

ASF STANDARDS · HOME CARE · STANDARD 9

Standard 9 — Sustainable Care

5 criteria · 0 core · 5 standard-level · Version 1.0 · Aligned to ISQua EEA
Principle 6, 6th Edition

CRITERIA IN THIS STANDARD

9.1 — Caregiver Travel Impact Is Genuinely Considered, Not Left Unexamined

9.2 — Single-Use Supplies in the Home Are Genuinely Minimised Where Clinically Safe

9.3 — Office and Administrative Operations Genuinely Consider Environmental Impact

9.4 — Caregivers Are Genuinely Engaged in Sustainability Practice

9.5 — Sustainability Commitments Are Genuinely Reviewed, Not Static

9.1 Caregiver Travel Impact Is Genuinely Considered, Not Left Unexamined STANDARD

The environmental impact of caregiver travel between client homes is genuinely considered in how visits are scheduled and routed — not left entirely unexamined simply because the provider has no central facility and travel is assumed to be an unavoidable cost of the service model.

In plain terms: The provider has actually thought about the travel caregivers do between homes, not just treated it as an unavoidable, unexamined cost of doing business.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A home care service’s travel footprint is genuinely concentrated in caregiver movement between homes, unlike a facility-based provider where most activity happens in one place. Genuine consideration of routing and scheduling is where real, meaningful impact reduction is actually achievable — and it often improves caregiver time and client continuity as a real side benefit.

WHAT GOOD LOOKS LIKE

- Travel is genuinely considered in scheduling.
- A real instance shows scheduling genuinely reducing travel.
- Personal-vehicle travel is genuinely factored in.

COMMON FAILURE MODES

- Scheduling is done purely by caregiver availability, with travel distance never genuinely considered.

WORKED EXAMPLE

IN PRACTICE	
<i>A provider whose scheduling ignored geography entirely.</i>	
BEFORE	Caregivers were assigned to clients purely by availability, sometimes resulting in long cross-town trips between consecutive visits.
ACTION	Scheduling software was configured to genuinely weight geographic proximity alongside availability.
AFTER	The Monitor reviewed scheduling data showing a real reduction in average inter-visit travel distance. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Review current scheduling practice for genuine geographic consideration.

The most common mistake: Scheduling purely by caregiver availability, with travel distance never genuinely factored in.

SELF-ASSESSMENT QUESTIONS

1. Is travel genuinely considered when scheduling visits? — *A real, considered approach.*

Evidence: Scheduling policy

2. Is there a real, documented instance of scheduling genuinely reducing travel? — *A concrete, real example.*

Evidence: Scheduling data

3. Is personal-vehicle travel genuinely factored into impact consideration? — *A real, considered inclusion.*

Evidence: Documented consideration

COMMON REASONS FOR A PARTIAL ANSWER

- **Geography is considered informally but not actually built into the scheduling process.**

IMPLEMENTATION PLAN

When	What
Week 1-2	Review and adjust scheduling to genuinely weight geographic proximity.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Scheduling data review	Reviews scheduling records for genuine geographic consideration.

SUPERVISOR TIPS

- **Ask a scheduler to explain how routing genuinely factors into their decisions.**

EVIDENCE BASE

Health Care Without Harm. Global Green and Healthy Hospitals Agenda. Reston: HCWH; 2020.

[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.

Single-Use Supplies in the Home Are

9.2 Genuinely Minimised Where Clinically Safe

STANDARD

The use of single-use supplies brought into the client's home is genuinely reviewed for opportunities to reduce waste where clinically safe to do so — not single-use treated as the unexamined default for every item regardless of genuine clinical necessity.

In plain terms: The provider has actually checked which single-use supplies are genuinely necessary versus just the unexamined default, and disposes of clinical waste from the home properly.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Clinical waste from home visits is genuinely easy to overlook since it doesn't accumulate visibly in one place the way facility waste does — each caregiver generates a small, dispersed stream across many separate homes. Genuine review ensures single-use items are used where clinically necessary, and disposed of properly rather than left to a client's ordinary household waste.

WHAT GOOD LOOKS LIKE

- Single-use practice has genuinely been reviewed.
- Clinical safety is genuinely maintained throughout.
- Clinical waste is genuinely collected and disposed of properly.

COMMON FAILURE MODES

- Clinical waste from home visits is left in the client's own household bin.

WORKED EXAMPLE

IN PRACTICE

A provider whose clinical waste disposal from homes was undefined.

BEFORE	Caregivers had no clear instruction on clinical waste disposal from client homes, and some was left in household bins.
ACTION	Caregivers were equipped with sealed containers to transport clinical waste back for proper disposal.
AFTER	The Monitor confirmed proper disposal records. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Establish a clear clinical waste transport and disposal protocol for home visits.

The most common mistake: Clinical waste from home visits genuinely left in the client's own household waste with no proper disposal protocol.

SELF-ASSESSMENT QUESTIONS

1. Has single-use supply practice been genuinely reviewed? — *A real, documented review.*
Evidence: *Supply review*
2. Is clinical safety genuinely protected throughout? — *Real, maintained safety.*
Evidence: *Clinical protocol*
3. Is clinical waste genuinely collected and disposed of properly? — *Real, proper disposal.*
Evidence: *Disposal protocol*

COMMON REASONS FOR A PARTIAL ANSWER

- A disposal protocol exists but isn't actually followed consistently by all caregivers.

IMPLEMENTATION PLAN

When	What
Week 1-2	Establish and distribute a clinical waste disposal protocol.

Method	What	Detail
ASK	Caregiver interview	Asks a caregiver to describe their actual waste disposal practice.

SUPERVISOR TIPS

- Ask specifically what happens to clinical waste after a home visit.

EVIDENCE BASE

World Health Organization. WHO Guidance for Climate-Resilient and Environmentally Sustainable Health Care Facilities. Geneva: WHO; 2020.

[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.

Office and Administrative Operations

9.3 Genuinely Consider Environmental Impact

STANDARD

The provider’s own administrative base — office energy use, paper records, equipment — genuinely factors in environmental impact, proportionate to its real scale, not sustainability treated as inapplicable simply because most service delivery happens in clients’ homes rather than a large facility.

In plain terms: Even though most care happens in homes, the provider’s own office operations still genuinely consider their real environmental footprint, sized appropriately to how big that office actually is.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A provider can genuinely overlook its own administrative footprint by focusing exclusively on home-based care delivery — but the office, paper records, and equipment still carry a real, if smaller, footprint

WHAT GOOD LOOKS LIKE

- The administrative base genuinely considers its footprint.
- Records genuinely minimise unnecessary paper use.
- Consideration is genuinely proportionate to real scale.

COMMON FAILURE MODES

- Sustainability is treated as entirely inapplicable because “most care happens in homes.”

WORKED EXAMPLE**IN PRACTICE**

A small office that had never considered its own footprint.

BEFORE

The office kept all client records on paper, with no genuine review of digital alternatives that would also support field access.

ACTION

A proportionate, genuine review introduced digital record-keeping for new clients, reducing both paper use and improving caregiver field access.

AFTER

The Monitor reviewed the transition plan. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Review the administrative base's own footprint proportionate to its real size.

The most common mistake: Assuming sustainability is entirely inapplicable because most care happens outside the office.

SELF-ASSESSMENT QUESTIONS

1. Does the administrative base genuinely consider its own impact?

— *A real, proportionate consideration.*

Evidence: Office practice review

2. Are client records genuinely managed to minimise unnecessary paper use? — *A real, considered balance.*
Evidence: Record-keeping practice

3. Is this consideration genuinely proportionate to real scale? — *A real, appropriately scaled approach.*
Evidence: Documented review

COMMON REASONS FOR A PARTIAL ANSWER

- Office practice has never actually been reviewed at all.

IMPLEMENTATION PLAN

When	What
Week 1-2	Review office practice proportionate to real scale.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Office review	Reviews documented consideration of office footprint.

SUPERVISOR TIPS

- Ask about this even for a very small office — the standard is proportionate, not absent.

EVIDENCE BASE

NHS England. Delivering a Net Zero National Health Service. London: NHS England; 2022.

[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.

9.4

Caregivers Are Genuinely Engaged in Sustainability Practice

STANDARD

Caregivers genuinely understand and participate in the provider's sustainability practices — not a policy known only to administrative staff with no real reach to a workforce that

spends most of its time in clients' homes rather than a shared office.

In plain terms: Caregivers actually know what the provider is doing to be more sustainable — not just the office staff who rarely see them.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Caregivers genuinely spend most of their working time away from any shared office, meaning communication designed for an in-person team easily misses them entirely. Genuine engagement requires deliberate, functioning outreach appropriate to a field-based workforce.

WHAT GOOD LOOKS LIKE

- Caregivers can genuinely describe a real practice.
- Caregiver input is genuinely sought.
- Communication genuinely reaches field-based caregivers.

COMMON FAILURE MODES

- Updates are posted only in the office, which caregivers rarely visit.

WORKED EXAMPLE

IN PRACTICE	
<i>A provider whose updates never reached field caregivers.</i>	
BEFORE	Sustainability updates were posted on an office noticeboard caregivers almost never saw.
ACTION	Updates were moved to the provider’s existing caregiver scheduling app, genuinely reaching the field workforce.
AFTER	The Monitor interviewed a caregiver who could describe a recent update. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

The most common mistake: Internal communication designed around an office setting that field caregivers genuinely never see.

SELF-ASSESSMENT QUESTIONS

1. Can caregivers describe a genuine sustainability practice? —

Real, demonstrated awareness.

Evidence: Caregiver interview

2. Is caregiver input genuinely sought? — *Real, two-way engagement.*

Evidence: Suggestion record

3. Does communication genuinely reach field caregivers? — *Real, functioning communication.*

Evidence: Field caregiver interview

COMMON REASONS FOR A PARTIAL ANSWER

- **Office staff are aware but field caregivers genuinely are not.**

IMPLEMENTATION PLAN

When	What
Week 1	Move communication to a channel that genuinely reaches field caregivers.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Caregiver interview	Asks a field caregiver to describe a specific practice.

SUPERVISOR TIPS

- **Interview a genuinely field-based caregiver, not office staff.**

EVIDENCE BASE

United Nations Environment Programme. Sustainable Healthcare Facilities Guidance. Nairobi: UNEP; 2022.

[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.

9.5

Sustainability Commitments Are Genuinely Reviewed, Not Static

STANDARD

The provider’s sustainability goals and practices are genuinely reviewed and updated as circumstances change — not a document written once and never genuinely examined for whether it still reflects actual practice.

In plain terms: The provider’s sustainability goals actually get revisited — not written once and left to go stale.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A document written once stops genuinely reflecting current practice as routing software, waste protocols, or the provider’s own scale change. Real, periodic review is what keeps the commitment meaningful.

WHAT GOOD LOOKS LIKE

- Goals are genuinely reviewed.
- A real revision instance exists.
- Responsibility is genuinely assigned.

COMMON FAILURE MODES

- A document was written once and never revisited.

WORKED EXAMPLE

IN PRACTICE	
<i>A provider whose sustainability statement predated its scheduling software upgrade.</i>	
BEFORE	The statement made no mention of routing improvements already in effect.
ACTION	A named person was assigned annual review responsibility.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Assign named review responsibility.

The most common mistake: A document nobody is specifically responsible for revisiting.

SELF-ASSESSMENT QUESTIONS

1. Are goals genuinely reviewed? — *A real, periodic review.*

Evidence: Review schedule

2. Is there a real revision instance? — *A concrete example.*

Evidence: Revision history

3. Is responsibility genuinely assigned? — *A real, named accountability.*

Evidence: Assigned responsibility documentation

COMMON REASONS FOR A PARTIAL ANSWER

- A schedule exists but hasn't been followed consistently.

IMPLEMENTATION PLAN

When	What
Week 1	Assign review responsibility and conduct the first review.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Revision history review	Reviews the document's revision history.

SUPERVISOR TIPS

- Ask who is specifically responsible for review.

EVIDENCE BASE

World Health Organization. Global Strategy on Digital Health 2020-2025. Geneva: WHO; 2021.

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

← Home Care Standards —
all standards

Self-assess against these
criteria →

Standard 10 — Digital Care
& AI →

ASF STANDARDS · HOME CARE · STANDARD 10

Standard 10 — Digital Care and Artificial Intelligence

5 criteria · 2 core · 3 standard-level · Version 1.0 · Aligned to ISQua EEA
Principle 7, 6th Edition

CRITERIA IN THIS STANDARD

- 10.1 — Digital Tools Are Genuinely Evaluated Before Adoption
- 10.2 — The Service Never Disadvantages a Client Who Cannot Engage With Digital Tools
- 10.3 — Family Members Have Genuine, Secure Access to Relevant Information
- 10.4 — AI-Assisted Monitoring Alerts Are Genuinely Validated, Not Trusted by Default
- 10.5 — Accountability for Digitally-Supported Care Decisions Is Explicitly Defined
- 10.6 — Clients Are Genuinely Informed When Their Care Involves AI

10.1

Digital Tools Are Genuinely Evaluated Before Adoption

STANDARD

Any digital tool used to support home care — scheduling systems, remote monitoring devices, caregiver check-in apps — is genuinely evaluated for reliability and appropriateness before adoption, not deployed on the

as assumption that any functioning app or device is automatically suitable for use in a client's home.

In plain terms: Before a new app or monitoring device goes into clients' homes, the provider has actually checked it works reliably there — not just assumed any functioning product is good enough.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A client's home has genuinely variable conditions — internet reliability, physical layout, a client's comfort with technology — that differ meaningfully from a controlled clinical environment. A tool that works well in a demonstration or a facility setting may not genuinely function the same way across the real diversity of client homes.

WHAT GOOD LOOKS LIKE

- A tool is genuinely evaluated before introduction.
- Evaluation genuinely considers the home setting specifically.
- A genuine reporting pathway exists for malfunction.

COMMON FAILURE MODES

- A tool is adopted based on vendor claims alone, with no genuine real-world testing in actual homes.

WORKED EXAMPLE

IN PRACTICE

A provider considering a new fall-detection sensor.

BEFORE	The vendor's demonstration was taken as sufficient evidence of reliability, with no genuine testing in actual client homes with varying internet connectivity.
ACTION	A pilot was run in five genuinely varied client homes before wider rollout, surfacing a

AFTER

The Monitor reviewed the pilot results and resulting adjustment. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Pilot any new digital tool in a genuinely varied sample of actual client homes before full rollout.

The most common mistake: Relying on a vendor's demonstration alone, without genuine testing in actual, varied home conditions.

SELF-ASSESSMENT QUESTIONS

1. Is a tool genuinely evaluated before introduction? — *A real, documented evaluation.*

Evidence: Evaluation record

2. Does evaluation genuinely consider the home setting specifically? — *A real, setting-specific consideration.*

Evidence: Pilot results

3. Is there a genuine process to report a malfunctioning tool? — *A real, usable feedback pathway.*

Evidence: Reporting protocol

COMMON REASONS FOR A PARTIAL ANSWER

- **Evaluation happened but wasn't genuinely tested across varied home conditions.**

IMPLEMENTATION PLAN

When	What
Before any rollout	Pilot in a genuinely varied sample of client homes.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Pilot review	Reviews pilot results and any resulting adjustment.

- **Ask whether any tool was ever genuinely tested across varied home conditions before rollout.**

EVIDENCE BASE

World Health Organization. Global Strategy on Digital Health 2020-2025. Geneva: WHO; 2021.

[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.

10.2 The Service Never Disadvantages a Client Who Cannot Engage With Digital Tools CORE

A client who cannot or does not want to engage with digital monitoring tools, apps, or portals — common among the elderly or isolated clients this service often serves — genuinely receives the same quality of care as one who does, with no digital requirement ever becoming a real barrier to appropriate home care.

In plain terms: A client who can't or doesn't want to use apps or digital monitoring still genuinely gets the same quality of care — digital tools support care but never become a real condition of receiving it.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

This is marked Core because home care genuinely, disproportionately serves elderly and isolated clients — a population genuinely more likely to face real digital access or comfort barriers than the general public. A service that lets digital tools become, even unintentionally, a real condition of quality care risks excluding exactly the population it most needs to serve well.

WHAT GOOD LOOKS LIKE

COMMON FAILURE MODES

- Care is genuinely equivalent regardless of digital engagement.
- Caregivers are genuinely trained to identify digital limitations.
- A real, documented instance shows genuine adaptation.

- A client without a smartphone genuinely receives a reduced or delayed version of the service.

WORKED EXAMPLE

IN PRACTICE

A client without a smartphone or reliable internet.

BEFORE	The provider's care update system relied on a client-facing app, which this client simply could not use, genuinely leaving them less informed than other clients.
ACTION	A parallel phone-call update process was established for this client, genuinely equivalent to the app-based updates others received.
AFTER	The Monitor confirmed the client genuinely received equivalent information. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Identify every client currently relying on a digital tool for information, and confirm a genuine non-digital equivalent exists.

The most common mistake: A digital update channel treated as the default, with no genuine equivalent for clients who can't use it.

SELF-ASSESSMENT QUESTIONS

1. Does a client unable to engage digitally genuinely receive equivalent care? — *Real, equivalent care.*

Evidence: Care records comparison

2. Are caregivers genuinely trained to identify and accommodate digital limitations? — *Real, specific staff awareness.*
Evidence: Training record

3. Is there a real, documented instance of care genuinely adapted for such a client? — *A real, concrete example.*
Evidence: Adaptation record

COMMON REASONS FOR A PARTIAL ANSWER

- A non-digital equivalent exists in theory but isn’t actually offered proactively.

IMPLEMENTATION PLAN

When	What
Week 1-2	Identify affected clients and establish genuine non-digital equivalents.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Care records comparison	Compares records for a digitally-engaged and non-digitally-engaged client.

SUPERVISOR TIPS

- Ask about a specific client known not to use digital tools and review their actual care record.

EVIDENCE BASE

World Health Organization. Global Strategy on Digital Health 2020-2025. Geneva: WHO; 2021.

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.

10.3

Family Members Have Genuine,
Secure Access to Relevant Information

STANDARD

Where digital tools allow family members to view care updates or monitoring data, access is genuinely secure and genuinely limited to what the client has actually consented

appropriate for every family member regardless of the client’s own wishes.

In plain terms: Family members only see what the client has actually agreed to share with them — not everything by default — and that access is genuinely secure.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Family involvement in home care is genuinely valuable and common, but a client’s own wishes about what to share — and with whom — deserve genuine respect, not an assumed blanket arrangement. Family dynamics genuinely vary, and a client may want to share different information with different family members, or none at all with some.

WHAT GOOD LOOKS LIKE

- Family access is genuinely secure.
- Access is genuinely limited to actual client consent.
- The client can genuinely revise or withdraw access.

COMMON FAILURE MODES

- All listed family members are given full access by default, with no genuine client-level consent step.

WORKED EXAMPLE

IN PRACTICE	
A provider whose family portal access was granted by default.	
BEFORE	Any family member listed as an emergency contact automatically received full portal access, with no genuine, separate consent step from the client.
ACTION	A genuine, explicit consent step was added, allowing the client to specify what each family member could see.

The Monitor reviewed the consent records.
Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Add an explicit, client-level consent step for family portal access.

The most common mistake: Treating emergency-contact status as equivalent to genuine consent for full information access.

SELF-ASSESSMENT QUESTIONS

1. Is family access genuinely secure? — *Real, verified security.*

Evidence: Security review

2. Is this access genuinely limited to actual client consent? — *A real, client-driven consent basis.*

Evidence: Consent records

3. Can the client genuinely revise or withdraw access? — *A real, usable mechanism.*

Evidence: Access revision process

COMMON REASONS FOR A PARTIAL ANSWER

- **Consent is collected once at intake but can't actually be revised later.**

IMPLEMENTATION PLAN

When	What
Week 1-2	Build explicit, revisable client consent for family access.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Consent record review	Reviews consent records for genuine, client-specific scope.

SUPERVISOR TIPS

- **Ask whether a client has ever genuinely limited or withdrawn a family member's access.**

[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.

10.4

AI-Assisted Monitoring Alerts Are Genuinely Validated, Not Trusted by Default

STANDARD

Where an AI-assisted monitoring system (such as a fall-detection sensor) generates an alert, there is a genuine process for appropriate human validation and response — not an automated alert trusted and acted on, or dismissed, with no real human judgement genuinely involved.

In plain terms: When a sensor or AI system flags something — like a possible fall — a real person actually checks and decides what to do, rather than the alert being blindly trusted or blindly ignored.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

AI-assisted monitoring in a client’s home — often unsupervised by clinical staff for long stretches — carries genuinely real stakes if an alert is wrongly dismissed as a false positive, or if a false positive leads to unnecessary, distressing intervention. Genuine human validation is what keeps this technology a support to good judgement rather than a replacement for it.

WHAT GOOD LOOKS LIKE

- A genuine human validation process exists.
- Alert accuracy is genuinely tracked.

COMMON FAILURE MODES

- Alerts trigger an automatic call-out with no genuine human review of the alert’s plausibility first.

WORKED EXAMPLE

IN PRACTICE

A provider using a fall-detection sensor with a high false-positive rate.

BEFORE

Every alert triggered an automatic emergency call-out, with no genuine tracking of how many were false positives, causing real, repeated distress to the client.

ACTION

A brief human review step was added — a call to the client or a check of a secondary indicator — before escalation, and false-positive rates began being genuinely tracked.

AFTER

The Monitor reviewed the tracked accuracy data showing a genuine reduction in unnecessary escalations. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Add a brief human validation step before any AI-triggered alert escalates.

The most common mistake: Automatic escalation with no genuine human check, leading to repeated, distressing false alarms.

SELF-ASSESSMENT QUESTIONS

1. Is there a genuine human validation process for an alert? — *Real, genuine human involvement.*

Evidence: Alert response protocol

2. Is alert accuracy genuinely tracked, including false positives and false negatives? — *A real, ongoing accuracy review.*

Evidence: Accuracy data

catching an unreliable alert? — *A real, concrete example.*

Evidence: Incident record

COMMON REASONS FOR A PARTIAL ANSWER

- A human validation step exists but false-positive rates aren't actually tracked over time.

IMPLEMENTATION PLAN

When	What
Week 1-2	Build a human validation step and begin tracking alert accuracy.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Accuracy data review	Reviews tracked alert accuracy over time.

SUPERVISOR TIPS

- **Ask what actually happens in the seconds after an alert fires, step by step.**

EVIDENCE BASE

US Food and Drug Administration. Artificial Intelligence and Machine Learning in Software as a Medical Device. Silver Spring: FDA; 2023.

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.

10.5 Accountability for Digitally-Supported Care Decisions Is Explicitly Defined

CORE

The provider has genuinely considered and documented accountability for care decisions informed by digital monitoring or AI-assisted tools — who is responsible when a tool fails or misleads — not leaving this as an unexamined question until an actual incident forces an

physically present to intervene.

In plain terms: Everyone knows, in advance, who's actually responsible if a monitoring tool fails or misleads — especially important since there's no clinical team on-site in the client's home to step in.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

This is marked Core because the absence of on-site clinical staff in a client's home genuinely raises the stakes of a digital tool's failure — there is no physically present team to immediately recognise and correct a problem the way there might be in a facility. Explicit, documented accountability is what ensures a real, prompt response rather than confusion about who is actually responsible when something goes wrong.

WHAT GOOD LOOKS LIKE

- Accountability is explicitly documented.
- Caregivers genuinely understand their own accountability.
- A defined process exists for reviewing accountability in an incident.

COMMON FAILURE MODES

- Accountability has never been genuinely examined until an actual incident forces the question.

WORKED EXAMPLE

IN PRACTICE

A provider whose monitoring tool failed to alert on a genuine fall.

BEFORE

Accountability for a tool failure had never been explicitly documented, leaving real confusion about responsibility when the incident was reviewed.

ACTION A clear policy was developed explicitly confirming the caregiver's and provider's own accountability for a tool's failure, alongside any vendor liability.

AFTER The Monitor reviewed the policy and interviewed a caregiver who could clearly describe their own accountability. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Document accountability for digitally-supported care decisions explicitly, before an incident forces the question.

The most common mistake: Leaving accountability genuinely unexamined until an actual incident forces an answer under pressure.

SELF-ASSESSMENT QUESTIONS

1. Is accountability for a digitally-supported care decision explicitly documented? — *A real, clear answer.*

Evidence: Documented accountability policy

2. Do caregivers genuinely understand their own accountability? —

Real, demonstrated understanding.

Evidence: Staff interview

3. Is there a defined process for reviewing accountability in a safety incident? — *A real, usable process.*

Evidence: Incident review protocol

COMMON REASONS FOR A PARTIAL ANSWER

- A policy exists but caregivers genuinely haven't been told about it.

IMPLEMENTATION PLAN

When	What
Week 1-2	Document accountability explicitly and communicate it to all caregivers.

Method	What	Detail
ASK	Staff interview	Asks a caregiver to describe their accountability for a digital tool's output.

SUPERVISOR TIPS

- Ask a caregiver directly: “If the sensor missed a real fall, who’s responsible?”

EVIDENCE BASE

European Commission. Ethics Guidelines for Trustworthy Artificial Intelligence. Brussels: European Commission; 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.

10.6

Clients Are Genuinely Informed When Their Care Involves AI

STANDARD

A client whose care involves an aspect delivered with AI-assisted support is genuinely informed of this — not left to assume every decision was made by their caregiver alone, with disclosure treated as optional rather than a genuine, standard part of informed home care.

In plain terms: If AI is actually involved in part of a client’s care — a fall-detection sensor, for instance — the client or their family genuinely knows this, not left to assume everything is purely caregiver-monitored.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A client's or family's genuine right to understand care includes knowing, in plain terms, when an AI-assisted monitoring tool is actually part of the care arrangement rather than purely human observation. This is especially relevant in home care, where AI-assisted monitoring

often runs continuously and unseen in the background — easy for a client or family to never genuinely realise is there at all unless actively disclosed.

WHAT GOOD LOOKS LIKE • Clients and families are genuinely informed when AI is involved in care. • Disclosure is genuinely understandable, in plain language. • A client or family member can genuinely confirm they were told.	COMMON FAILURE MODES • AI-assisted monitoring runs in the background with no genuine disclosure ever made to the client or family.
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WORKED EXAMPLE

IN PRACTICE <i>A provider using an AI-assisted fall-detection sensor in a client's home.</i>	
BEFORE	The sensor's role was mentioned only in a lengthy general service agreement, which the family signed without genuine awareness that an AI tool was actually monitoring their relative.
ACTION	A brief, plain-language conversation at the start of care now explains: "A sensor helps alert your caregiver to a possible fall; your caregiver always checks before responding."
AFTER	The Monitor interviewed a family member who could genuinely confirm they understood AI was involved. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Add a brief, plain-language disclosure point at the start of care for any AI-assisted monitoring in use.

The most common mistake: AI-assisted monitoring that runs continuously with no genuine disclosure ever actually reaching the

SELF-ASSESSMENT QUESTIONS

1. Is a client (or family, where the client cannot meaningfully participate) genuinely informed when AI-assisted monitoring is part of their care? — *Real, standard disclosure.*

Evidence: Disclosure protocol

2. Is this disclosure genuinely understandable, not buried in a general service agreement? — *A real, plain-language explanation.*

Evidence: Service agreement wording

3. Can a client or family member asked directly confirm they were genuinely told? — *A real, concrete confirmation.*

Evidence: Family interview

COMMON REASONS FOR A PARTIAL ANSWER

- **Disclosure exists in the service agreement but families genuinely cannot recall or explain it when asked directly.**

IMPLEMENTATION PLAN

When	What
Week 1-2	Draft plain-language disclosure wording for the care start conversation and train caregivers to deliver it.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Family interview	Asks a family member whether they were genuinely told AI was involved in their relative's care.

SUPERVISOR TIPS

- **Ask a family member directly rather than relying on the service agreement's existence alone.**

EVIDENCE BASE

World Health Organization. Ethics and Governance of Artificial Intelligence for Health: Guidance on Large Multi-Modal Models. Geneva: WHO; 2024.

[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 9 — Sustainable
Care**

**Standard 11 — Supporting
the Care Workforce** →

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ASF STANDARDS · HOME CARE · STANDARD 11

Standard 11 — Supporting the Care Workforce

5 criteria · 1 core · 4 standard-level · Version 1.0 · Aligned to ISQua EEA
Principle 8, 6th Edition

Caregiver screening is addressed in Standard 2, and physical safety in the home environment in Standard 5. This standard addresses the additional workforce-support dimensions genuinely distinct to a field-based caregiver working alone across many separate homes.

CRITERIA IN THIS STANDARD

11.1 — Ongoing Competency Is Genuinely, Regularly Evaluated

11.2 — Caregivers Have Genuine Access to Ongoing Education and Peer Connection

11.3 — Caregiver Wellbeing and Isolation Risk Are Genuinely Monitored

11.4 — Workplace Issues Raised by Caregivers Are Genuinely Investigated and Resolved

11.5 — Caregiver Feedback Is Genuinely Gathered and Acted On

11.6 — Equality, Diversity and Inclusion Across the Workforce Are Genuinely Monitored

11.1 Ongoing Competency Is Genuinely, Regularly Evaluated

CORE

The continued caregiving competency of every caregiver is genuinely, regularly evaluated through direct observation in the home setting — not assumed to remain adequate indefinitely once initial screening under Standard 2 is complete, with no caregiver genuinely observed delivering care again afterward.

In plain terms: Caregiver skill keeps getting genuinely checked through real, direct observation in the home — not just assumed fine after the initial hiring process.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A caregiver working alone in a client's home has genuinely no colleague present to notice a developing skill gap or a drift from best practice — unlike a facility setting where a colleague might naturally observe and flag an issue. This is marked Core because real, direct, in-home observation is often the only genuine mechanism that can actually catch a problem before it affects client safety.

WHAT GOOD LOOKS LIKE

- Competency is genuinely evaluated on a real schedule.
- Evaluation genuinely includes direct, in-home observation.
- A genuine gap triggers a real response.

COMMON FAILURE MODES

- Evaluation relies entirely on self-report or a classroom-based refresher, with no genuine in-home observation.

WORKED EXAMPLE

IN PRACTICE

A provider whose evaluation never included in-home observation.

BEFORE	Annual competency reviews were conducted entirely through a written questionnaire, with no caregiver genuinely observed delivering actual care since initial screening.
ACTION	A supervisor-accompanied home visit was introduced annually for every caregiver, with consent from the client.
AFTER	The Monitor reviewed a recent accompanied visit record. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

- 1. Introduce an annual, consented, supervisor-accompanied home visit for every caregiver.

The most common mistake: Relying on written self-assessment alone, with no genuine direct observation of actual in-home practice.

SELF-ASSESSMENT QUESTIONS

- 1. Is ongoing competency genuinely evaluated on a real schedule?
— *A real, periodic evaluation.*
Evidence: Evaluation records
- 2. Does this genuinely include direct, in-home observation? — *A real, setting-specific evaluation.*
Evidence: Accompanied visit records
- 3. When a genuine gap is identified, is there a real, defined response? — *A genuine corrective process.*
Evidence: Correction record

COMMON REASONS FOR A PARTIAL ANSWER

- Direct observation happens at hire but is never genuinely repeated afterward.

IMPLEMENTATION PLAN

When	What
Week 1-2	Build a consented, supervisor-accompanied visit protocol.

Method	What	Detail
DOCUMENT	Evaluation record review	Reviews records for genuine, recent direct observation.

SUPERVISOR TIPS

- **Ask when a given caregiver was last genuinely, directly observed delivering care, by name.**

EVIDENCE BASE

Institute of Medicine. Health Professions Education: A Bridge to Quality. Washington DC: National Academies Press; 2003.

[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.

11.2 Caregivers Have Genuine Access to Ongoing Education and Peer Connection

STANDARD

Every caregiver has genuine access to ongoing education and, specifically, genuine opportunities for peer connection and consultation — which a workforce that spends its entire working day alone in separate client homes can easily lack compared to colleagues who work alongside each other daily in a shared facility.

In plain terms: Caregivers can actually keep learning and genuinely connect with peers — something that doesn't happen naturally when everyone works alone, in separate homes, all day.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A facility-based caregiver naturally has colleagues nearby to ask a quick question or discuss a difficult case; a home care caregiver spends the entire day alone with a single client, with no such natural

WHAT GOOD LOOKS LIKE

- Genuine, ongoing access to education beyond onboarding.
- Real, structured peer consultation opportunities exist.
- A caregiver can describe a real opportunity taken.

COMMON FAILURE MODES

- Education is purely individual online modules, with no genuine peer connection ever built in.

WORKED EXAMPLE

IN PRACTICE

A provider whose caregivers had no genuine peer connection.

BEFORE

Education consisted entirely of individual online modules, with caregivers having no structured way to discuss challenging client situations with colleagues.

ACTION

A monthly in-person or virtual case discussion session was introduced, genuinely scheduled to accommodate field caregivers' varied hours.

AFTER

The Monitor interviewed a caregiver who described genuine value from a recent session. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Introduce a regular, structured peer case discussion session.

The most common mistake: Treating individual online courses as a complete substitute for genuine peer connection.

SELF-ASSESSMENT QUESTIONS

1. Does every caregiver have genuine, ongoing access to education? — *Real, continuing access.*

2. Are genuine peer consultation opportunities offered? — *Real, structured peer connection.*

Evidence: Case discussion schedule

3. Can a caregiver describe a genuine opportunity taken in the past year? — *A real, specific example.*

Evidence: Staff interview

COMMON REASONS FOR A PARTIAL ANSWER

- A peer session exists but attendance is genuinely low due to scheduling exclusion.

IMPLEMENTATION PLAN

When	What
Week 1-2	Introduce a regular, accessibly-scheduled peer session.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Staff interview	Asks a caregiver to describe a genuine peer connection opportunity.

SUPERVISOR TIPS

- Ask about actual attendance at peer sessions, not just their existence.

EVIDENCE BASE

World Health Organization. Global Strategy on Human Resources for Health: Workforce 2030. Geneva: WHO; 2016.

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

11.3 Caregiver Wellbeing and Isolation Risk Are Genuinely Monitored STANDARD

The provider genuinely monitors for the real wellbeing and professional isolation risk distinct to solo, in-home

caregiving — a caregiver spending each day alone with a single client, often with emotionally demanding work and no colleague present, faces genuinely different wellbeing risks than one working in a shared team setting, not treated identically to facility-based workforce wellbeing.

In plain terms: The provider actually pays attention to the real emotional weight and isolation of spending all day, alone, with one client — not treating this the same as a team-based job.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Solo, in-home caregiving is genuinely emotionally demanding work — a caregiver may be present for a client’s decline, grief, or difficult family dynamics, entirely alone, with no colleague to immediately debrief with. This real, distinct isolation risk deserves genuine, specific attention rather than a generic wellbeing policy copied from a facility setting.

WHAT GOOD LOOKS LIKE

- Isolation risk is genuinely, specifically considered.
- Real, regular check-ins happen beyond clinical/scheduling matters.
- A caregiver can describe a real instance where this made a difference.

COMMON FAILURE MODES

- Check-ins, if they happen, cover only scheduling and caseload, never genuine personal wellbeing.

WORKED EXAMPLE

IN PRACTICE

A provider with no genuine wellbeing check-in process.

BEFORE

Supervisor contact was limited to scheduling confirmations, with no real space for a caregiver to raise genuine emotional strain after a difficult client situation.

ACTION

A separate, explicitly wellbeing-focused check-in was introduced monthly, distinct from scheduling calls.

AFTER

The Monitor interviewed a caregiver who described the monthly check-in as genuinely valuable after a difficult period with a client. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Introduce a wellbeing-specific check-in, separate from scheduling contact.

The most common mistake: Treating scheduling contact as equivalent to genuine attention to emotional wellbeing and isolation.

SELF-ASSESSMENT QUESTIONS

1. Does the provider genuinely consider isolation risk specific to solo caregiving? — *A real, setting-specific consideration.*

Evidence: Wellbeing policy

2. Are genuine, regular check-ins conducted beyond clinical or scheduling matters? — *Real, human contact.*

Evidence: Check-in schedule

3. Can a caregiver describe a real instance where this genuinely made a difference? — *A real, concrete example.*

Evidence: Staff interview

COMMON REASONS FOR A PARTIAL ANSWER

- Check-ins happen but genuinely never move beyond scheduling and caseload.

When	What
Week 1-2	Introduce a wellbeing-specific check-in.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Staff interview	Asks a caregiver about genuine wellbeing check-in content.

SUPERVISOR TIPS

- **Ask whether check-ins ever actually move beyond scheduling and caseload.**

EVIDENCE BASE

World Health Organization. Health Worker Safety Charter. Geneva: WHO; 2020.

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

Workplace Issues Raised by Caregivers

11.4 Are Genuinely Investigated and Resolved

STANDARD

A genuine process exists for investigating and resolving workplace issues raised by caregivers — including whistleblowing concerns and concerns about a specific client's household — with real protection from adverse treatment, not a grievance process that exists on paper with no real follow-through, which a dispersed, home-based workforce may have genuinely less visibility into than colleagues at a shared site.

In plain terms: When caregivers raise a concern — including about something happening in a specific client's home — it actually gets looked into, and they're genuinely protected.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Home caregivers genuinely face a distinct kind of workplace concern — an uncomfortable dynamic in a specific client’s household, for instance — that a facility-based grievance process may not have been designed with in mind. A genuinely accessible, dispersed-workforce-appropriate process is what ensures these real concerns actually surface and get addressed.

WHAT GOOD LOOKS LIKE

- A genuine, accessible process exists, reaching dispersed caregivers.
- Real evidence of genuine resolution.
- Genuine protection from adverse treatment.

COMMON FAILURE MODES

- The process exists but caregivers were never actually told about it during onboarding.

WORKED EXAMPLE

IN PRACTICE

A provider whose grievance process was undocumented for caregivers.

BEFORE	The grievance process was outlined in a handbook given at an in-person orientation, but caregivers onboarded remotely had never received it.
ACTION	The process was added to onboarding materials every caregiver genuinely receives, with a specific example of a household-dynamic concern.
AFTER	The Monitor interviewed a caregiver who could correctly describe the process. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

The most common mistake: A process documented in materials that genuinely never reach every onboarded caregiver.

SELF-ASSESSMENT QUESTIONS

1. Is there a genuine, accessible process reaching all caregivers? —

A real, known process.

Evidence: Process documentation

2. Is there real evidence of genuine resolution? — *Genuine follow-through.*

Evidence: Resolution log

3. Are caregivers genuinely protected from adverse treatment? —

Real, demonstrated protection.

Evidence: Staff interview

COMMON REASONS FOR A PARTIAL ANSWER

- **The process exists in materials some caregivers genuinely never saw.**

IMPLEMENTATION PLAN

When	What
Week 1	Confirm all onboarding materials genuinely include the reporting process.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Staff interview	Asks a caregiver to describe the reporting process.

SUPERVISOR TIPS

- **Ask specifically about a household-related concern — is there a real, known path to raise one?**

EVIDENCE BASE

International Labour Organization. Violence and Harassment Convention, 2019 (No. 190). Geneva: ILO; 2019.

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11.5 Caregiver Feedback Is Genuinely Gathered and Acted On

STANDARD

The provider has a genuine, systematic approach to gathering feedback from its caregiver workforce, with real analysis and a genuine, implemented response — not feedback collected occasionally with no real pattern of actual improvement, particularly important given the genuine absence of informal, in-person feedback moments a dispersed, home-based workforce naturally lacks.

In plain terms: Caregivers get genuinely asked how working here actually is, and real changes happen as a result — this can't rely on hallway conversations that simply don't happen when staff work alone, across many homes.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A facility naturally generates informal feedback moments that simply don't occur when a workforce spends its entire day alone, across separate homes. A provider relying on informal signals alone, without a genuine, structured feedback process, is effectively collecting no real feedback from its caregiver workforce at all.

WHAT GOOD LOOKS LIKE

- Feedback is genuinely gathered systematically.
- Feedback is genuinely analysed.
- A documented instance shows a genuine, implemented change.

COMMON FAILURE MODES

- The provider relies on informal signals that simply don't exist for a dispersed, home-based workforce.

IN PRACTICE

A provider with no structured feedback process for its caregivers.

BEFORE

Leadership believed they had a good sense of caregiver sentiment, based on informal interactions that, with a fully dispersed workforce, essentially never occurred.

ACTION

A quarterly structured survey was introduced, revealing genuine concerns about travel time between visits that had never previously surfaced.

AFTER

The Monitor reviewed the survey results and the resulting scheduling adjustment. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Introduce a structured, quarterly feedback survey.

The most common mistake: Assuming informal awareness of caregiver sentiment that, in a genuinely dispersed workforce, doesn't actually exist.

SELF-ASSESSMENT QUESTIONS

1. Is feedback genuinely gathered on a systematic, recurring basis?

— *Real, ongoing collection.*

Evidence: Survey records

2. Is collected feedback genuinely analysed? — *A real, documented analysis.*

Evidence: Analysis notes

3. Is there a documented instance of feedback genuinely leading to a change? — *A real, concrete example.*

Evidence: Change record

COMMON REASONS FOR A PARTIAL ANSWER

- A survey exists but results are never actually shared back or acted on.

When	What
Week 1-2	Design and launch a structured feedback survey.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Survey review	Reviews survey results and resulting changes.

SUPERVISOR TIPS

- Ask for a specific example of a change made because of feedback.

EVIDENCE BASE

NHS England. NHS Staff Survey National Results. Leeds: NHS England; 2023.

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

Equality, Diversity and Inclusion

11.6 Across the Workforce Are Genuinely Monitored

STANDARD

The provider genuinely monitors and responds to real patterns of equity across recruitment, work allocation, scheduling, and promotion — including across a genuinely dispersed, home-based caregiver workforce — not an assumption that fair treatment exists simply because no formal complaint has been raised.

In plain terms: The provider actually looks at real patterns — who gets hired, which clients or hours people get, who gets promoted — not just assuming things are fair because nobody has formally complained.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

Inequity in recruitment, client assignment, or promotion can genuinely persist for years without a single formal complaint — people often don't report a pattern they can't fully see themselves, or don't trust reporting to change anything. This genuinely matters more, not less, for a dispersed, home-based caregiver workforce that already has less natural visibility into organisational patterns than a co-located team. Genuine, proactive monitoring of real workforce data is what actually surfaces a pattern that individual complaints alone would likely never reveal.

WHAT GOOD LOOKS LIKE

- Workforce data is genuinely monitored for patterns.
- A genuine pattern triggers a real response.
- A real instance shows monitoring informing a change.

COMMON FAILURE MODES

- No formal complaint has been raised, so the provider genuinely assumes no issue exists, with no actual data ever reviewed.

WORKED EXAMPLE

IN PRACTICE	
<i>A provider that had never reviewed its own client-assignment data across caregivers.</i>	
BEFORE	Client assignments were managed informally with no genuine review of whether certain caregivers consistently received more difficult or lower-paying assignments.
ACTION	A quarterly equity review was introduced, which identified and corrected a genuine, unintentional pattern.
AFTER	The Monitor reviewed the review documentation and the resulting correction. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

The most common mistake: Assuming fairness exists because no one has formally complained, with no actual data ever reviewed.

SELF-ASSESSMENT QUESTIONS

1. Is workforce data genuinely monitored for patterns of inequity? —

A real, documented monitoring process.

Evidence: Monitoring protocol

2. Where a genuine pattern is identified, is there a real, defined response? — *A genuine corrective process.*

Evidence: Response record

3. Is there a real, documented instance of this genuinely informing a change? — *A concrete, real example.*

Evidence: Change record

COMMON REASONS FOR A PARTIAL ANSWER

- **Data exists but has genuinely never been reviewed specifically for equity patterns among dispersed caregivers.**

IMPLEMENTATION PLAN

When	What
Week 1-2	Introduce a quarterly equity review of recruitment, client assignment, and promotion data.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Equity review record	Reviews the monitoring data and any resulting corrective action.

SUPERVISOR TIPS

- **Ask to see the actual data behind the last equity review, including dispersed caregivers specifically.**

World Health Organization. Gender Equity and Human Rights in the Health Workforce. 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 10 — Digital Care & AI**