caregiver transfers safely, washes with dignity, or feeds a client patiently is to watch. A conversation with the client afterward tells you if they are unhappy enough to say so; it does not tell you if the transfer technique will injure them next month. Observation means the supervisor is present for a care task, uses a structured observation form, gives feedback, and records what was seen. It is the difference between supervision and a visit.

**WHAT GOOD LOOKS
LIKE**

**COMMON FAILURE
MODES**

- The caregiver is genuinely present and actively providing care during the visit.
- The visit is genuinely conducted by a registered nurse specifically.
- The visit genuinely occurs within the defined interval.

- The visit is conducted without the caregiver genuinely present.
- The visit is conducted by an unauthorized role.
- The visit occurs beyond the defined interval.

WORKED EXAMPLE

IN PRACTICE

A 100-client agency where supervisory visits were conversations.

BEFORE	Supervisors visited and talked with the client. Care was not observed. A caregiver had been using an unsafe transfer technique for months; the client had shoulder pain she attributed to age. Nobody had watched.
ACTION	Supervisory visits for personal care clients are now timed to coincide with a care task. The supervisor observes using a structured form: hand hygiene, communication, dignity, technique, safety, documentation. Feedback is given on the spot and recorded. Deficiencies trigger retraining (6.5). Each caregiver is observed at least quarterly.
AFTER	The Monitor reviewed 25 observation forms with structured findings and feedback; three showed technique corrections with follow-up. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Schedule the next supervisory visit for personal care clients during a care task.
2. Use a structured observation form.
3. Give feedback on the spot.
4. Observe every caregiver quarterly.

The most common mistake: Visiting the client after the caregiver has left — the care is already over.

SELF-ASSESSMENT QUESTIONS

1. Does the personal care supervisory visit genuinely include the caregiver actively present and providing care? — *Real, genuine presence and active observation, not a visit conducted in the caregiver's absence.*

Evidence: Personal care supervisory visit record

2. Is this visit genuinely conducted by a registered nurse specifically, not another staff type? — *Real, correct conductor of the visit, not substituted by an unauthorized role.*

Evidence: N/A — tested directly

3. Does the visit genuinely occur within the applicable defined interval, not exceeding it? — *Real, timely occurrence within the defined interval, not a lapse beyond it.*

Evidence: Visit timing record

COMMON REASONS FOR A PARTIAL ANSWER

- **Presence is generally arranged but scheduling occasionally results in the caregiver's shift ending just before the visit occurs.** — Genuine coordination of timing is what ensures the visit actually accomplishes its real purpose.
- **The correct conductor requirement is understood but not consistently confirmed before scheduling a specific visit.** — Confirming the conductor's qualification before scheduling prevents a visit from being genuinely non-compliant after the fact.
- **Visits generally occur within the interval but timing is occasionally close to the outer limit without margin.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current personal care supervisory visit practice for genuine caregiver presence and correct conductor.
Week 2	Establish scheduling coordination ensuring caregiver presence during the visit.
Week 3	Confirm every supervisory visit is genuinely conducted by a registered nurse.

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

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Presence verification	Confirms the caregiver was genuinely present and actively providing care during the supervisory visit.
DOCUMENT	Conductor verification	Reviews records confirming the visit was genuinely conducted by a registered nurse.
DOCUMENT	Timing review	Reviews whether the visit genuinely occurs within the applicable defined interval.

SUPERVISOR TIPS

- **Ask to see a real, recent supervisory visit record and confirm the caregiver's genuine presence.** — A real, specific record reveals genuine practice, not an assumption of compliance.
- **Ask who specifically conducts these visits and confirm this matches the required role.** — A specific, confident answer reveals genuine attention to this requirement, not assumed compliance.

EVIDENCE BASE

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

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.

6.3 Supervision Documentation Captures Objective, Measurable Observations

NON-NEGOTIABLE

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

In plain terms: Supervisory visit notes record specific, measurable things — what was observed, what the client said, what was checked — not 'client seems well, care satisfactory.'

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

'Care satisfactory' is an opinion. 'Client transferred with stand aid, technique correct; skin intact on inspection; weight 62 kg (61 last month); client states caregiver arrives on time; medication chart complete for the month; hallway rug removed as planned' is evidence. Objective documentation lets the next supervisor see change, lets an auditor verify, and lets the agency defend its supervision. A structured form with specific fields produces it; a blank box produces 'satisfactory.'

WHAT GOOD LOOKS LIKE

- Documentation genuinely captures objective, measurable observations.
- Documentation across visits genuinely allows real comparison over time.
- Staff are specifically trained on this objective documentation standard.

COMMON FAILURE MODES

- Documentation consists of vague, general statements providing no real information.
- Documentation across visits can't genuinely be compared to reveal change.
- Staff aren't specifically trained; vague documentation is the default.

WORKED EXAMPLE

IN PRACTICE

A 120-client agency whose supervisory notes were a paragraph of free text.

BEFORE	Notes read 'visited, client happy, no concerns.' The Coordinator reviewed 40 notes: no weights, no skin checks, no medication chart reviews, no environmental checks documented. A client's deterioration over four months was invisible in the notes.
ACTION	A structured supervisory visit form was introduced: client condition (weight, skin, mobility, mood — observed), care delivery (observed task, technique, documentation reviewed), environment (hazards checked, remediation status), client feedback (verbatim), caregiver feedback, actions. Every field is completed. The form is compared to the previous visit to identify change.
AFTER	The Monitor reviewed 30 structured forms with objective observations and identified changes. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Read your last ten supervisory notes. Could you tell whether the client is better or worse than last month?
2. Build a structured form with measurable fields.
3. Require every field.
4. Compare each visit to the last.

The most common mistake: 'No concerns' — the note that tells the next supervisor nothing.

SELF-ASSESSMENT QUESTIONS

1. Does supervisory documentation genuinely capture objective, measurable observations, not vague general statements? — *Real, specific, measurable content, not a vague reassurance that provides no comparable information.*

Evidence: Supervisory documentation sample

2. Can documentation from different visits genuinely be compared to identify a real change over time? — *Real, comparable documentation, not language too vague to reveal any actual change.*

Evidence: N/A — tested directly

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

Evidence: Documentation training record

COMMON REASONS FOR A PARTIAL ANSWER

- **Documentation is objective for physical observations but vague regarding cognitive or behavioral status.** — Every dimension of a client's real status deserves the same objective, measurable documentation standard.
- **Training addresses the general principle but doesn't specifically model what genuinely adequate documentation looks like.** — Concrete examples make an abstract documentation standard genuinely actionable in daily practice.
- **Documentation is generally objective but occasionally reverts to vague language during high-volume periods.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current supervisory documentation for genuine, objective, measurable content.
Week 2	Train staff specifically on this documentation standard with concrete examples.
Week 3	Establish documentation review to catch and correct vague language.
Ongoing	Confirm documentation quality holds during high-volume periods specifically.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Documentation quality review	Reviews a sample of actual supervisory documentation for genuine, objective, measurable content.

Method	What	Detail
DOCUMENT	Comparability review	Reviews whether documentation across different visits genuinely allows comparison over time.
DOCUMENT	Training review	Reviews training records confirming staff are specifically taught this documentation standard.

SUPERVISOR TIPS

- **Ask to see actual, real supervisory documentation for a specific client across two or more visits.** — A real, direct comparison reveals whether documentation genuinely allows tracking change over time.
- **Ask a staff member to explain what makes documentation genuinely objective, not just to confirm a policy exists.** — A specific, confident answer reveals genuine, internalized understanding, not assumed general competence.

EVIDENCE BASE

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

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.

6.4 A Change in Client Needs Triggers Genuine Care Plan Review

NON-NEGOTIABLE

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

needs that no longer accurately describe the client's real, current situation.

In plain terms: When a client's needs change — a service no longer needed, a new need, a family member taking over a task — the care plan is reviewed and updated, not left running on autopilot.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Adapted	Full

WHY THIS MATTERS

The client recovered from her hip replacement; the agency is still sending a caregiver to help her shower. The client's dementia progressed; the care plan still says 'independent with meals.' The daughter moved in and does the shopping; the agency still charges for it. Care plans drift from reality unless changes trigger review. Triggers: any change in condition, any change in household, any hospital episode, any client or family request, any caregiver observation of change. The review is documented and the plan updated within a defined time.

WHAT GOOD LOOKS LIKE

- A genuine change in client needs actively triggers care plan review.
- Responsibility for the plan is genuinely, clearly assigned when it shifts.
- The updated plan genuinely, completely reflects current needs.

COMMON FAILURE MODES

- Changed needs don't trigger any genuine plan review.
- Responsibility for the plan is ambiguous when circumstances shift.
- Updates are partial, leaving outdated elements alongside new ones.

WORKED EXAMPLE

IN PRACTICE

A 150-client agency with annual care plan reviews.

BEFORE

Plans were reviewed annually. Between reviews, care continued as planned regardless of change. A client whose needs had tripled after a stroke

	was receiving the same visits for five months. Another was receiving — and paying for — shopping her daughter now did.
ACTION	Change triggers were defined and caregivers trained to report them on a one-line form. Any trigger leads to a supervisor review within seven days, with the client and family, and a plan update. Six-monthly scheduled reviews continue. The number of triggered reviews is tracked as a quality measure.
AFTER	The Monitor reviewed 30 triggered reviews with documented changes and plan updates; median time from trigger to review 4 days. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask caregivers which clients' needs have changed since the plan was written.
2. Define triggers and give caregivers a one-line report form.
3. Review within seven days of any trigger.
4. Update the plan every time.

The most common mistake: A care plan written at intake, reviewed annually, and wrong for eleven months.

SELF-ASSESSMENT QUESTIONS

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

elements alongside new ones.

Evidence: Updated care plan review

COMMON REASONS FOR A PARTIAL ANSWER

- **Review is triggered for a major change like discontinued therapy but not consistently for a more gradual shift in need.** — A gradual change carries the same real risk of an increasingly inaccurate plan as an abrupt one.
- **Responsibility is understood generally but isn't specifically documented at the moment it actually transfers.** — Documented, specific assignment at the point of transfer prevents genuine ambiguity about current ownership.
- **Updates address the specific change but don't prompt a genuine review of the plan's other elements for continued accuracy.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current practice for genuine care plan review triggered by changed client needs.
Week 2	Establish clear, documented responsibility assignment at the point of any discipline transfer.
Week 3	Build a process ensuring complete, not partial, plan updates.
Ongoing	Extend review triggers to gradual, not only abrupt, changes in need.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Trigger review	Reviews evidence that a genuine change in client needs actively triggers care plan review.
DOCUMENT	Responsibility assignment review	Reviews whether responsibility for the plan is genuinely, clearly assigned when it shifts.
DOCUMENT	Update completeness review	Reviews whether the updated plan genuinely reflects current needs, not a partial revision.

SUPERVISOR TIPS

- **Ask for a real, recent example of a client whose needs changed and trace what happened to their care plan.** — A real, traceable example reveals genuine practice, not policy language alone.
- **Ask who currently owns responsibility for a specific client's plan and how that was determined.** — A specific, confident answer reveals genuine, clear assignment, not ambiguity.

EVIDENCE BASE

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

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.

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

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

In plain terms: When a supervisor sees a caregiver doing something wrong, the caregiver is retrained — specifically, documented — and observed again to confirm it has been fixed.

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

WHY THIS MATTERS

The supervisor observed a poor transfer technique. What happened next? If the answer is 'I mentioned it,' nothing changed. Retraining means: the specific deficiency named; specific training delivered (a demonstration, a course, a supervised practice); documented; and a re-observation within a defined time to confirm competence. If the deficiency persists, escalation. A supervision finding that leads nowhere is a finding the agency has decided to live with.

WHAT GOOD LOOKS LIKE

- Identified deficiencies genuinely lead to documented retraining.
- A genuine competency evaluation confirms resolution before independent care resumes.
- The evaluation is genuinely conducted with the supervisor present.

COMMON FAILURE MODES

- Deficiencies are noted without any genuine, resulting retraining.
- Independent care resumes without a genuine, confirming evaluation.
- Improvement is self-reported without genuine, supervised confirmation.

WORKED EXAMPLE

IN PRACTICE

A 100-client agency where supervision findings were noted but not followed up.

BEFORE

Observation forms recorded deficiencies. Nothing was done. A caregiver observed twice with poor hand hygiene continued unchanged. The Coordinator found 15 recorded deficiencies in six months with no documented retraining.

ACTION

A deficiency response process was written: any deficiency observed → specific retraining within two weeks (method documented) → re-observation within four weeks → competence confirmed or escalation (further training, restricted duties, capability process). Tracked in a register. Recurrent deficiencies across caregivers trigger a team-wide training update.

AFTER

The Monitor reviewed the register: 22 deficiencies, all with retraining and re-observation documented; 20 resolved, 2 escalated. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Review your last 20 observation forms. For every deficiency, what was done?
2. Write the process: retrain in two weeks, re-observe in four.
3. Track it in a register.
4. Escalate persistent deficiencies.

The most common mistake: Mentioning the problem to the caregiver and moving on.

SELF-ASSESSMENT QUESTIONS

1. Does an identified deficiency lead to genuine, documented retraining, not noted without resulting action? — *Real, specific retraining actually delivered, not a deficiency recorded without follow-through.*

Evidence: Retraining record

2. Does the caregiver genuinely undergo a subsequent competency evaluation before resuming independent care? — *Real, confirmed re-evaluation, not resumed independent care assumed safe without verification.*

Evidence: Post-retraining competency evaluation record

3. Is this evaluation genuinely conducted with the supervisor present, confirming the deficiency is actually resolved? — *Real, supervised, confirmed resolution, not self-reported improvement accepted without verification.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Retraining happens promptly for significant deficiencies but is delayed for more minor ones.** — Every genuine deficiency deserves the same prompt, real correction, regardless of apparent severity.
- **Re-evaluation happens but isn't consistently documented as specifically addressing the original deficient skill.** —

Documentation specifically tied to the original concern is what confirms genuine resolution, not general competency confirmation.

- **The process works well for skills-based deficiencies but is less clearly defined for a judgment or communication concern.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current deficiency response for genuine retraining and re-evaluation practice.
Week 2	Establish prompt retraining for every identified deficiency, regardless of apparent severity.
Week 3	Build documentation specifically tying re-evaluation to the original identified concern.
Ongoing	Extend clear process definition to judgment and communication concerns, not skills alone.

HOW THE MONITOR VERIFIES THIS

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

SUPERVISOR TIPS

- **Ask for a real, recent example of an identified deficiency and trace the full retraining and re-evaluation sequence.** — A real, traceable example reveals genuine follow-through, not policy language without practical application.
- **Ask how a judgment or communication-related deficiency would be specifically retrained and re-evaluated.** — A specific, thoughtful answer reveals whether the process genuinely extends beyond straightforward skills-based concerns.

EVIDENCE BASE

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

[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.

6.6 **The Initial Comprehensive Assessment Actually Builds the Care Plan**

NON-NEGOTIABLE

Before care begins, a qualified individual performs a genuine, comprehensive assessment of the client — not only the specific tasks requested — drawing in other relevant disciplines where the client’s needs call for it, and the resulting care plan states explicit goals the client, and family where appropriate, genuinely helped set, not a task list decided for them and only delivered.

In plain terms: Before a caregiver starts, someone qualified actually assesses the whole client — not just the list of chores requested — brings in a nurse or other specialist if needed, and together with the client sets a real goal for the care, not a task list drawn up and handed over.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A home care agency can supervise beautifully — genuine on-site visits, real observation, objective documentation, everything this standard’s other criteria require — and still have started from the wrong place, because nobody ever actually assessed the client comprehensively before writing the plan being supervised. A plan built only from the family’s phone call request (“we need help with bathing

and meals”) misses fall risk, medication complexity, cognitive status, and the client’s own priorities. The entire supervisory structure this standard builds exists to protect the integrity of a plan — but a plan assembled from an unqualified intake call, with no stated goal and no real client voice in shaping it, isn’t worth protecting as carefully as one built on a genuine comprehensive assessment.

WHAT GOOD LOOKS LIKE

- A qualified individual performs a genuine comprehensive assessment before care begins.
- Other relevant disciplines are drawn in when the client’s needs call for it.
- The care plan states explicit goals the client genuinely helped set.

COMMON FAILURE MODES

- The “assessment” is only an intake call logging the specific tasks requested.
- The assessment is completed by whoever is available, not someone verifiably qualified.
- The care plan lists tasks with no stated goal, decided without genuine client involvement.

WORKED EXAMPLE

IN PRACTICE

An agency whose intake process was a phone call logging requested tasks.

BEFORE

New clients were onboarded through a phone call with a scheduling coordinator, who logged the family’s requested tasks — bathing assistance, meal prep — into a care plan template. No clinical assessment occurred, no goal was ever documented, and the family’s own priorities beyond the task list were never discussed.

ACTION	The agency built a mandatory in-home comprehensive assessment visit, led by a qualified nurse supervisor, before any caregiver was assigned — covering fall risk, medication complexity, cognitive status, and the client's and family's own stated priorities, producing a documented goal (for example, remaining safely in the home for as long as possible) that shaped which tasks were actually prioritized.
AFTER	The Monitor reviewed a newly started client's file and found a genuine comprehensive assessment and a specific, client-involved goal, and the family could describe that goal in their own words. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check whether intake currently includes anything beyond logging requested tasks.
2. Build a mandatory comprehensive assessment visit led by a qualified individual.
3. Ask new clients and families directly what they want from the care, and document it as the goal.

The most common mistake: Treating the intake phone call — a list of requested tasks — as equivalent to a comprehensive assessment, when no qualified individual has actually evaluated the client or established a real goal behind the task list.

SELF-ASSESSMENT QUESTIONS

1. Does a qualified individual perform a genuine comprehensive assessment before care begins, not only a task checklist? — *A real, holistic evaluation of the client's needs, not only the specific tasks initially requested.*

Evidence: Comprehensive assessment record

2. Is the assessment performed by someone genuinely qualified to perform it, with other relevant disciplines drawn in where the client's needs call for it? — *A named, qualified assessor — a nurse or qualified supervisor, not the caregiver alone — with real referral when complexity*

warrants it.

Evidence: Assessor qualification record

3. Does the resulting care plan state explicit goals, and was the client, and family where appropriate, genuinely involved in setting them? — *A real, stated goal and genuine involvement, not a task list decided for the client and only delivered.*

Evidence: Care plan goal documentation and family interview

COMMON REASONS FOR A PARTIAL ANSWER

- **A comprehensive assessment happens but produces no explicitly stated goal.** — Gathering information isn't the same as using it to set a real direction for the care.
- **A goal is documented but reflects the agency's standard language, not a genuinely client-specific one.** — Genuine involvement means the client's own priorities shape the goal, not a generic phrase applied to every client.
- **The assessment happens for complex clients but is skipped for seemingly straightforward requests.**

IMPLEMENTATION PLAN

When	What
Week 1	Review whether intake currently includes a genuine comprehensive assessment.
Week 2	Build a mandatory comprehensive assessment visit led by a qualified individual.
Week 3	Build a genuine goal-setting conversation into that assessment.
Ongoing	Audit that every new client has a documented, client-involved goal.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Comprehensive assessment review	Reviews a new client's file for a genuine comprehensive assessment and stated goal, not only a task list.
ASK	Client or family interview	Asks a client or family member to describe the stated goal behind the care plan.

SUPERVISOR TIPS

- **Pick a recent client's file and ask for the one place that states their care goal.** — If no such place exists, the comprehensive assessment hasn't produced its intended result.
- **Ask the family what the agency is working toward with them, beyond the task list.** — Genuine involvement shows in whether the family can describe their own goal.

EVIDENCE BASE

World Health Organization. Integrated Care for Older People (ICOPE) Guidelines. Geneva: WHO; 2019.

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 5 — Caregiver Safety in an Uncontrolled Environment**

Standard 7 — Governance & Staffing →

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Standard 7 — Governance & Staffing

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

CRITERIA IN THIS STANDARD

- 7.1 — A Genuine Coverage Plan Exists for a Solo Caregiver's Absence
- 7.2 — Caregiver Continuity Is Actively Tracked and Prioritized for High-Need Clients
- 7.3 — New Caregiver Retention Receives Structured Attention in the First 100 Days
- 7.4 — Caregiver Isolation Is Addressed Through Genuine, Regular Supervisor Contact
- 7.5 — Incident Reporting Accounts for Genuine Detection Delay in an Unsupervised Setting

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

NON-NEGOTIABLE

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

In plain terms: For a client served by one regular caregiver, there is a named backup who knows the client and can step in when the regular caregiver is ill or away.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

The regular caregiver is sick. The client, who needs help to get out of bed, gets no visit — or a stranger who does not know her routine, her medications, her dog. A backup arrangement means: a named second caregiver introduced to the client in advance, who has read the care plan and visited at least once; a defined process for activating cover; and a client informed how it works. For high-dependency clients, two backups. The plan is tested before it is needed.

WHAT GOOD LOOKS LIKE

- A genuine, defined coverage arrangement exists and is real, not theoretical.
- A specific, named alternative caregiver is identified for coverage gaps.
- Clients are genuinely, proactively aware of the coverage plan.

COMMON FAILURE MODES

- No defined coverage arrangement exists beyond an assumption the client will manage.
- No specific alternative is identified; the client is vaguely told to seek help elsewhere.
- Clients only learn about coverage gaps when they actually encounter one.

WORKED EXAMPLE

IN PRACTICE

A 120-client agency with many single-caregiver arrangements.

BEFORE

When a regular caregiver was off sick, the office found whoever was available — often someone who had never met the client. A client with dementia became distressed and refused care from a stranger; she was left unwashed and unfed for a day. No backup was planned.

ACTION

Every client has a named backup caregiver recorded in the care plan, introduced during a joint visit with the regular caregiver, who has read the plan and knows the home. High-dependency clients have two. The cover activation process is written: the caregiver reports absence to the office by 6am; the office contacts the backup; the client is informed. Backups are refreshed at each care plan review.

AFTER

The Monitor reviewed 20 care plans with named backups and joint visit records, and 12 absence events with backup cover activated. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List clients with only one regular caregiver.
2. Name a backup for each and arrange a joint introduction visit.
3. Write the activation process.
4. Refresh at every plan review.

The most common mistake: Finding cover on the morning — the stranger at the door is a crisis for a client with dementia.

SELF-ASSESSMENT QUESTIONS

1. Does a genuine, defined coverage arrangement exist for when a solo caregiver is unavailable? — *A real, specific arrangement, not an assumption the client will manage without care.*

Evidence: Coverage arrangement documentation

2. Is there a real, named alternative caregiver or service the client can be directed to during a coverage gap? — *A specific, real alternative, not a vague suggestion to seek help elsewhere.*

Evidence: Named alternative caregiver documentation

3. Is the client genuinely informed of the coverage plan in advance, not left to discover it only when they need it? — *Real, proactive client awareness, not information only encountered during an actual gap.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **A coverage plan exists for planned absences but not genuinely for sudden, unplanned unavailability.** — A genuine emergency doesn't announce itself in advance, and the plan needs to cover this reality too.
- **An alternative caregiver is named but the relationship hasn't been recently reconfirmed as still active.** — A coverage relationship needs to remain genuinely active, not just historically established.
- **The plan exists but client awareness relies on them happening to ask, not proactive communication.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current coverage arrangements for genuine readiness, including sudden, unplanned absence.
Week 2	Establish or reconfirm a specific, named alternative caregiver relationship.
Week 3	Build proactive client communication about the coverage plan.
Ongoing	Periodically reconfirm the coverage relationship remains genuinely active.

HOW THE MONITOR VERIFIES THIS

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

SUPERVISOR TIPS

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

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

EVIDENCE BASE

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

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.

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

Caregiver continuity is genuinely, actively tracked, with specific priority given to clients with the highest care needs — not treated as a passive outcome of scheduling convenience, given real research shows exactly these highest-need clients currently experience the lowest continuity.

In plain terms: The agency measures how often each client sees the same caregiver, and gives highest-need clients priority for consistency.

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

WHY THIS MATTERS

A client with dementia seen by seven different caregivers in a month is confused and frightened. A client with complex care needs seen by someone unfamiliar is at risk. Continuity — the same caregiver, or a small consistent team — is the single strongest predictor of quality in home care and the thing clients value most. It must be measured: number of different caregivers per client per month. Then prioritised:

the clients with the highest needs (dementia, complex care, end of life) get the most consistent teams. Measuring reveals where scheduling is sacrificing continuity for convenience.

WHAT GOOD LOOKS LIKE • Caregiver continuity is genuinely, actively tracked as a measured outcome. • High-need clients genuinely receive specific continuity prioritization. • A real, active response follows when high-need client continuity is identified as low.	COMMON FAILURE MODES • Continuity is assumed adequate, never genuinely tracked. • High-need clients receive no specific continuity priority over lower-need clients. • Low continuity for a high-need client is noted without any genuine, resulting action.
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WORKED EXAMPLE

IN PRACTICE	
<i>A 150-client agency scheduling for route efficiency.</i>	
BEFORE	Continuity was not measured. When the Coordinator calculated it: average 5.2 different caregivers per client per month; some dementia clients had 9. Scheduling prioritised travel time. Clients complained constantly about 'new faces.'
ACTION	Continuity is now calculated monthly per client. Clients are tiered by need; tier 1 (dementia, complex, end of life) target ≤ 2 caregivers per month; tier 2 ≤ 3 ; tier 3 ≤ 4 . Scheduling was reconfigured to prioritise continuity for tier 1 over route efficiency. Continuity is reported to the management meeting and to clients on request.
AFTER	The Monitor reviewed six monthly continuity reports: tier 1 average down from 6.1 to 1.9. Interviewed two tier 1 clients who described 'my caregiver.' Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Count different caregivers per client last month. Sort by need.
2. Set targets by tier.
3. Reconfigure scheduling to prioritise continuity for the highest need.
4. Report monthly.

The most common mistake: Scheduling for the route — the client with dementia meets a new person every day.

SELF-ASSESSMENT QUESTIONS

1. Is caregiver continuity genuinely, actively tracked, not left to passive scheduling outcomes? — *Real, active tracking of continuity as a specific, measured outcome, not an assumption it's adequate.*

Evidence: Continuity tracking documentation

2. Do clients with the highest care needs genuinely receive specific priority for continuity, not treated the same as lower-need clients? — *Real, specific prioritization, not uniform scheduling regardless of actual client need level.*

Evidence: High-need client continuity priority documentation

3. Is there a specific, active response when continuity for a high-need client is identified as genuinely low? — *A real, active, resulting response, not a low continuity score noted without genuine action.*

Evidence: Low continuity response record

COMMON REASONS FOR A PARTIAL ANSWER

- **Continuity is tracked generally but not specifically broken out by client need level to reveal this real, documented pattern.** — Genuine tracking needs to reveal exactly the disparity real research has documented, not obscure it in an aggregate figure.
- **Prioritization happens informally but isn't reflected in the actual scheduling system's structured logic.** — Informal intention is less reliable than continuity priority genuinely built into how scheduling actually works.
- **A response exists for a severe continuity gap but not for a moderate, still genuinely concerning decline.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current continuity tracking for genuine measurement broken out by client need level.
Week 2	Build specific, structured continuity prioritization into scheduling for high-need clients.
Week 3	Establish a genuine response process for identified continuity concerns, including moderate declines.
Ongoing	Monitor continuity specifically for the highest-need clients over time.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Continuity tracking review	Reviews whether caregiver continuity is genuinely, actively tracked as a measured outcome.
DOCUMENT	High-need prioritization review	Reviews whether high-need clients genuinely receive specific continuity prioritization.
DOCUMENT	Low continuity response review	Reviews evidence of genuine, active response when continuity for a high-need client is found to be low.

SUPERVISOR TIPS

- **Ask for the service's actual, current continuity data specifically for its highest-need clients.** — A specific, real number reveals genuine tracking, not an assumption of adequacy.
- **Ask how scheduling logic specifically prioritizes continuity for a high-need client, not just convenience.** — A specific, confident answer reveals genuine, structural prioritization, not informal intention.

EVIDENCE BASE

[32] Research on home health aide continuity found that clients with the highest care needs and greatest cognitive impairment experience the lowest continuity scores, despite being the most dependent on stable, familiar caregivers and most likely to benefit from consistency.

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

7.3

New Caregiver Retention Receives
Structured Attention in the First 100 Days

CORE

New caregiver retention receives specific, structured attention during their first 100 days of employment — genuine onboarding support, regular check-ins, realistic scheduling — not left to general workplace culture alone, given real industry data shows this exact period is where the overwhelming majority of caregiver departures actually occur.

In plain terms: New caregivers get structured attention in their first 100 days — a mentor, check-ins, feedback, a clear path — because that is when most leave.

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

WHY THIS MATTERS

Home care turnover is brutal, and most of it happens in the first three months: the new caregiver is sent alone to difficult clients, has no one to ask, feels unsupported, and leaves. Every departure costs a recruitment, a training, and a client's continuity. Structured retention in the first 100 days: a mentor caregiver for the first month; shadowing before solo visits; check-in calls at week 1, 2, 4, 8, and 12; a supervisor visit in week 3; feedback both ways; and a stay conversation at 90 days. The agency that does this keeps its new staff; the agency that does not is a training school for competitors.

WHAT GOOD LOOKS LIKE

- Genuine, structured onboarding support exists specifically for the first 100 days.
- Regular, genuine check-ins occur with new

COMMON FAILURE MODES

- No specific structure exists beyond general workplace culture.
- Check-ins are informal or occasional, not genuinely scheduled.

caregivers during this window.

- Scheduling for new caregivers is genuinely realistic, not immediately as demanding as for experienced staff.

- New caregivers face the same demanding scheduling as experienced staff immediately.

WORKED EXAMPLE

IN PRACTICE

A 120-client agency losing 45% of new caregivers within 90 days.

BEFORE	New caregivers completed induction and were scheduled solo from day two. No mentor, no check-ins. Exit interviews (when done) cited feeling unsupported and unprepared. The agency was recruiting constantly.
ACTION	A first-100-days programme was built: a mentor caregiver assigned for four weeks with paid time for joint visits; two shadowed shifts before solo work; structured check-in calls at weeks 1, 2, 4, 8, 12 by the supervisor; a supervised observation in week 3; a 90-day stay conversation. Retention is tracked by cohort.
AFTER	The Monitor reviewed the programme, check-in records for 20 new caregivers, and retention data: 90-day retention up from 55% to 82%. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Calculate your 90-day retention rate.
2. Assign a mentor to every new caregiver for a month.
3. Schedule check-in calls at weeks 1, 2, 4, 8, 12.
4. Hold a stay conversation at 90 days.

The most common mistake: Sending a new caregiver solo on day two and wondering why they left in week three.

SELF-ASSESSMENT QUESTIONS

1. Does the service provide genuine, structured onboarding support specifically during the first 100 days? — *Real, specific structure for this exact period, not general workplace culture applied uniformly.*

Evidence: First-100-days onboarding program documentation

2. Do regular, genuine check-ins occur with new caregivers during this specific window? — *Real, scheduled check-ins, not informal or occasional contact left to chance.*

Evidence: Early-tenure check-in record

3. Is scheduling for new caregivers genuinely realistic during this period, not immediately as demanding as for experienced staff? — *Real, adjusted scheduling reflecting a new caregiver's actual, current experience level.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Onboarding covers technical training but not the emotional and isolation-related challenges new caregivers genuinely face.** — The real, documented drivers of early departure include isolation and emotional demand, not technical skill gaps alone.
- **Check-ins happen but the specific 100-day window isn't tracked as a distinct period requiring genuine, heightened attention.** — Genuine attention aligned to the documented risk period is more effective than check-ins applied without this specific timing focus.
- **Scheduling is adjusted initially but ramps up to full demand faster than a new caregiver's actual, current comfort level.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current onboarding and retention practice against the specific first-100-days risk window.
Week 2	Build structured onboarding addressing both technical and emotional aspects of the role.
Week 3	Establish genuine, scheduled check-ins throughout this specific period.
Ongoing	Track early-tenure departure specifically to confirm the structured approach is genuinely working.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Onboarding program review	Reviews the actual, structured onboarding program specifically covering the first 100 days.
DOCUMENT	Check-in record review	Reviews records of genuine, regular check-ins during this specific early period.
DOCUMENT	Scheduling review	Reviews whether new caregiver scheduling is genuinely adjusted to reflect their current experience level.

SUPERVISOR TIPS

- **Ask a relatively new caregiver whether they've received genuine, structured check-ins since starting.** — A specific, real answer reveals genuine practice, not an assumption of adequate support.
- **Ask the service for its own current departure rate within the first 100 days.** — A specific, real number reveals whether this focus is genuinely producing results, not just existing as a stated priority.

EVIDENCE BASE

[33] Nearly four in five departing caregivers leave within their first 100 days of employment, establishing this specific period as the point of greatest genuine retention risk and impact, distinct from general workplace culture applied without this specific, structured focus.

[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.

7.4 Caregiver Isolation Is Addressed Through Genuine, Regular Supervisor Contact CORE

Caregiver isolation is genuinely, actively addressed through regular, real supervisor contact and peer connection opportunities — not left unaddressed on the assumption that working alone is simply an inherent, unavoidable feature of the role that can't be meaningfully improved.

In plain terms: Caregivers who work alone all day have regular real contact with a supervisor and with peers — not just a phone number they can call if something goes wrong.

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

WHY THIS MATTERS

A home care worker may go a week without speaking to a colleague. Isolation breeds burnout, unreported problems, drift in practice, and departure. Regular contact means: a scheduled supervisor call or visit at least fortnightly; a monthly team meeting (in person or video) where caregivers see each other; a peer buddy; a messaging group for practical support. It is structured, not left to whether the caregiver reaches out. The isolated caregiver rarely does.

WHAT GOOD LOOKS LIKE

- Regular, genuine supervisor contact is actively provided beyond isolated visits.
- Genuine peer connection opportunities are actually offered.
- Caregivers genuinely value and use available contact and connection.

COMMON FAILURE MODES

- Isolation is treated as unavoidable, with no active mitigation.
- No genuine peer connection opportunities exist.
- Contact and connection are offered nominally but not genuinely used.

WORKED EXAMPLE

IN PRACTICE

A 150-client agency where caregivers' only contact with the office was scheduling.

BEFORE

Caregivers saw the office at induction and at problems. No team meetings. No regular supervisor contact. Exit interviews cited isolation. Practice drift was found at supervisory observations — caregivers had developed their own methods over years alone.

ACTION	A contact structure was set: fortnightly supervisor check-in call (15 minutes, structured: how are you, any concerns about clients, anything you need); monthly team meeting with a training topic and time to talk; a peer buddy for every caregiver; a moderated messaging group. Attendance is tracked; caregivers are paid for meeting time.
AFTER	The Monitor reviewed check-in logs (94% completed), team meeting attendance (80%), and interviewed three caregivers who described feeling part of a team. Turnover down 30%. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask five caregivers when they last spoke to a colleague about work.
2. Schedule a fortnightly supervisor call for every caregiver.
3. Hold a monthly team meeting and pay for attendance.
4. Assign peer buddies.

The most common mistake: Assuming caregivers will call if they need anything — the isolated ones do not.

SELF-ASSESSMENT QUESTIONS

1. Does the service genuinely provide regular, real supervisor contact beyond the isolated visit itself? — *Real, scheduled, meaningful contact, not isolation treated as unavoidable and unaddressed.*

Evidence: Supervisor contact schedule documentation

2. Are genuine peer connection opportunities offered, not left entirely absent given the isolated nature of visits? — *Real, actual opportunities for caregiver-to-caregiver connection, not an assumption this isn't feasible.*

Evidence: Peer connection opportunity documentation

3. Is this contact and connection genuinely valued and used by caregivers, not merely offered without real uptake? — *Real, genuine uptake, not a nominal offering caregivers don't actually engage with.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Supervisor contact happens but is limited to scheduling logistics, not genuine check-in on the caregiver's actual wellbeing.** — Genuine connection addresses the real emotional isolation this criterion exists to mitigate, not logistics alone.
- **Peer connection opportunities exist but aren't genuinely accessible given caregivers' varied, often conflicting schedules.** — An opportunity that's practically inaccessible provides limited real value in addressing genuine isolation.
- **Contact is offered consistently but caregiver uptake is inconsistent, suggesting the format may not genuinely meet their needs.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current supervisor contact and peer connection practice for genuine, regular provision.
Week 2	Establish contact specifically addressing caregiver wellbeing, not logistics alone.
Week 3	Build genuinely accessible peer connection opportunities accounting for varied schedules.
Ongoing	Monitor genuine caregiver uptake and adjust format based on real engagement.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Contact schedule review	Reviews the actual, regular schedule of supervisor contact provided to caregivers.
DOCUMENT	Peer connection review	Reviews genuine opportunities offered for caregiver-to-caregiver connection.
ASK	Caregiver uptake interview	Asks a caregiver whether they genuinely value and use available contact and connection opportunities.

SUPERVISOR TIPS

- **Ask a caregiver directly how often they have genuine contact with a supervisor beyond scheduling logistics.** — A specific,

honest answer reveals genuine practice, not an assumption contact is meaningful.

- **Ask whether caregivers have ever used a peer connection opportunity and what their experience was.** — A real, specific answer reveals genuine uptake, not a nominal offering without actual use.

EVIDENCE BASE

[34] Caregivers working in isolation with little support from supervisors or colleagues is specifically identified as a genuine, documented contributor to caregiver burnout and turnover, establishing active mitigation through regular supervisor contact as necessary, distinct from isolation accepted as an unavoidable feature of the role.

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.

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

NON-NEGOTIABLE

Incident reporting practice genuinely accounts for the real possibility that a problem in an unsupervised home setting may not be discovered immediately — building in specific mechanisms for delayed discovery, not designed only around incidents that happen to be witnessed or reported in real time.

In plain terms: The incident system expects that problems in a home may be found days later — by the next caregiver, the family, a supervisor — and captures them when found, without blaming the finder.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Adapted	Full

WHY THIS MATTERS

In a hospital, an incident is seen when it happens. In a home, a fall on Friday night may be found by Monday's caregiver as a bruise. A medication error on Tuesday may be found at Thursday's dosette check. A pressure injury may be found at the fortnightly supervisor visit. If the incident system only accepts reports 'at the time,' or blames the person who found it, delayed-detection incidents are never reported. The system must expect delay: a report form that asks 'when discovered' as well as 'when occurred'; a culture that thanks finders; and analysis that looks for the detection gap.

WHAT GOOD LOOKS LIKE

- Incident reporting genuinely accounts for the real possibility of delayed discovery.
- Specific mechanisms exist that could catch a delayed-discovery incident.
- A defined investigation process is genuinely adapted for this evidentiary challenge.

COMMON FAILURE MODES

- Reporting assumes real-time detection, with no accommodation for delayed discovery.
- No specific mechanisms exist beyond the caregiver's own real-time reporting.
- Investigation is treated identically regardless of whether a real-time witness exists.

WORKED EXAMPLE

IN PRACTICE

A 120-client agency whose incident form assumed real-time reporting.

BEFORE

The form asked 'date of incident' and 'reported by.' Caregivers who found evidence of an earlier incident either did not report (unsure whether it counted) or were questioned as if responsible. Falls found as bruises were rarely reported.

ACTION

The incident form was redesigned: 'date/time occurred (if known)', 'date/time discovered', 'discovered by', 'how discovered'. Guidance states that finding evidence of a prior incident is a report, not a fault. Detection delay is analysed monthly: which incidents are found late, why, and

what would catch them sooner (e.g. skin checks at every visit). Finders are thanked.

AFTER

The Monitor reviewed 40 incident reports, 15 with detection delay documented, and the monthly analysis that led to skin checks at every personal care visit. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Add 'when discovered' and 'how discovered' to the incident form.
2. Tell caregivers that finding evidence of an incident is a report, not a fault.
3. Analyse detection delays monthly.
4. Thank finders.

The most common mistake: An incident form that has no way to record something found three days later.

SELF-ASSESSMENT QUESTIONS

1. Does incident reporting genuinely account for the real possibility of delayed discovery? — *Real, specific accommodation, not a system designed only around real-time witnessing.*

Evidence: Incident reporting protocol documentation

2. Are there specific mechanisms — check-ins, family contact — that could catch a delayed-discovery incident? — *Real, specific mechanisms beyond the caregiver's own real-time reporting alone.*

Evidence: Delayed-discovery detection mechanism documentation

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

Evidence: Delayed-discovery investigation process

COMMON REASONS FOR A PARTIAL ANSWER

- **Periodic client check-ins exist but aren't specifically designed to surface a delayed-discovery incident.** — A check-in's real value for this purpose depends on genuinely being structured to catch this specific kind of concern.

- **Family contact happens but isn't consistently leveraged as a genuine detection mechanism for this purpose.** — Family members present at other times represent a real, additional opportunity to catch what a caregiver's own reporting might miss.
- **An investigation process exists but hasn't been specifically tested against a real, delayed-discovery scenario.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current incident reporting for genuine accommodation of delayed discovery.
Week 2	Establish specific mechanisms, including structured check-ins, designed to catch delayed-discovery incidents.
Week 3	Build a defined investigation process adapted for the absence of a real-time witness.
Ongoing	Test this process against a real or simulated delayed-discovery scenario.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Reporting protocol review	Reviews the incident reporting protocol for genuine accommodation of delayed discovery.
DOCUMENT	Detection mechanism review	Reviews specific mechanisms in place that could catch a delayed-discovery incident.
DOCUMENT	Investigation process review	Reviews the defined investigation process adapted for incidents without a real-time witness.

SUPERVISOR TIPS

- **Ask how the service would investigate a concern that surfaced days after it may have actually occurred.** — A specific, thoughtful answer reveals genuine adaptation to this real challenge, not an assumption real-time detection is the norm.
- **Ask whether family contact is specifically used as a detection mechanism, not just general communication.** — A specific,

confident answer reveals genuine, deliberate use of this real opportunity.

EVIDENCE BASE

[35] The isolated, unsupervised nature of one-on-one home caregiving is established as creating genuine, distinct challenges for incident detection compared with facility-based care, requiring reporting mechanisms specifically designed to account for delayed discovery, not assumed real-time detection.

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 6 — Care Plan Development & Ongoing Supervision**

Standard 8 — Health & Migration →

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Standard 8 — Health & Migration

10 criteria · 4 non-negotiable · 6 core · Version 3.0

CRITERIA IN THIS STANDARD

- 8.1 — Care Is Genuinely Adapted to a Client's Migration and Displacement Experience
- 8.2 — Language Support Accounts for Persistent, Daily Interaction
- 8.3 — Cultural and Religious Practices in the Client's Home Are Genuinely Respected
- 8.4 — Caregiver Work Authorization Is Verified Through Legal, Non-Discriminatory Practice
- 8.5 — A Caregiver's Legal Status Change Is Handled With Genuine Support
- 8.6 — Immigrant Caregivers' Genuine Retention Advantage Is Recognized and Supported
- 8.7 — Legal Status Diversity Recognition for Clients
- 8.8 — Care Is Documented and Provided to Clients Regardless of Immigration or Legal Status
- 8.9 — Staff Reflective Practice and Bias Awareness Extends to How Immigrant Caregivers Are Treated
- 8.10 — Continuity Across a Client's Relocation Is Actively Supported

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

Care is genuinely adapted to a client's migration and displacement experience — including trauma-informed practice and awareness of legal-status barriers to access — not delivered identically regardless of that history, given a caregiver's daily, ongoing presence in the home makes this context genuinely relevant to nearly every aspect of the relationship.

In plain terms: Care in the home is adapted for a client who has been displaced — trauma-informed, alert to fear of authorities, aware of loss — not delivered as if their history did not exist.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

A refugee client receiving care in her home may be terrified of a stranger with a key, may not disclose symptoms that could mark her as a burden, may react to being undressed with a fear rooted in what was done to her before, may fear that the caregiver reports to authorities. Trauma-informed home care means: the caregiver explains before touching, asks permission, is predictable, avoids triggers the client has identified; the agency has told the client explicitly that status is not asked and not reported; the care plan records what the client has said about their history and needs. The home is the one place the client should feel safe; the caregiver must not undermine that.

- WHAT GOOD LOOKS LIKE**

 - Care is genuinely, visibly adapted to migration and displacement history.
 - Trauma-informed practice is sustained throughout the ongoing relationship.
 - The caregiver demonstrates specific awareness of legal-status access barriers.

- COMMON FAILURE MODES**

 - Care is delivered identically regardless of migration history.
 - Trauma-informed practice is referenced once at intake and not sustained.
 - The caregiver shows no specific awareness of legal-status barriers.

WORKED EXAMPLE

IN PRACTICE

A 100-client agency serving refugee clients through a resettlement contract.

BEFORE

Refugee clients were served identically to others. Caregivers had no training on displacement or trauma. A client who had been detained resisted personal care violently; the caregiver did not know why. Another did not disclose a serious symptom for months, fearing it would affect her status.

ACTION

A trauma-informed home care module was developed with a refugee NGO and delivered to all caregivers. Intake for refugee clients includes a gentle conversation about history, triggers, and fears, recorded in the care plan with the client's consent. The agency's written statement — status not asked, never reported — is explained at intake. Caregivers explain each step and ask permission. A refugee liaison worker supports complex cases.

AFTER

The Monitor reviewed training records, 10 refugee care plans with trauma-informed sections, and interviewed the liaison worker and a client who described feeling safe with her caregiver. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask refugee-serving organisations what their clients say about home care.
2. Train caregivers in trauma-informed care with an NGO.
3. Add a history/triggers/fears section to refugee clients' care plans.
4. State in writing: status not asked, never reported.

The most common mistake: Treating a refugee client 'like everyone else' — for a traumatised person, a stranger with a key is not like everyone else's experience.

SELF-ASSESSMENT QUESTIONS

1. Is care genuinely adapted to a client's migration and displacement experience, not delivered identically regardless of history? — *Genuine adaptation, not a generic cultural-awareness statement.*

Evidence: Training record on migration-adapted care

2. Is trauma-informed practice genuinely applied throughout the ongoing relationship, not only referenced once at intake? — *Real, sustained practice adaptation, not a one-time consideration.*

Evidence: N/A — tested directly

3. Is the caregiver aware of legal-status barriers to access that may affect this specific client? — *Specific awareness, not a general sense that barriers can exist.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Adaptation happens for clients who disclose their history but isn't proactively considered otherwise.** — Not every client will volunteer this history unprompted, even when it is clinically relevant.
- **The caregiver is aware of the principle but hasn't received specific training on applying it day to day.** — General awareness doesn't reliably translate into sustained, genuine practice adaptation without specific training.
- **Adaptation is strong initially but isn't sustained as the caregiving relationship continues over months.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current practice for genuine adaptation to migration and displacement history.
Week 2	Train caregivers specifically on trauma-informed, migration-adapted practice.
Week 3	Build awareness of legal-status access barriers into standard practice.

When	What
Ongoing	Revisit adaptation as the ongoing caregiving relationship continues.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Migration-adapted care interview	Asks the caregiver how they adapt practice specifically for a client's migration and displacement history.
OBSERVE	Trauma-informed practice observation	Observes an actual visit for genuine trauma-informed practice, not generic sensitivity.
DOCUMENT	Training content review	Reviews training materials for specific coverage of migration-adapted, trauma-informed care.

SUPERVISOR TIPS

- **Ask a caregiver to describe a specific example of adapting care for a client's migration history.** — A real, specific example reveals genuine practice, not familiarity with the principle.
- **Ask how this awareness has been sustained over months of ongoing care, not just at the initial visit.** — This reveals whether adaptation genuinely persists, not fading with familiarity.

EVIDENCE BASE

[36] WHO Competency Standard 1 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) requires health workers to adapt practice to migration and displacement experiences, address trauma-informed care and psychosocial needs, and support continuity of care regardless of legal status.

[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.

8.2 Language Support Accounts for Persistent, Daily Interaction

NON-NEGOTIABLE

Language and communication support genuinely accounts for the persistent, daily nature of home care — not designed only around occasional, episodic interpreter access, given a caregiver and client with limited shared language must communicate meaningfully every single day care occurs.

In plain terms: Language support is built for daily, repeated interaction — caregiver matching, key phrases, translated care plans, picture boards — not just an interpreter for the intake meeting.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Adapted	Full

WHY THIS MATTERS

An interpreter at intake solves the intake. Then the caregiver comes every day, and the client cannot tell them where it hurts, what they want to eat, that they are frightened. Home care is daily; language support must be daily: matching caregivers by language where possible; a translated care plan and daily task list; a pictorial communication board in the home; key phrases learned by the caregiver; a phone interpretation service for anything complex; and family involvement where the client wishes. The client who cannot communicate with their daily caregiver is silenced in their own home.

WHAT GOOD LOOKS LIKE

- Language support genuinely accounts for daily, ongoing interaction, not episodic access alone.
- Caregiver matching or practical daily tools are genuinely arranged for sustained communication.
- Staff confirm, without hesitation, that a minor is never used to interpret.

COMMON FAILURE MODES

- Language support is planned only around occasional, scheduled interpretation.
- No genuine matching or practical tools exist for daily communication needs.
- A minor has been used to interpret, even occasionally.

WORKED EXAMPLE

IN PRACTICE

A 120-client agency with clients speaking eight languages.

BEFORE

Interpreters were used at intake. Daily care was by gesture. A client could not tell her caregiver she was in pain; it emerged at a supervisory visit through an interpreter. Care plans were in the local language only.

ACTION

Caregivers were recruited from the main language communities and matched where possible. Care plans and daily task lists are translated into the client's language. A pictorial communication board (pain, food, toilet, help, phone, family) is in every language-discordant client's home. Caregivers learn 20 key phrases in the client's language from a card. A phone interpretation service is used for anything beyond daily routine. Supervisory visits use an interpreter.

AFTER

The Monitor reviewed language matching records (65% of language-discordant clients now matched), translated care plans, observed a communication board in use, and interviewed a client through an interpreter who described communicating daily. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List language-discordant clients and their caregivers' languages.
2. Recruit from the main language communities.
3. Translate care plans and put a picture board in every home.
4. Give caregivers a 20-phrase card.

The most common mistake: Solving language at intake and leaving the daily relationship to gesture.

SELF-ASSESSMENT QUESTIONS

1. Does language support genuinely account for the daily, ongoing nature of home care, not episodic interpreter access alone? — *Real, sustained communication planning, not a model built for a single scheduled encounter.*

Evidence: Ongoing communication support plan

2. Is the caregiver genuinely matched for shared language where feasible, or given practical daily communication tools where not? — *Real, practical accommodation for daily communication, not an assumption occasional interpretation is sufficient.*

Evidence: N/A — tested directly

3. Is a minor ever used to facilitate interpretation between caregiver and client? — *This should never happen — a specific, absolute rule, not a judgement call.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Language matching is attempted for new client-caregiver pairings but not reconsidered if a pairing changes.** — Every new pairing carries the same real communication need, not only the original assignment.
- **Practical daily tools exist but aren't proactively introduced, relying on the caregiver or client to request them.** — A tool neither party knows to request provides limited real value for genuine, ongoing communication.
- **Awareness of the no-minors rule is strong among caregivers but not reinforced with family members who might otherwise step in.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current language support for genuine attention to daily, ongoing interaction needs.
Week 2	Establish caregiver-client language matching practice where feasible.
Week 3	Build practical daily communication tools for pairings without shared language.
Ongoing	Reinforce the no-minors rule specifically with families, not caregivers alone.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Communication plan review	Reviews the specific plan for sustained, daily communication support, not episodic interpretation alone.
ASK	Caregiver matching interview	Asks how caregiver-client language matching or daily communication tools are genuinely arranged.
ASK	Minor-interpreter policy check	Asks staff directly whether a minor has ever been used to interpret, confirming this is never acceptable.

SUPERVISOR TIPS

- **Ask how a caregiver and client without shared language communicate on an ordinary, daily basis.** — A specific, real answer reveals genuine, sustained practice, not an assumption occasional interpretation covers it.
- **Ask staff directly whether a child has ever interpreted between a caregiver and a family member.** — A direct question often surfaces informal practice a policy review wouldn't catch.

EVIDENCE BASE

[37] WHO Competency Standard 3 establishes language access and cultural mediation as a genuine, ongoing responsibility, with home care's persistent, daily interaction structure requiring communication support planning distinct from episodic clinical encounter models.

[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.

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

NON-NEGOTIABLE

A client's cultural and religious practices are genuinely respected within their own home — dietary requirements,

prayer routines, gender-appropriate care preferences — not overridden by the caregiver's own habits or convenience, given this document's own foundational principle that the home remains genuinely the client's to control.

In plain terms: The client's religious and cultural practices in their own home — food, prayer, modesty, who may touch them, gender of caregiver — are learned and respected as a matter of course.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Adapted	Full

WHY THIS MATTERS

It is the client's home. A Muslim client's prayer times, a Jewish client's kosher kitchen, a Hindu client's dietary laws, a client of any tradition who requires a same-gender caregiver for personal care, a client whose home has rules about shoes or the kitchen — each is a non-negotiable for the client and a matter of basic respect for the caregiver. The agency asks at intake, records in the care plan, matches caregivers accordingly, and trains staff. A caregiver who brings pork into a halal kitchen, or a male caregiver sent to a woman who cannot accept one, has violated the home.

WHAT GOOD LOOKS LIKE

- The caregiver genuinely respects the client's specific dietary, religious, and cultural practices.
- Gender-appropriate care preferences are genuinely accommodated where expressed.
- Specific inquiry, not assumption from background, informed these accommodations.

COMMON FAILURE MODES

- The caregiver's own habits or convenience override the client's actual practices.
- Gender-appropriate preferences are disregarded or not genuinely accommodated.
- Accommodations are assumed from general background, not specifically confirmed with the client.

WORKED EXAMPLE

IN PRACTICE

A 100-client agency in a diverse city with no cultural assessment.

BEFORE

Caregivers were assigned by availability. A male caregiver was sent for personal care to a woman whose faith prohibited it; she refused care and was recorded as 'non-compliant.' A caregiver used a client's kosher utensils for non-kosher food. No cultural preferences were recorded.

ACTION

A cultural and religious practices section was added to intake: dietary rules and kitchen practices, prayer and observance times, modesty and gender requirements, home customs. Recorded in the care plan and honoured in caregiver matching (gender, and where possible faith or language). Caregivers receive a briefing card per client. Staff completed a cultural competence session. Requirements are conditions the agency meets, not preferences it considers.

AFTER

The Monitor reviewed 20 care plans with cultural sections and matching records; interviewed a client who described her caregiver respecting her kitchen. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask every client about dietary, faith, modesty, and home customs at intake.
2. Record them in the care plan as requirements.
3. Match caregiver gender to the client's requirement.
4. Brief every caregiver per client.

The most common mistake: Recording a client's refusal of a male caregiver as 'non-compliance' — the agency failed, not the client.

SELF-ASSESSMENT QUESTIONS

1. Does the caregiver genuinely respect the client's specific dietary, religious, and cultural practices? — *Real, active respect for the client's actual practices, not the caregiver's own habits.*

Evidence: N/A — tested directly

2. Are gender-appropriate care preferences genuinely accommodated where expressed? — *Real, active accommodation of the client's own stated preference.*

Evidence: Care preference documentation

3. Was the caregiver genuinely asked about these preferences, not assumed from background? — *Real, specific inquiry, not assumption based on broad cultural category.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Dietary practices are respected but prayer routines aren't specifically accommodated in the daily care schedule.** — Every genuine practice the client values deserves the same specific accommodation, not only the most visible one.
- **Gender-appropriate preferences are accommodated for personal care but not consistently for other aspects of daily assistance.** — This preference reflects the client's genuine comfort across the full scope of care, not personal care alone.
- **Inquiry happened at intake but hasn't been revisited as the caregiving relationship has continued.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current practice for genuine, specific respect of client cultural and religious practices.
Week 2	Establish specific inquiry into dietary, religious, and gender-appropriate care preferences.
Week 3	Build these preferences into the actual daily care schedule and routine.
Ongoing	Revisit preferences periodically as the caregiving relationship continues.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Practice respect observation	Observes an actual visit for genuine respect of the client's specific cultural and religious practices.
DOCUMENT	Preference documentation review	Reviews whether gender-appropriate care preferences are genuinely documented and accommodated.
ASK	Specific inquiry interview	Asks whether the caregiver specifically asked about the client's own practices, not assumed from background.

SUPERVISOR TIPS

- **Ask a client directly whether their specific cultural or religious practices are genuinely respected during care.** — A specific, honest answer reveals genuine respect, not an assumption based on general politeness.
- **Ask the caregiver how they learned about the client's specific preferences.** — A specific, confident answer reveals genuine inquiry, not an assumption based on broad cultural background.

EVIDENCE BASE

[38] Genuine respect for a client's cultural and religious practices within their own home, consistent with established client autonomy principles in home care, carries particular relevance for refugee and migrant clients for whom these practices often represent continuity preserved through displacement.

[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.

Caregiver Work Authorization Is Verified

8.4 Through Legal, Non-Discriminatory Practice

CORE

Caregiver work authorization is genuinely verified through the same legal, standard employment practice applied to

every prospective employee — not subjected to excess scrutiny beyond what the law actually requires, and not applied inconsistently based on a caregiver's perceived national origin or accent.

In plain terms: Caregivers' right to work is checked the same lawful way for everyone — the same documents, the same process — never selectively for people who look or sound foreign.

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

WHY THIS MATTERS

Employment law requires work authorisation checks; discrimination law prohibits doing them selectively. An agency that checks 'foreign-looking' applicants more carefully, asks some for documents it does not ask of others, or refuses to consider candidates with certain names, is breaking the law and losing good staff. The process is the same for every applicant: the same document list, at the same stage, recorded the same way. Immigrant caregivers are the backbone of home care in most countries; the process must welcome them lawfully.

WHAT GOOD LOOKS LIKE

- Work authorization is verified through the same standard, legal process for every candidate.
- Verification is genuinely consistent, not varying by perceived national origin or accent.
- Staff are specifically trained on the legal requirement's actual scope.

COMMON FAILURE MODES

- Verification is skipped or informal, creating real legal exposure.
- Some candidates face excess scrutiny based on perceived national origin or accent.
- Staff apply verification inconsistently, without specific training on its actual legal scope.

WORKED EXAMPLE

IN PRACTICE

A 150-client agency with a large immigrant workforce.

BEFORE	Work authorisation checks were inconsistent: some applicants were asked for extensive documentation, others waved through on a driving licence. Managers admitted asking 'more carefully' when someone had an accent. A discrimination complaint was pending.
ACTION	A single work authorisation procedure was written to national employment law: the same acceptable document list for all applicants; checked at the same stage (after conditional offer); recorded on the same form; no additional requests based on appearance, name, or accent. Managers were trained on the procedure and on discrimination law. HR audits a sample quarterly for consistency.
AFTER	The Monitor reviewed the procedure, training records, and a quarterly audit showing identical process for 20 files across nationalities. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Write one work authorisation procedure with one document list for everyone.
2. Check at the same stage for every applicant.
3. Train managers on discrimination law.
4. Audit for consistency quarterly.

The most common mistake: Checking 'more carefully' when the applicant has an accent — that is discrimination.

SELF-ASSESSMENT QUESTIONS

1. Is work authorization verified through the same standard, legal process for every candidate? — *Real, consistent verification, not excess scrutiny applied selectively.*

Evidence: Work authorization verification process

2. Is verification applied consistently, not varying by perceived national origin or accent? — *Real, consistent application, not*

discriminatory differentiation.

Evidence: N/A — tested directly

3. Are staff trained on the requirement's actual legal scope, not exceeding what's required? — *Real, specific training on the genuine standard, not over-scrutiny.*

Evidence: Staff training on verification scope

COMMON REASONS FOR A PARTIAL ANSWER

- **Verification is consistent for direct hires but less standardized for contracted or agency-placed caregivers.** — Every caregiver entering a client's home carries the same real legal and practical requirement.
- **The process is generally consistent but hasn't been specifically reviewed to confirm no unconscious pattern of differential scrutiny exists.** — A genuine review for unintended patterns is what confirms the process is actually fair in practice, not just in written policy.
- **Training covers basic requirements but not the specific legal boundary against exceeding what's actually required.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current verification practice for genuine, consistent, legally appropriate scope.
Week 2	Establish standardized verification applying equally to direct hires and contracted caregivers.
Week 3	Train staff specifically on the legal requirement's actual scope, avoiding excess scrutiny.
Ongoing	Review verification records periodically for any unintended pattern of differential treatment.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Verification process review	Reviews the standard, legal work authorization verification process applied to candidates.
OBSERVE	Consistency observation	Observes or reviews records for consistent application regardless of perceived national origin.

Method	What	Detail
DOCUMENT	Staff training review	Reviews training records confirming staff understand the verification requirement's actual, legal scope.

SUPERVISOR TIPS

- **Ask staff to describe the specific verification process, not a general assurance of legal compliance.** — A specific, real process description reveals genuine, standardized practice, not an assumption of adequacy.
- **Ask how the service would ensure verification doesn't vary based on a candidate's accent or apparent background.** — A specific, thoughtful answer reveals genuine attention to consistency, not an assumption bias couldn't occur.

EVIDENCE BASE

[39] Work authorization or right-to-work verification is a standard legal employment requirement in most countries, applying equally to every prospective employee, with migrant caregivers representing a genuine, substantial share of the home care workforce in many countries and often remaining in direct care positions longer than caregivers born in the country where they work, providing important workforce stability.

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.

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

CORE

When a caregiver's own legal work authorization status genuinely changes — a permit expiring, a visa category ending, a policy shift removing a pathway that existed when they were hired — the service provides genuine support and transition time, not abrupt termination without any real transition process.

In plain terms: When a caregiver's work permit or visa status changes, the agency helps — information, time, flexibility — rather than dropping them at the first sign of complexity.

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

WHY THIS MATTERS

An immigrant caregiver's permit expires, their visa category changes, a renewal is delayed. The agency can help — pointing to advice, allowing time off for appointments, adjusting hours during a transition, keeping the job open where the law allows — or it can terminate at the first complication and lose a trained, trusted caregiver whose clients depend on them. Support is lawful (the agency cannot employ someone without authorisation) and humane (it can do everything within the law to keep them). A written approach means managers know what they can do.

WHAT GOOD LOOKS LIKE

- Genuine support and transition time are provided when a caregiver's status changes.
- Affected clients receive genuine support and coverage planning through the transition.
- The service maintains genuine, current awareness of the relevant regulatory landscape.

COMMON FAILURE MODES

- A status change results in abrupt termination without any genuine transition process.
- Affected clients are left without notice or a coverage plan.
- The service is caught unaware, reactive only after a status has already lapsed.

WORKED EXAMPLE

IN PRACTICE

A 120-client agency where a permit renewal delay had led to a caregiver's immediate dismissal.

BEFORE

A caregiver's permit renewal was delayed by the authorities. The agency, unsure of the law,

terminated her. She had five long-term clients. Two months later her permit was renewed; she was working for a competitor.

ACTION

A status change support policy was written with employment law advice: the agency provides information on renewal processes and a referral to an immigration advice service; paid time for appointments; where the law permits continued employment during a pending renewal, employment continues with documentation; where it does not, unpaid leave with the position held for a defined period; managers consult HR before any action. Caregivers are told the policy.

AFTER

The Monitor reviewed the policy with legal basis, and three cases: two continued employment during pending renewals lawfully, one held position during a gap and returned. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Get employment law advice on what you can do during a pending renewal.
2. Write a support policy: information, time off, position held where lawful.
3. Tell caregivers.
4. Require HR consultation before any status-related action.

The most common mistake: Dismissing a caregiver the day their permit expires when the law allowed you to wait for the renewal.

SELF-ASSESSMENT QUESTIONS

1. Does the service provide genuine support when a caregiver's legal status changes? — *Real, active support, not abrupt termination without transition.*

Evidence: Status change support process

2. Is the affected client genuinely supported through this transition? — *Real, proactive support and coverage planning, not an unexplained*

loss.

Evidence: Client transition support documentation

3. Is the service genuinely, currently informed about relevant legal status changes? — Real, current awareness, not reactive discovery after a lapse.

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Support exists for a caregiver whose status change is identified in advance but not for one discovered after the fact.** — Every genuine status change deserves the same support, regardless of how much advance notice existed.
- **Client coverage planning happens but isn't communicated to the client with genuine transparency about what's actually happening.** — Genuine transparency helps a client understand and adjust to a transition, not simply experience an unexplained change.
- **Awareness of the regulatory landscape exists at a leadership level but isn't specifically monitored on an ongoing basis.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current practice for genuine support versus abrupt response to a caregiver status change.
Week 2	Establish a defined support and transition process for affected caregivers and clients.
Week 3	Build ongoing monitoring of the relevant regulatory landscape.
Ongoing	Communicate transitions to affected clients with genuine transparency.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Support process review	Reviews the specific process for supporting a caregiver through a genuine legal status change.
DOCUMENT	Client transition review	Reviews whether affected clients receive genuine support and coverage planning during this transition.

Method	What	Detail
ASK	Current awareness interview	Asks leadership how they stay genuinely, currently informed about relevant legal status changes.

SUPERVISOR TIPS

- **Ask for a real, recent example of a caregiver status change and how it was actually handled.** — A real, traceable example reveals genuine support, not an assumption of adequate response.
- **Ask how leadership currently stays informed about relevant legal status developments affecting the workforce.** — A specific, confident answer reveals genuine, ongoing awareness, not reactive discovery.

EVIDENCE BASE

[40] Changes to immigration or work-permit policy can disrupt legal work authorization for caregivers who built their employment relationships around a pathway that existed at the time of hire, establishing genuine transition support as necessary practice distinct from abrupt termination, a pattern documented across multiple countries that rely on migrant care workers.

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.

8.6 Immigrant Caregivers' Genuine Retention Advantage Is Recognized and Supported CORE

The service genuinely recognizes and supports the real, documented retention advantage immigrant caregivers bring to continuity of care — not undermining this advantage through precarious employment practices that create instability regardless of a caregiver's own genuine commitment to staying.

In plain terms: The agency recognises that immigrant caregivers stay longer and are more committed — the evidence is clear — and supports them accordingly rather

than treating them as temporary.

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

WHY THIS MATTERS

Research across countries shows immigrant care workers have lower turnover, higher commitment, and often greater cultural competence with diverse clients. Agencies that treat them as a transient, second-tier workforce — fewer training opportunities, no progression, no recognition — waste that advantage. Supporting them means: the same progression pathways; language and qualification support; recognition of overseas experience; representation in supervision and management; and a culture where immigrant staff are the agency's strength, not its stopgap.

WHAT GOOD LOOKS LIKE

- The service genuinely recognizes immigrant caregivers' documented retention advantage.
- Employment practices are genuinely stable and supportive, not precarious.
- Recognition translates into real, practical support, not remaining theoretical.

COMMON FAILURE MODES

- This documented advantage goes unrecognized or unused.
- Precarious employment practices undermine genuine retention regardless of caregiver commitment.
- Any recognition remains theoretical, without practical, resulting support.

WORKED EXAMPLE

IN PRACTICE

A 150-client agency where 70% of caregivers were immigrants and 0% of supervisors were.

BEFORE

Immigrant caregivers had the longest service and the least progression. Overseas nursing qualifications were not recognised in any way. Training was offered to 'permanent' staff first. Supervisors were all locally born.

ACTION	A workforce development review acknowledged the retention data. Progression pathways were opened to all with structured support: language classes funded for caregivers wanting supervisory roles; overseas qualifications reviewed for recognition; a mentoring programme pairing immigrant caregivers with supervisors; training allocated by need and tenure, not status. Two immigrant caregivers were promoted to supervisor within a year.
AFTER	The Monitor reviewed the review, the progression records, the training allocation data, and interviewed a newly promoted supervisor. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Calculate retention by immigrant status. Look at the result.
2. Look at who is in supervisory roles.
3. Open progression with language and qualification support.
4. Mentor immigrant caregivers toward supervision.

The most common mistake: Treating your most loyal workforce as temporary.

SELF-ASSESSMENT QUESTIONS

1. Does the service genuinely recognize immigrant caregivers' documented retention advantage, not overlook this real strength? — *Real, specific recognition of this documented pattern, not treated as incidental or unnoticed.*
Evidence: N/A — tested directly
2. Are employment practices genuinely supportive, not precarious in ways that undermine this real advantage? — *Real, stable employment practice, not conditions that create instability regardless of a caregiver's own commitment.*
Evidence: Employment practice review
3. Is this recognition reflected in genuine, practical support — benefits, advancement opportunities — not merely acknowledged in principle? — *Real, practical support, not recognition that remains only*

theoretical.

Evidence: Practical support documentation

COMMON REASONS FOR A PARTIAL ANSWER

- **Recognition exists informally but isn't reflected in specific, structural employment policy.** — Genuine, structural support provides more reliable benefit than informal acknowledgment alone.
- **Support exists for full-time immigrant caregivers but not consistently for those in part-time or contracted arrangements.** — Every immigrant caregiver contributing to genuine retention deserves the same recognition and support.
- **Practical support exists but hasn't been specifically evaluated to confirm it's genuinely improving retention outcomes.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current employment practices for genuine stability versus precariousness.
Week 2	Establish specific, structural recognition of immigrant caregivers' documented contribution.
Week 3	Build practical support extending to part-time and contracted caregivers, not full-time staff alone.
Ongoing	Evaluate whether practical support is genuinely improving retention outcomes.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Recognition interview	Asks leadership whether and how they specifically recognize this documented retention pattern.
DOCUMENT	Employment practice review	Reviews employment practices for genuine stability, not precarious conditions undermining retention.
DOCUMENT	Practical support review	Reviews whether recognition translates into genuine, practical support, not remaining theoretical.

SUPERVISOR TIPS

- **Ask leadership how they specifically recognize and support immigrant caregivers' documented retention contribution.** — A specific, thoughtful answer reveals genuine, active recognition, not incidental awareness.
- **Ask a caregiver whether they feel genuinely supported in stable, ongoing employment.** — A specific, honest answer reveals whether recognition translates into real, felt support.

EVIDENCE BASE

[41] Migrant direct care workers are documented in multiple countries as remaining in direct care positions longer than caregivers born in the country where they work, providing important workforce stability and continuity of care, establishing genuine recognition and support of this documented advantage as directly relevant to addressing the home care sector's broader turnover challenges.

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.

8.7 Legal Status Diversity Recognition for Clients

CORE

The service can name which legal status categories its clients actually represent — asylum seeker, recognised refugee, stateless person, and others — and demonstrates it doesn't apply a single, uniform assumption about access rights across all of them.

In plain terms: The agency can name which legal status groups its clients belong to — refugees, asylum seekers, undocumented, stateless — and knows what each is entitled to and what the agency's own policy is.

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

WHY THIS MATTERS

This is the home care version of hospital 9.10. Entitlement to publicly funded home care varies by legal status. An agency that does not know its clients' categories either turns away entitled people or serves un-entitled people without knowing it is unfunded. Knowing the categories, the entitlements, and the agency's own policy for those with no entitlement (a charity fund, a referral, a sliding scale) is the basis for consistent, fair, and financially sustainable practice — handled by the administrator, never as a barrier to care.

WHAT GOOD LOOKS LIKE

- Staff can name the specific legal status categories clients actually represent.
- Policy genuinely differentiates access considerations across status categories.
- A specific, defined process exists for verifying unclear status.

COMMON FAILURE MODES

- Staff have only a general sense that "migrants" are served, without specific categories.
- A single, uniform assumption about access rights is applied regardless of status.
- No process exists for verifying status when it's genuinely unclear.

WORKED EXAMPLE

IN PRACTICE

A 100-client agency in a city with a large mixed-status migrant population.

BEFORE

Intake staff did not know the entitlement rules. Some entitled refugees were turned away as 'not covered'; some clients were served for months before the agency discovered funding did not apply. No policy existed for un-entitled clients.

ACTION

The administrator obtained the entitlement rules by legal status from the funding authority. A one-page reference was created. The policy states: care is never withheld pending status; the administrator handles funding after care starts; clients with no entitlement are served via a charity fund or referred to NGO-funded care.

	Status is recorded only for funding purposes with consent, separately from the care record.
AFTER	The Monitor reviewed the entitlement reference, the policy, and 15 client files with funding status correctly recorded. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List the legal status categories in your area.
2. Find out what each is entitled to.
3. Write a policy for those with no entitlement.
4. Handle status separately from care.

The most common mistake: Turning away an entitled refugee because the intake worker did not know the rules.

SELF-ASSESSMENT QUESTIONS

1. Can staff name the specific legal status categories this service's clients actually represent? — *Specific, named categories, not a general sense that "migrants" are served.*

Evidence: N/A — tested directly

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

Evidence: Status-specific access policy documentation

3. Is there a specific process for verifying which category applies when it's genuinely unclear? — *A real, defined process, not guesswork or assumption when status is ambiguous.*

Evidence: Status verification process

COMMON REASONS FOR A PARTIAL ANSWER

- **Staff can name the most common category served but not less frequent ones the service still encounters.** — Even infrequent categories deserve genuine, specific awareness, not the risk of misapplied assumptions.
- **Differentiation exists in one staff member's own understanding but isn't shared with the wider caregiving team.** — Every caregiver interacting with clients benefits from the same genuine understanding.

- **A verification process exists but staff are inconsistently confident applying it.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current staff awareness of the specific legal status categories clients actually represent.
Week 2	Build specific, differentiated access guidance for each relevant status category.
Week 3	Establish a clear verification process for genuinely unclear status.
Ongoing	Refresh staff awareness periodically, particularly for less frequently encountered categories.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Status category awareness interview	Asks staff to name the specific legal status categories this service's clients actually represent.
DOCUMENT	Status-specific policy review	Reviews documentation for genuine differentiation across status categories, not a uniform assumption.
DOCUMENT	Verification process review	Reviews the process for verifying status when it's genuinely unclear.

SUPERVISOR TIPS

- **Ask staff to name every specific legal status category the service has served recently.** — Specificity reveals genuine, current awareness rather than a general assumption.
- **Ask what happens when a client's specific status is genuinely unclear.** — A confident, specific answer reveals a genuine process, not improvisation.

EVIDENCE BASE

[42] WHO's Competency Standards explicitly distinguish these legal status categories throughout, noting that access to health care and legal entitlements vary meaningfully by status and by country, and that health workers need specific awareness of this rather than a single generalised assumption.

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

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

NON-NEGOTIABLE

Care is provided and fully documented for every client regardless of immigration or legal status, with no differential standard of care, documentation practice, or record-keeping applied based on status — not a lesser or informal standard applied to a client without documented status.

In plain terms: Every client receives the same care and the same documentation regardless of immigration status — no lower standard, no incomplete record, no 'off the books.'

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

The principle is identical across facility types. An undocumented client cared for informally has no care plan, no supervision, no protection. A refugee given less because 'they won't complain' is discriminated against. Same care, same record, status not asked, funding separate.

WHAT GOOD LOOKS LIKE

- Care and documentation are genuinely consistent regardless of status.
- Staff are specifically trained on this principle, not assumed to understand it.
- Confidentiality protection is applied equally without

COMMON FAILURE MODES

- Care or documentation practice differs based on a client's known or assumed status.
- No specific training addresses this principle.
- Status-related information is handled less carefully

exception.

than other confidential information.

WORKED EXAMPLE

IN PRACTICE

A 120-client agency serving undocumented clients informally.

BEFORE	Undocumented clients were served by sympathetic caregivers without a care plan or agency record 'to protect them.' No supervision. No medication list. One client's deterioration went unnoticed for weeks.
ACTION	A written policy: every client is registered, assessed, planned, supervised, and documented identically; status is not asked; funding is the administrator's matter. All informally served clients were brought into the system. The agency's data practices were reviewed to ensure no pathway to immigration authorities.
AFTER	The Monitor reviewed the policy, the data review, and 10 records of previously informal clients now fully documented. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask: is every person we serve on our register with a care plan?
2. Write the policy.
3. Bring every client into the system.
4. Confirm your data does not reach immigration authorities.

The most common mistake: Protecting undocumented clients by not documenting them.

SELF-ASSESSMENT QUESTIONS

1. Is the same standard of care applied and documented the same way regardless of a client's immigration or legal status? — *Genuinely equal treatment, not a lesser or informal standard for undocumented*

clients.

Evidence: N/A — tested directly

2. Are staff specifically trained that immigration status is never a reason to withhold or alter care or documentation? — *Specific, documented training, not assumed understanding.*

Evidence: Staff training record

3. Is client information protected with the same confidentiality standard regardless of status, with no informal sharing of status-related information? — *The same confidentiality protection extended to every client, without exception.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **The principle is understood by caregivers but not consistently by administrative or scheduling staff.** — A client's first interaction is often with administrative staff, where the same principle needs to hold.
- **Care is consistent but documentation habits vary informally based on individual staff assumptions.** — Consistency needs to extend to documentation practice specifically, not only the clinical care itself.
- **The principle is followed but has never been specifically, formally trained.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current practice for any differential treatment based on status.
Week 2	Establish specific staff training on this principle, covering all staff, not only caregiving roles.
Week 3	Confirm documentation practice is genuinely consistent regardless of status.
Ongoing	Reinforce training periodically, particularly for new staff.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
OBSERVE	Care standard observation	Observes whether care and documentation practice is genuinely consistent regardless of client status.
DOCUMENT	Staff training review	Reviews training records confirming staff understand immigration status is never a basis for differential care.
ASK	Confidentiality practice interview	Asks staff how client status information, where known, is protected.

SUPERVISOR TIPS

- **Ask administrative staff, not only caregivers, about this principle.** — This reveals whether the principle genuinely extends beyond caregiving staff.
- **Ask how client status information, where it becomes known, is protected.** — A specific, confident answer reveals genuine practice, not just a stated value.

EVIDENCE BASE

[43] Equal standard of care and documentation regardless of immigration or legal status, without differential record-keeping practice, is established practice in international guidance on healthcare access for migrant and refugee populations.

[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.

Staff Reflective Practice and Bias

8.9 Awareness Extends to How Immigrant Caregivers Are Treated

CORE

Staff reflective practice and bias awareness genuinely extends to how immigrant caregivers themselves are treated by the organization, clients, and families — not limited to awareness of bias toward migrant clients alone,

given a caregiver can face genuine discrimination in the course of their own employment.

In plain terms: The agency's work on bias and reflection includes how immigrant caregivers themselves are treated — by clients, by colleagues, by managers — not only how clients are treated.

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

WHY THIS MATTERS

Bias runs in every direction. A client who refuses a caregiver because of their race. A colleague who mocks an accent. A manager who assumes the immigrant caregiver will accept worse shifts. The agency's reflective practice must include this: what do immigrant caregivers experience, from clients and from the organisation? How does the agency respond when a client is racist toward a caregiver? Is the caregiver's dignity protected as the client's is? A written response to client discrimination against staff, and a forum where immigrant caregivers can raise their experience, are the minimum.

WHAT GOOD LOOKS LIKE

- Bias awareness training genuinely covers discrimination toward immigrant caregivers themselves.
- A real, known reporting process exists for a caregiver experiencing this.
- The organization genuinely, actively supports a caregiver who reports this concern.

COMMON FAILURE MODES

- Bias awareness training addresses only bias toward clients, not caregivers.
- No known process exists for a caregiver to report discrimination they experience.
- A caregiver reporting this concern is left to manage the situation without organizational support.

WORKED EXAMPLE

IN PRACTICE

A 150-client agency with a majority immigrant workforce and no policy on discrimination against staff.

BEFORE	Caregivers reported clients refusing them on racial grounds, being called names, being treated as servants. The agency reassigned the caregiver and said nothing to the client. Caregivers felt the agency sided with clients. No forum existed.
ACTION	A policy on client discrimination against staff was written: the agency does not accept racial or ethnic refusal of a caregiver; the client is told this, and offered a conversation; persistent discrimination is grounds for ending service. A quarterly forum for immigrant caregivers to raise experiences with management was created. Reflective practice sessions include staff-directed bias. Managers were trained.
AFTER	The Monitor reviewed the policy, two cases where clients were addressed (one service ended), forum minutes, and interviewed two immigrant caregivers who described feeling backed. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask immigrant caregivers what they experience from clients and colleagues.
2. Write a policy: the agency does not accept discriminatory refusal of staff.
3. Create a forum for immigrant caregivers.
4. Add staff-directed bias to reflective practice.

The most common mistake: Quietly reassigning the caregiver when a client is racist — the caregiver learns the agency will not defend them.

SELF-ASSESSMENT QUESTIONS

1. Does bias awareness training address discrimination immigrant caregivers might experience? — *Real, specific coverage, not training*

focused only on bias toward clients.

Evidence: Bias awareness training content review

2. Is there a known process for a caregiver to report discrimination they experience? — *A real, accessible process, not an assumption a caregiver would simply tolerate this.*

Evidence: Caregiver discrimination reporting process

3. Does the organization genuinely support a caregiver who reports this concern? — *Real, active support, not a caregiver expected to resolve it alone.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Training mentions this direction of bias but doesn't provide specific, practical guidance for caregivers or supervisors.** — Concrete, practical guidance is what makes this awareness genuinely actionable, not acknowledgment alone.
- **A reporting process exists but caregivers report uncertainty about whether using it would be genuinely welcomed.** — Genuine psychological safety in using this process matters as much as the process technically existing.
- **Support exists for severe incidents but not for the more common, subtler forms of bias caregivers may experience.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current bias awareness training for genuine coverage of discrimination toward caregivers.
Week 2	Establish specific, practical guidance and a known reporting process for caregivers.
Week 3	Train supervisors on genuinely supporting a caregiver who reports this concern.
Ongoing	Extend genuine attention to subtler, more common forms of bias, not only severe incidents.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Training content review	Reviews bias awareness training for genuine coverage of discrimination toward immigrant caregivers.
DOCUMENT	Reporting process review	Reviews the specific, known process for a caregiver to report discrimination experienced.
ASK	Caregiver support interview	Asks a caregiver whether they would feel genuinely supported reporting this kind of concern.

SUPERVISOR TIPS

- **Ask a caregiver whether they would feel genuinely comfortable reporting discrimination from a client or family member.** — A specific, honest answer reveals genuine psychological safety, not an assumption a process alone is sufficient.
- **Ask a supervisor how they would specifically support a caregiver who raised this kind of concern.** — A specific, thoughtful answer reveals genuine, practical readiness, not a stated policy alone.

EVIDENCE BASE

[44] WHO Competency Standards 8 and 9 require structured awareness of bias and its impact, with genuine application of this principle extending to recognizing and addressing bias directed at immigrant workers within the care relationship itself, not limited to bias affecting migrant clients alone.

[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.

8.10 Continuity Across a Client's Relocation Is Actively Supported CORE

When a migrant or refugee client relocates, the service actively supports continuity of care — a portable, patient-held summary of care needs, active handover where a new provider is known — not treating relocation as an

automatic, unavoidable end to the caregiving relationship's accumulated understanding of the client.

In plain terms: When a migrant or refugee client moves, the agency helps their care continue — a portable summary, a handover to the next provider, a follow-up call — not 'we can't do anything once they leave.'

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

WHY THIS MATTERS

This is the home care version of PHC 8.8. Refugee and migrant clients move for housing, work, family, or status reasons. The care plan, medication list, and knowledge of the client's needs are valuable to whoever provides care next. Continuity support: a portable summary in the client's hand, in their language and the destination's; a handover to the next provider where known; the agency's contact number; a follow-up call for high-need clients. It cannot guarantee continuity; it makes it possible.

WHAT GOOD LOOKS LIKE

- The service actively supports continuity when a client relocates.
- A genuine, portable summary reflects real, accumulated understanding of the client.
- Active handover is genuinely attempted when a new provider becomes known.

COMMON FAILURE MODES

- Relocation is treated as an automatic, unavoidable end to continuity.
- Any summary provided is generic, not reflecting genuine accumulated understanding.
- No handover is attempted, even when a new provider is known.

WORKED EXAMPLE

IN PRACTICE

A 100-client agency serving refugee clients who relocated frequently.

BEFORE	When a client moved, service ended. No summary, no handover. A client with complex medication needs moved to another city; the new agency started from nothing; medications were missed for two weeks.
ACTION	A relocation protocol was written: any client indicating a move receives a portable care summary (needs, care plan, medication list, contacts) in their language and English; if the destination is known, the summary is sent to the local agency or NGO with consent; the agency's number is on the summary; high-need clients receive a follow-up call at two weeks. Community organisations help maintain contact.
AFTER	The Monitor reviewed 8 relocation cases with summaries issued and 5 with documented handovers; follow-up calls logged. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask what you gave the last client who moved. If nothing, that is the gap.
2. Create a portable care summary template.
3. Send it to the destination provider with consent.
4. Phone high-need clients at two weeks.

The most common mistake: Ending care at the door when the client leaves — the summary in their hand is the continuity.

SELF-ASSESSMENT QUESTIONS

1. Does the service actively support continuity when a client relocates, not treat relocation as an automatic end to continuity? — *Real, active support, not passive acceptance that continuity simply ends. Evidence: Relocation continuity support process*
2. Is a portable, client-held summary of care needs genuinely provided, capturing the accumulated understanding built over time? — *A real, usable summary reflecting genuine accumulated*

understanding, not a generic intake form.

Evidence: Portable care summary documentation

3. Where a new provider is known, is active handover genuinely attempted, not assumed impossible? — *A real, attempted handover, not an assumption that contact with a future provider isn't achievable.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **A summary is provided but isn't updated close to the point of relocation, quickly becoming outdated.** — A summary's real value depends on reflecting the client's genuinely current status at the time they carry it forward.
- **Handover is attempted when the new provider is known well in advance but not for sudden, unplanned relocations.** — Sudden relocation doesn't reduce a client's genuine need for continuity support.
- **Support exists in principle but staff aren't confident in how to actually provide a portable summary in practice.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current practice for genuine continuity support versus assumed end at relocation.
Week 2	Establish a standard, portable care summary format reflecting genuine accumulated understanding.
Week 3	Train staff on attempting genuine handover when a new provider becomes known.
Ongoing	Confirm summaries are updated close to the actual point of relocation.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Relocation support process review	Reviews the service's actual process for supporting continuity when a client relocates.
DOCUMENT	Portable summary review	Reviews whether clients genuinely receive a portable summary reflecting real, accumulated understanding.

Method	What	Detail
ASK	Handover attempt interview	Asks staff whether they've genuinely attempted handover to a new provider when one becomes known.

SUPERVISOR TIPS

- **Ask for a real, recent example of continuity support provided to a relocating client.** — A real example reveals whether this is genuine practice, not an assumed impossibility.
- **Ask to see an actual client-held summary and check how current and specific it genuinely is.** — A specific, current document is the real evidence of genuine support, not a stale or generic one.

EVIDENCE BASE

[45] Continuity of care as genuine infrastructure, distinct from an assumption that relocation automatically ends the possibility of continuity, is established practice for protecting health outcomes in mobile and displaced populations specifically.

[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 7 — Governance & Staffing**

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